May 24, 2016

Dear Commission Members,

The June Commission meeting has historically been reserved for reflection and planning for the upcoming fiscal year. On June 1, 2016 the Commission members will convene at the THINK Together Conference Center for a special meeting and presentation by the Bridgespan Group on their recent assessment of the Commission.

The Bridgespan Group initially conducted a comprehensive assessment of the Commission's goals, investments, and evaluation processes in 2008. Since that time, funding strategies and programs were adjusted to focus on children most in need. About 30 percent of the Commission's resources are currently allocated to high-impact early learning initiatives. Significant strides have also been made to shift toward a catalytic funding approach. In addition, a stronger set of outcome measures were developed, including the implementation of the Early Development Index (EDI) kindergarten readiness assessment for children across Orange County.

Bridgespan's recent assessment that was completed this month recognizes the practices, competencies and relationships that have been developed to improve children's outcomes. Mike Perigo, head of Bridgespan's education practice, will present specific recommendations for leveraging the Commission's assets to continue the delivery of sustained levels of impact with a declining revenue source. The Bridgespan assessment and recommendations are a solid foundation for future funding decisions. They are also important as we begin the rigorous process of reviewing agreements for potential renewal over the upcoming year.

In addition to the presentation and discussion of the Bridgespan assessment, Mr. Randy Barth, THINK Together's Founder and CEO, will present an update on one of the first catalytic agreements for the Early Literacy and Math Program. A special video has also been created to highlight a few programs that model the Commission's investments in successful programs that are improving children's outcomes.

I truly appreciate your dedication and leadership to serve as members of the Children and Families Commission of Orange County. Your participation at the June Planning Meeting will help to set the course for the next year.

Sincerely,

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Children & Families
Commission of Orange County

Looking Back and Looking Forward

Prepared by The Bridgespan Group
June 2016

CONTEXT

The Children and Families Commission of Orange County (Commission) supports organizations that provide health, education, and development services to children (prenatal to age five) and their families so that Orange County's children grow up healthy and ready to learn. The Commission was created in 2000 as a result of Proposition 10, the California Children and Families Act, which added a tax to the sale of tobacco products and allocated the funds to counties to support early childhood development. Since its inception, the Commission has focused on understanding community needs, funding research-based interventions to meet these needs, and tracking measurable outcomes.

In 2008, Bridgespan was asked to review the Commission's goals, investment portfolio, and evaluation processes and to provide recommendations to increase the impact of the Commission's efforts. We analyzed the efficacy of the Commission's actions and investments, assessed the state of countywide needs, collected feedback from external stakeholders, engaged with Commissioners and staff, and shared a set of recommendations with the Commission and staff.

We found that Orange County children's health outcomes were relatively strong, demonstrated, for example, by a low mortality rate and increase in immunizations. However, we found significant educational achievement gaps among young children, at the time most evident in second-grade assessments with variations across racial/ethnic groups and levels of family income.

In assessing the Commission's approach, work, and reputation in the county and state, we found numerous and distinctive strengths, including a strong focus on impact, high-performing staff, and a strong reputation for making material and measurable progress on child development outcomes and for developing strong and collaborative relationships within and across Orange County.

Therefore, in 2008, we recommended four primary areas of focus to guide the Commission's continued development of stronger early childhood outcomes in Orange County:

1. More closely align the Commission's resources with community needs by directing a greater proportion of resources, where effective approaches can be identified or developed, to address the education achievement gap;
2. More closely align the Commission's resources with community needs by directing a greater proportion of resources, where effective approaches can be identified or developed, to the county's neediest children, shifting from universal approaches to targeted approaches;
3. Shift the Commission's measurement and evaluation system from one focused primarily on program outputs (e.g., children served) to one focused on child-level outcomes; and,
4. Shift a greater percentage of the Commission's funding from supporting program or organization operations to various forms of "catalytic" funding capable of delivering long-lived impact from temporary funding, in order to maximize the impact of each dollar.

Earlier in 2016, the Commission invited Bridgespan to provide an assessment of progress relative to the recommendations made in 2008, and to provide refreshed guidance on how the Commission could continue to increase its impact over the next several years. In addition, the Commission requested specific guidance on potential high-impact ways of leveraging the Early Development Index (EDI) that is now being administered countywide as a result of the Commission's work.

LOOKING BACK

Bridgespan engaged Commissioners, Commission staff, and external experts, and reviewed historical grant data in order to assess the progress the Commission has made since 2008. We focused on understanding the Commission's work, past and present, and the Commission's strengths, opportunities, and role within the Orange County ecosystem. With the support of Commission staff, we reviewed data from annual reports, budgets, and Board supplements dating back to 2008 in order to analyze patterns of investment in general, with particular reference to the recommendations made in 2008. Our assessment of progress on the 2008 recommendations follows.

Resources devoted to early learning

We found that the proportion of resources devoted to the early learning category has increased since 2008, in line with the recommendation made.

From FY 2008-09 to FY 2014-15, investment in the Early Learning portfolio increased as a percent of total grantmaking from 26 percent to 32 percent. To fund a portion of this increase in proportional investment, the Commission leveraged state and federal funding to support investments in the Early Learning portfolio, over and above the resources invested from the Proposition 10 revenue. Since FY 2011-12, the Commission has leveraged $3.7 million from non-Proposition 10 state and federal funding sources. These funds have covered a significant portion of the Child Signature Program and CARES Plus (Comprehensive Approaches to Raising Educational Standards) Early Educator Professional Development program within the Early Learning portfolio.

Support to the neediest children

We found that the proportion of resources devoted to the neediest children in Orange County has increased since 2008, in line with the recommendation made.

First, a grant-by-grant analysis reveals that 66 percent of Commission spending in FY 2014-15 went to programs that specifically targeted the neediest children, either through location or through the focus of the program, relative to 58 percent of Commission spending in FY 2008-09. Moreover, FY 2014-15 client-level data shows that 83 percent of the recipients of the most intensive services are below 200 percent of the poverty line.

Since FY 2008-09, the Commission has refined its approach to targeting the highest need children, differentiating services across the portfolio. Optimization of the Bridges Maternal Child Health Network (Bridges Network) program is concentrating services in hospitals with the greatest need, and the elimination of the light touch Project Connections program has enabled the Commission to include more mothers in the higher touch and more effective Bridges Network home visitation programming. Additionally, programs such as the School Readiness Nursing and Early Learning Specialists are differentiated in terms of resourcing based on need.

Second, the Commission has made significant investments that are available to all Orange County residents, but that are designed specifically to result in referrals to match services to need. For example, the Bridges Network is supported countywide and is designed to provide a path for low-income mothers to access the services they need through a system of screenings and referrals. This approach results in particularly high rates of referrals for low-income mothers and subsequent resource flows that are focused on the neediest children.

From a focus on program outputs to a focus on child-level outcomes
We found that the Commission has made significant progress on shifting to a focus on child-level outcomes, in line with the recommendation made.

The Commission has developed and frequently references community-wide indicators of child wellness, against which summative progress can be assessed. Through the Annual Conditions of Children Report, the Commission has tracked many important indicators of children's well-being. The focus on measurement and data is further demonstrated in the Commission's investment in the Early Development Index (EDI). Achieving 100% participation of Orange County public elementary schools in the EDI assessment took several years and a great deal of effort. But now, the Commission has access to a data about Orange County children's developmental needs and where that need is concentrated.

More generally, the Commission has modeled an exemplary orientation toward results. For example, the Commission, in partnership with the Orange County Social Services Agency (SSA), supported a randomized control trial (RCT) to measure the impact of a program piloting early intervention on reducing child maltreatment. The Commission has strategically planned to scale learnings by implementing the intervention through a network of providers coordinated by a backbone agency. Such efforts have the potential to increase the funding flows available to effective programs at scale.

The Commission also has adapted its approach in response to research. For example, when research identified early math skills as a driver of later academic success, the Commission adjusted programs to integrate math skills into existing literacy programming. In the Healthy Children portfolio, the Commission conducted a process assessment in FY15-16 of the Bridges Network, and will be providing continuous quality improvement training and technical assistance to Network providers in order to maximize efficiency and increase service uptake.

Catalytic grantmaking
We found that the Commission has made significant progress in shifting a greater percentage of the Commission's funding from that which supports program or organization operations to various forms of "catalytic" funding, in line with the recommendation made. The Commission created a Catalytic Fund in 2011, by drawing down funds held in reserve, and this fund has been used in multiple catalytic ways.

First, the Commission has helped organizations develop capacity and credible plans for long-term sustainability. For example, the Commission provided funding to create the Healthy Smiles for Kids initiative and supported efforts to enlist dentists to commit to providing uninsured families with dental screenings. The design is one that will leverage public funding streams (Denti-Cal reimbursements) to support ongoing costs. Similarly, the Commission invested in the expansion of the number of beds in emergency shelters for families with young children, enabling greatly expanded service capacity.

Second, the Commission has developed the local capacity to bring new and sustainable services to Orange County through matching fund partnerships. For example, The Center for Autism and Neurodevelopmental Disorders, developed in partnership with the Thompson Foundation, now exists with the potential to provide ongoing services capacity without ongoing Commission funding.

Third, the Commission has established a sub-fund to provide capacity-building grants to well-qualified organizations with successful approaches, administered through a competitive application process. By supporting strategic planning for Network Anaheim, for example, the Commission is investing to set the organization on a path toward greater focus and success. Finally, we note that the Commission has invested deeply in measurement tools, such as the EDI, and in convening, each of which has the potential to increase the impact potential of numerous organizations.

THE CURRENT POSITION OF THE COMMISSION

As a foundation for the recommendations that appear in the final portion of this report, we first articulate a set of practices, competencies, and relationships that we believe position the Commission for greater levels of impact over the next several years, despite expected continued declines in revenue.

A set of effective practices employed by the Commission

A focus on evidence-based programs and approaches

The Commission has long demonstrated a preference for evidence-based programs and approaches, and we observed that the Commission now encourages the use of evidence to support improvement in the efficacy of programs and approaches. For example, based on research indicating that dental problems are the leading reason for kindergarten absences, the Commission prioritized programs that provide early dental services to underserved families in order to improve school readiness. Similarly, when 2013 research from the Children's Data Network showed that the greatest predictor of future child maltreatment is an early call to a child abuse hotline when the child is between 0 and 5, the Commission partnered with SSA on a pilot to reduce the incidence of abuse and neglect, incorporating this finding.

A rigorous, data-driven commitment to continuous improvement

The Commission has developed a proactive orientation to supporting the improvement of outcomes delivered by its partners. For example, the Commission has worked closely with the Bridges Network, from piloting it in 2000 to growing it to the large-scale network of today. In 2009, the Commission restructured it to operate with the efficiencies of a network including cost savings, streamlined processes, and improved program management. Similarly, the Commission adapted based on its learnings to improve program quality. For example, the Bridges Network will be piloting a continuous quality improvement program that, if successful, will be expanded to other Health-focused grantees. The Commission has shown similar persistence in the countywide administration of the EDI, as it achieved 100% participation among Orange County public elementary schools. With an assessment of five dimensions of readiness across every neighborhood in the County, the Commission has started to engage communities in thinking about interventions to act upon this data.

A persistent focus on program sustainability

The Commission recognizes that the greatest impact it can achieve is to catalyze and support the work of others and do so in a manner that results in services that are both highly effective and sustainable beyond the period of Commission investment. While this perspective is most clearly embodied in the Catalytic Fund portfolio, it has become integrated into other aspects of the Commission's work. As former Executive Director Christina Altmayer noted, the Commission learned that "…when we design an investment, from day one, we acknowledge that we will not be able to sustain the program… We hope that if we can demonstrate the outcomes, [others will]… continue this program." This focus on sustainability enabled, for example, the homelessness programs to develop business plans that show how these organizations will leverage the upfront investment they receive from the Commission to build the necessary systems and infrastructure within their own agencies to sustain them for the long-term.

A set of valuable competencies developed by the Commission

The ability to access other public funding sources

The Commission has developed knowledge about, and expertise in, leveraging public resources to sustainably support its strategic priorities and projects. The Commission has used this knowledge to build sustainable strategies in both its Early Learning and Healthy Children portfolios. For example, faced with a reduction in overall funding due to the expected decline in tobacco tax revenue, the Commission worked with elementary school districts to apply for state funding to support public preschool. This application resulted in a $4 million award from the state to eight elementary schools to serve 800 children. Building on this precedent, 24 Orange County school districts today have California Department of Education contracts for early learning, using public funding for sustainable support. Additionally, in the Healthy Children portfolio, the pediatrics program is now almost completely federally funded upon designation as Federally Qualified Health Centers.

The ability to integrate research into programming

The Commission has developed strong relationships with researchers at the University of California Irvine, Chapman University, California State University Fullerton, the University of California Los Angeles, and the University of Southern California. These relationships have provided access to leading research in early childhood development, enabling the Commission to continually improve its programming to impact outcomes for young children in Orange County. These partnerships also position the Commission as an essential bridge to help these researchers begin to implement their findings at greater scale. For example, the Commission's relationship with Greg Duncan, Ph.D. from the University of California Irvine connected the Commission with findings showing that early math achievement has emerged as the single most powerful predictor of future educational attainment. As a result, the Commission was able to work with THINK Together to expand its early literacy grant to also include early math interventions.

Strong data and evaluation capabilities

The Commission's focus on measurement and outcomes has enabled it to analyze the efficacy of its own programs and to provide evaluation-based technical assistance to other funders and initiatives. For example, the Commission has built a partnership with the Orange County Community Foundation, the Anaheim Ducks, the Los Angeles Angels of Anaheim, and Disneyland through the ACT Anaheim collaborative, and now uses the Commission's own data collection platform and web-based systems to provide technical assistance to ACT Anaheim and an evaluation of ACT Anaheim's investments. This platform is itself an asset, but it is the Commission's expertise and capabilities in this area that are increasingly being noticed; the Commission has already signed a contract with the County and is in conversation with another local foundation about conducting an evaluation of key programming.

The ability to play value-added convening role

The Commission has demonstrated the ability to convene leaders and organizations in Orange County to increase awareness of the needs in the county and to highlight effective approaches to meet these needs. For example, convening played an important role in the evolution of the Healthy Smiles dental program. Through the development of a backbone organization, and by incentivizing dental residents to provide pediatric dentistry services through grants to support student loan repayments, the Commission funded Healthy Smiles to identify and bring together independent dentists countywide to provide dental services to families in the county that otherwise would not have received them.

A set of valuable relationships and a trusted reputation

Creating an innovation platform for others in Orange County

The Commission's rigorous data-driven approach is recognized and valued by others and has caused other funders to look to the Commission to share its learnings and practices more broadly, and to partner on innovative service financing strategies. For example, the Commission has received several technical assistance grants to support its work and learning around Pay for Success, including grants from the James Irvine Foundation, the Non Profit Finance Fund, and Third Sector Capital Partners. These grants have allowed the Commission to explore the feasibility of creating a more sustainable financing model for the Bridges Network, via Medicaid reimbursement. Additionally, the Commission received grants from the Laura and John Arnold Foundation, as well as from the Institute for Child Success, to conduct a randomized controlled trial (RCT) to evaluate the impact of Dr. Emily Putnam Hornstein's (of the Children's Data Network) project on the prevention of child maltreatment, and to implement the Neighborhood Resource Network Program based on Dr. Hornstein's research. The trust demonstrated by these funders is a credit to the caliber of the Commission's rigorous approach.

Playing a trusted role in identifying programs worthy of investment

Over the past several years, the Commission's rigor of expectations, focus on outcomes, and pursuit of evidence-based practices have been valued by the broader Orange County funder and non-profit community. Increasingly, the philanthropic community is recognizing the quality of the Commission's work and regarding Commission investment as a "Good Housekeeping Seal of Approval." The president of a local foundation noted that the Commission has an "unduplicated experience and knowledge set in terms of the funder community, [with] in-depth knowledge in the landscape of their focus." This recognition as an expert in early childhood provides not only an important external validation of the Commission's work, but also speaks to the ability of the Commission to bring local, and perhaps national, philanthropic resources to bear in services to the Commission's outcome goals for Orange County children and families.

Collaborating directly with other funders

The Commission has cultivated a collaborative approach that invites other funders to support opportunities the Commission has identified and developed. Through the Orange County Science, Technology, Engineering, and Mathematics (STEM) Initiative, the Commission has partnered with the Samueli Foundation, among others, to encourage STEM programming in Orange County's schools. By combining the Commission's perspective with that of the other funders, the Commission was able to introduce STEM not only into early education but also ensure that targeted interventions that build on each other are incorporated throughout the K-12 experience. The Commission continues to collaborate with other funders in Orange County, most notably the Orange County United Way and the Orange County Community Foundation.

LOOKING FORWARD

The Commission has done much to improve outcomes of the children and families of Orange County over the past several years and has developed a set of practices, competencies, and relationships that create a powerful platform for future impact. Leveraging these intangible assets will be critical to delivering sustained levels of impact in an environment with continued declining revenues and without significant reserves to draw upon.

We offer the following recommendations for consideration as the Commission continues its journey to improve significantly the outcomes of the children and families of Orange County.

Using the Early Development Index (EDI) as a summative indicator of progress

The Commission has invested deeply in the Early Development Index, a holistic summative assessment of young children entering kindergarten across five domains: physical health, emotional maturity, social competence, language and cognitive skills, and general knowledge. The EDI's five domains span areas of the Commission's portfolio, including Health and Early Learning. Lisa Stanley, Project Director at UCLA's Center for Healthier Children, Families, and Communities, notes that the EDI is "the most direct measure of child well-being."

Beyond its informative value as a one-time snapshot of outcomes, the EDI could be used to track progress across the county on the collective work underway to improve outcomes. Such information would be valuable not only to the Commission's grantees and partners, but also to the Commission itself. While the EDI does not capture the outcomes for children aged 0-4, the comprehensiveness of the assessment of children in kindergarten (across sub-indicators and by neighborhood) would provide a powerful external validation of the progress being made over time. We recommend that the Commission continue to fund, and/or encourage others to fund, the ongoing periodic implementation of the EDI assessment across Orange County. We believe that the resulting information, if utilized well, could become one of the highest impact catalytic investments made by the Commission.

Sustaining the catalytic orientation to investment

The Commission has adopted an objective of sustaining the services that support children in Orange County and has continually made progress in shifting from an approach that funds individual programs to an objective of building sustainable services. The Commission has made a significant number of catalytic investments in alignment with this objective, with many large investments enabled by the creation of the Catalytic Fund developed to spend down a large, previously accumulated reserve.

We suggest that the Commission continue the shift from programs to sustainable services and continue to invest in a catalytic manner wherever possible and warranted. While finding the sources of funds required to make catalytic investments will be more challenging in a future without a reserve fund, the imperative to invest catalytically becomes stronger as the Commission's direct revenues continue to decline. Catalytic investments can come in the form of efficient and effective investments that result in a long-term increase in the number of children and families with access to a program or service and/or in the form of one-time investments that increase the quality/impact of a program for future beneficiaries. In so doing, the Commission may make one-time grants to assist long-term partners in identifying sustainable future funding models without Commission investment. The Commission staff have developed strong capabilities in the identification and design of catalytic funding opportunities and we recommend that they be given the encouragement to continue to do so.

Accelerating the transition from funding programs to building sustainable services

To enable continued effective catalytic grant-making as revenues decline, the Commission will need to be judicious about the number of multi-year grants in the portfolio. In general, we recommend that the Commission seek to reduce the proportion of the portfolio allocated to multi-year and operating grants as rapidly as possible without harming the delivery of essential programs and services.

There are a few multi-year initiatives in the current portfolio that, through their distinctive levels of impact and lack of identified sources of sufficient non-Commission funding, are strong candidates for continued funding. We recommend that the Commission identify a small number of such initiatives to be approved for continued funding – and, concurrently, commit resources to what may be a multi-year approach to identifying other sustaining sources of funding for these critical initiatives, recognizing that otherwise their sustainability will be threatened by the decline in Commission revenues.

We recommend that the Commission move as rapidly as possible to shift all other funding to shorter-term grants invested in a catalytic manner, thereby increasing the number of places in which the Commission may be able to extend the impact of its catalytic approaches. In all cases, the Commission's demonstrated focus on results should continue to be applied to grant renewal decisions.

Continuing to bring supplemental financial resources to bear

The Commission has been successful in increasing the sustainable resources available for Orange County children and families through funding partnerships that bring local and national philanthropy to bear and by increasing access to local, state, and federal funding streams. Already, the Early Learning portfolio has expanded through the inclusion of non-Proposition 10 funding. The First 5 California early learning programs, which has included Child Signature Program and CARES Plus Early Educator Professional Development program, were funded from such sources, and nearly $3 million of Early Learning support in FY 2014-15 came from sources other than Commission revenues.

As direct Commission revenues decline, and with an imperative to shift a greater proportion of the portfolio from operating support to catalytic investments, leveraging the Commission's strong competencies in bringing public and philanthropic funding to bear will become more and more valuable. We recommend that the Commission provide Commission staff with the guidance and resources required to accelerate the rate at which such additional sources of funds can be identified.

Leveraging the Commission's reputation and non-financial assets

As the Commission's practices improve, competencies grow, and relationships and reputation strengthen, the Commission has the ability to increase the proportion of its impact that originates from non-financial aspects of its work. We recommend that the Commission and its staff continue to use data, evaluation, and research to influence the investments of others, and continue to use convening as a means of raising awareness about, and aligning efforts behind, issues and opportunities to improve outcomes across the county. We recognize that increasing these aspects of the work requires time and effort and therefore we recommend that that Commission give the staff the authority, time, and resources to increase their ability to pursue these high-impact activities in the future.

Using the Early Development Index to guide the allocation of the Commission's own resources

The results from the universal administration of the Early Development Index reveal both the magnitude and geographic distribution of the needs that remain in Orange County, despite the excellent work of the Commission, its grantees, and its partners over the past several years. The EDI results indicate that young children in Orange County are most ready in kindergarten in the areas of physical health and well-being and emotional maturity, and are least ready in the area of language and cognitive development.

We also noted that Greg Duncan, Ph.D. from the University of California Irvine, in his presentation at the recent Commission-sponsored "Learners Today, Leaders Tomorrow" summit, shared extensive research that links kindergarten readiness and future school success. His analysis showed that the gaps that are evident when young children come to school in kindergarten are only exacerbated by the educational experience they receive in school, highlighting the importance of addressing the significant gaps noted above in language and cognitive development as early as possible.

Accordingly, we recommend that the Commission continue to increase its focus on the early learning deficits of the neediest children in the county. The EDI assessment provides unprecedented clarity on the degree and geographic location of these needs, but these outcomes will not improve unless such information is utilized to increase resources and/or improve the effectiveness of existing resources serving these areas of significant need. There is perhaps no organization better-suited than the Commission itself – with its objective of improving the very outcomes being measured by the EDI, with its focus on the effectiveness of sustainable services, and with its ability to allocate resources across cities, neighborhoods, and school districts – to take action based on the information revealed by the EDI. If the Commission itself does not change its allocation of resources in response to this new powerful information, it is not clear that it should expect others to do so.

To support such an associated reallocation of resources, we recommend that the Commission state a goal of increasing the proportion of children in the county who achieve the threshold of well-being on future administrations of the EDI assessment. The articulation of such a goal by the Commission may catalyze the aligned actions of many others in the county.

Children & Families
Commission of Orange County

The Bridgespan Group

Children and Families Commission of Orange County

Summary of Recommendations

March 5, 2008

This information is confidential and was prepared by The Bridgespan Group solely for the use of our client; it is not to be relied on by any 3rd party without The Bridgespan Group's prior written consent.

Objectives

- Share and discuss final recommendations
- Identify any outstanding questions in preparation for 3/15 report

Contents

- Assessment and recommendations summary (p. 4-6)
- Appendix A: Assessment and recommendations detail (p. 8-17)
- Appendix B: Project overview (p. 19-21)

Summary of our assessment

- **Health outcomes** for children birth to five in Orange County **are generally quite strong**, with some gaps
- **Education outcomes are poor for significant numbers** of children. By 2nd grade, nearly half of all students are not performing adequately on state tests
- The **Commission has achieved great success to date** in improving outcomes for children, particularly in health. It is viewed by stakeholders as a leader among First 5 organizations due to its strong Executive Director and staff, and its ability to foster innovation and partnerships
- However, **there is pressure to become increasingly strategic with each dollar** given projected declines in funding and the state budget crisis. All stakeholders emphasize the importance of focusing to maximize impact and sustainability
- **CFCOC has the opportunity to increase its impact** by focusing on children most at risk of poor health and education outcomes, investing in more catalytic activities, and evaluating and communicating children's outcomes versus program outputs
- The strength of CFCOC's brand and regard among its peers indicates that, if CFCOC wished to, **it could do even more to lead First 5s** regionally and at the state level
- **To realize these opportunities, the Commission will need to make changes** across the organization, within its programs, strengthen its staff and key processes, and refine its resource allocation across goal areas

Source: Bridgespan assessment. See final recommendation document for additional detail.

Recommendations summary

Objectives and principles		1. Prioritize serving the most at risk of poor outcomes 2. Direct more resources to support children's early learning needs 3. Enhance evaluation system to focus on select children's outcomes data 4. Shift a greater percentage of funding to catalytic (versus sustaining) activities
Portfolio goal area invest-ments	Healthy Children	1. Define primary beneficiary as those with no access to critical services 2. Align programs to prioritize children with no access; support programs for all children only under three specific conditions 3. Invest more in catalytic activities via charging fee for services and developing cost sharing plans with grantees and other funding partners
	Ready to Learn	1. Define primary beneficiary as those at most risk for poor education outcomes 2. Expand home-based pre-literacy programs significantly 3. Align State and Local School Readiness funds to support children with greatest needs 4. Promote and reward quality by measuring outcomes for children in CFCOC-supported programs, and providing funding only to those that meet quality thresholds 5. Promote common "ready to learn" assessment at Kindergarten
Staff		1. Strengthen the leadership team by identifying a Chief Program Officer and Performance Management and Evaluation Director

Next steps

- Hold update session with staff and consultants on 3/11 to begin sharing findings
- Submit final assessment and recommendation by March 15th
- CFCOC staff to develop programmatic recommendations and detailed implementation plan by June

Contents

- Assessment and recommendations summary (p. 4-6)
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Assessments and recommendations focus on three areas

Objectives and principles

- Changes CFCOC should consider across the organization as a whole (we shared a preliminary version of these recommendations on 2/6)

Portfolio goal area investments

- Changes the Commission should consider to its Healthy Children and Ready to Learn goal areas. These changes would align CFCOC's portfolio with the objectives and principles
  - We focus on these areas as they represent 75% of CFCOC's program expenditures
  - As a next step, CFCOC should investigate Strong Families and Capacity Building goal areas

Staff

- Changes CFCOC should consider to key staff positions to most effectively implement the objectives and principles and portfolio recommendations

Objectives and principles recommendations

Recommendation 1: Target program investments to prioritize serving those most at risk of poor outcomes

- Provide more services for children at risk of poor outcomes rather than all children, particularly in Ready to Learn goal area
- Provide services to all children only where serving all is required to achieve outcomes or where program is critical to building community support (this applies to several programs in Healthy Children, for example)
- Concentrate funds increasingly (though not exclusively) in the most needy communities

Recommendation 2: Direct more resources to support children's early learning needs

- Expand programs in the Ready to Learn goal area
- Increase funding for Ready to Learn drawing from long term sustainability fund or unspent cash in the short term, and from current programs based on staff recommendations in the long term

Recommendation 3: Enhance evaluation system to focus on select children's outcomes data

- Orient systems to track children's outcomes across programs
- Streamline data collection, balancing decision-making needs and data consistency needs
- Use data dashboards at the Commission, portfolio and program level to monitor effectiveness and inform decision-making

Recommendation 4: Shift a greater percentage of funding to catalytic (versus sustaining) activities

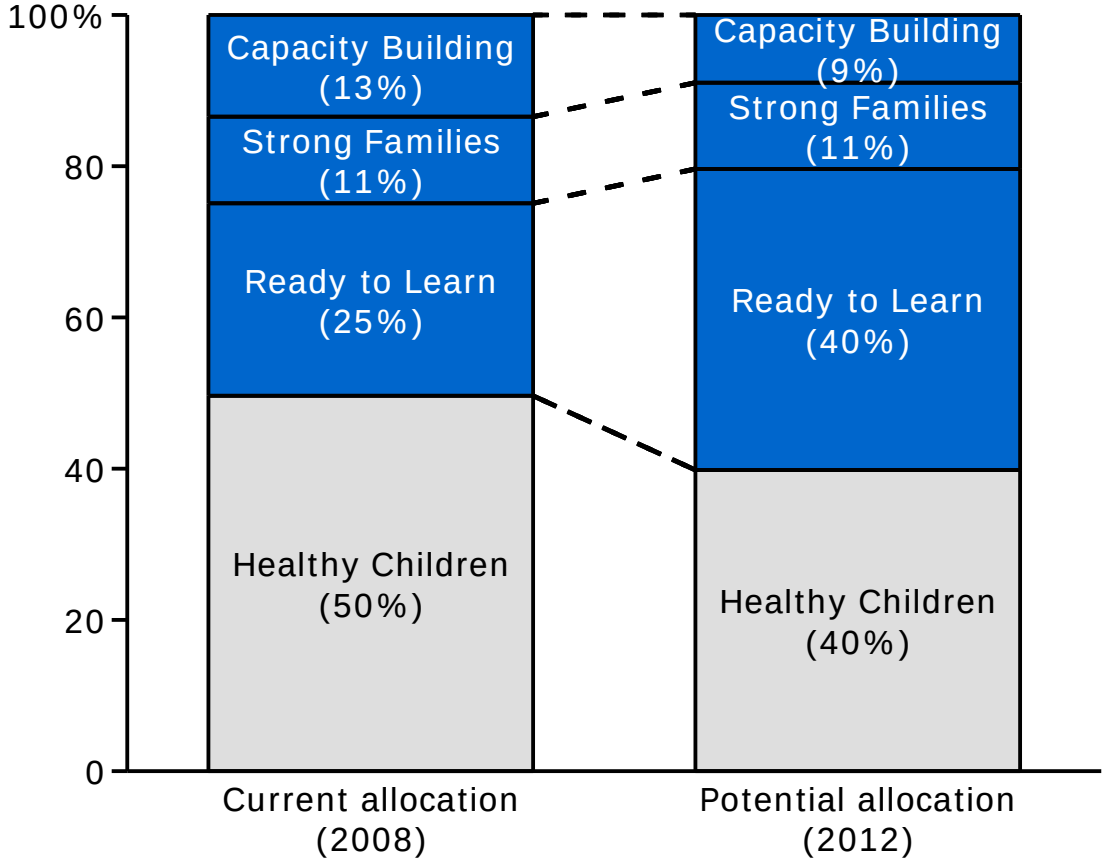
- Aggressively seek to share funding via funding partners or fees for service where appropriate
- Increase best practice sharing across similar grantees to increase impact

ILLUSTRATIVE

To direct more resources to early learning CFCOC could fund Ready to Learn and Health Children goal areas equally

By 2012 CFCOC could rebalance some funds from Healthy Children and Capacity Building to the Ready to Learn goal area*

Potential shift in portfolio



Key assumptions

- Revenue and cost-sharing opportunities exist in Healthy Children goal area
- Capacity Building goal area aligned to support investment in select key communities

* CFCOC staff will finalize financial analysis and make final proposal to Commissioners

Source: CFCOC FY08 adopted annual operating budget; Ten year financial plan May 07; Bridgespan analysis

Healthy Children: Assessment summary and what we've heard from the Commission

Our assessment indicates

- **Health outcomes in Orange County are generally quite strong**. For example, the percent of low birth weight babies and infant mortality rates in Orange County are lower than both California and US averages. Over 95% of Orange County parents report that their children are in good or excellent health
- **There are some health gaps**. For example, almost 20% of Orange County children from birth to four were overweight in 2005, and these rates are increasing rapidly
- The **funding environment for healthcare services is challenging** and is likely to worsen given California's budget crisis
- **Healthy Children targets children that are "under-served"** by the current healthcare system with the goal to ensure families have access to a medical care system that is of high quality and with sufficient capacity to meet their children's health needs
- **Healthy Children programs strive to fill gaps in the medical care system**, by providing screenings, referrals and direct services where these services do not exist or where the Commission believes they do not exist in sufficient quantity

We've heard from you that

- The Commission believes **health is foundational**. A child must be healthy in order to thrive and learn
- The Commission believes that **prevention is critical**. Healthy Children services often focus on early identification of risks such as screening for developmental delays
- Because many services are relatively easy to measure (e.g., number of children immunized), and are delivered by healthcare professionals, the Commission is **fairly confident that funding in this area is not wasted**
- However, the **Commission recognizes its resources are limited and wishes to be sure it is maximizing the impact of every dollar** spent in Healthy Children

Source: Bridgespan assessment. See final recommendation document for additional detail

Healthy Children recommendations (1 of 2)

While Healthy Children programs are strong, there is room to increase impact by prioritizing services to those most at risk of poor outcomes and by funding more catalytic activities.

Recommendation 1: Define the primary beneficiary as those with no access to critical services

- Today, **Healthy Children serves both those who have no access to health care and those who have limited access** (an example of limited access is families who face long wait times or who would otherwise seek services in other counties)
- CFCOC should **define the primary Healthy Children beneficiary as children with no access to critical services.** No access means that without CFCOC's intervention it is probable that these children would not receive critical health care services and would be at high risk of negative health outcomes
  - This group would include low income children and children with special needs or a chronic medical condition without the ability to access adequate care
  - CFCOC should serve individuals with limited access only where doing so is critical to ensuring health outcomes
  - If services are made available to families that have the means to pay for them, CFCOC should ensure these families pay for service

Recommendation 2: Align programs to prioritize children with no access; support programs for all children only under three specific conditions

- The **Commission should support services for all children only under three conditions**:
  - The intervention is critical to strong health outcomes and the children served would not otherwise receive the intervention (an example is areas where there are major gaps in critical healthcare services such as developmental screenings)
  - The Commission believes providing the service to all is critical to maintain community support (e.g., School Readiness Nurses)
  - Data is required from all children to effectively evaluate outcomes
- **Where these two conditions are not met, we recommend CFCOC should align services to prioritize the most vulnerable**
  - For example, Bridges for Newborns provides socio-economic screenings to all children at birth, regardless of income. CFCOC should focus these screenings on the most vulnerable, those families that earn less than 200% of the Federal Poverty Line. These low income families make up nearly 100% of those that are identified as high risk. The Commission should continue providing new parent kits for all assuming these kits provide critical information that every family needs, and families would not have access to the information otherwise

Source: Bridgespan assessment. See final recommendation document for additional detail.

Healthy Children recommendations (2 of 2)

While Healthy Children programs are strong, there is room to increase impact by prioritizing services to those most at risk of poor outcomes and by funding more catalytic activities.

Recommendation 3: Invest more in catalytic activities via charging fees for services and developing cost sharing partnerships with grantees and other funding partners

- Healthy Children has some promising examples of catalytic activities that the Commission can build from (e.g., PHS Developmental Services partnerships)
- However, the assessment suggests that the Commission pays ongoing salaries and operating expenses for some grantees without a clear exit plan or a compelling demonstration that the grantee has been able to increase its impact over time
- Given limited resources, the Commission should seek opportunities to share costs
  - The Commission should price the direct services it supports, charging those who can pay and giving scholarships to those who can't afford it. This will ensure that for those programs made available to all, those families with the means to pay for care share the cost burden with the Commission
  - Develop program sustainability plans to increase cost sharing. Build funding partners into the program planning and implementation process. For example, there may be opportunities to share costs with school district and hospital partners
- Where feasible, the Commission should seek opportunities to move "upstream" to build provider capacity rather than fund ongoing services indefinitely

Source: Bridgespan assessment. See final recommendation document for additional detail.

Ready to Learn: Assessment summary and what we've heard from the Commission

Our assessment indicates

- **Education outcomes are poor for significant numbers of Orange County children**. By second grade, 47% of students are not advanced or proficient on state English Language Arts tests. This achievement gap would affect over 100K Orange County children (47% of the 265K children birth to five)
- **Most of the children that are behind are low income and / or Latino students, and these students cluster** in a limited number of schools and communities. They are less likely than their more advantaged peers to be in formal care settings such as preschool or childcare centers
- Research shows that **children who start school behind struggle to catch up to their peers**. One critical element of school readiness is pre-literacy. Pre-literacy abilities can predict later school and life outcomes
- Data show that **quality early learning interventions can make a marked difference in a child's long term outcomes.** Quality interventions that work share common characteristics like program durations of one or more years, culturally relevant approaches and age-appropriate curricula, deep parent engagement, highly skilled service providers, and small numbers of children per provider
- **Early learning interventions that are low quality do not improve children's outcomes**
- There are **emerging promising early literacy programs specific to Hispanic children,** such as the Commission's HABLA program
- Because there is no uniformly accepted way to measure "readiness to learn" in California nor a standard test administered at Kindergarten, **the Commission does not know how well it is achieving its goal of all children beginning school "ready to learn."** There are emerging promising assessment tools
- While CFCOC has established a strong set of programs, **Ready to Learn services are not fully focused on the most needy and appear to be spread thinly** across a wide variety of issues

We've heard from you that

- The **Commission is supportive of serving early learning needs**
- The Commission could never reach every needy child, therefore the **Commission wishes to invest in programs that will have maximum impact, and leverage other funding sources** wherever possible

Source: Bridgespan assessment. See final recommendation document for additional detail.

Ready to Learn recommendations (1 of 2)

CFCOC can maximize the impact of Ready to Learn by prioritizing those most in need, expanding home-based pre-literacy programs, aligning State and Local School Readiness dollars to the most needy schools, rewarding quality, and promoting a common assessment at Kindergarten.

Recommendation 1: Define the primary beneficiary as those most at risk of poor education outcomes

- Today, Ready to Learn programs serve both very needy children (e.g., HABLA and Special Needs programs), and all children (e.g., Local School Readiness and Kid Builders)
- We recommend that the Commission **define the primary beneficiary for Ready to Learn programs as those most at risk of poor education outcomes**. In Orange County, this would include low income children, many Latino children, and special needs children, among others

Recommendation 2: Expand home-based pre-literacy services significantly

- Research shows that pre-literacy skills are critical to later success and that parents are instrumental to their children's reading ability. Home-based interventions are needed since the most needy children are not in formal care settings (only 42% of all children birth to five in Orange County are in formal care settings)
- The Commission's HABLA program currently serves ~50 families from a single site. CFCOC should **expand home-based pre-literacy services to ~500 – 1000 of the most at-risk families** in a limited number of communities. At this scale the program will have sufficient numbers to demonstrate relevance
- The Commission should **rigorously evaluate program outcomes**, using pre and post intervention assessments, and track children's outcomes in Kindergarten and beyond to demonstrate long term effects
- In order to make this investment catalytic, the Commission should **aggressively seek funding partners**, **carefully select pilot sites** to be most meaningful and representative to key stakeholders, and package and **communicate outcomes and best practices**
- The Commission should consider co-locating pre-literacy programs with other CFCOC services in order to demonstrate the power of comprehensive support for children's needs

Source: Bridgespan assessment. See final recommendation document for additional detail

Ready to Learn recommendations (2 of 2)

CFCOC can maximize the impact of Ready to Learn by prioritizing those most in need, expanding home-based pre-literacy programs, aligning State and Local School Readiness dollars to the most needy children, rewarding quality, and promoting a common assessment at Kindergarten.

Recommendation 3: Align State and Local School Readiness funds to support children with greatest needs

- State and Local School Readiness funds could be more strategically allocated to the most needy. Local School Readiness dollars are distributed among all districts in Orange County. State School Readiness dollars are directed to the 13 lowest performing districts in Orange County, but within these districts there is no requirement to direct dollars to the most needy children
- We recommend the Commission **direct School Readiness funds commensurate with student need by setting an explicit allocation method** that takes into account which districts have the greatest numbers of children failing to achieve adequate outcomes and greatest numbers of disadvantaged students
- Furthermore we recommend that the Commission **set explicit guidelines for the beneficiaries in its School Readiness pre-K programs**, and require that programs report back demographics of those served

Recommendation 4: Promote and reward quality by measuring outcomes for children in CFCOC-funded programs, and providing funding only to those that meet quality thresholds

- High quality early learning interventions, particularly pre-K, have strong evidence of improving outcomes for children. The Commission can have a catalytic effect on improving provider performance in Orange County by rewarding programs that achieve strong outcomes
- We recommend the Commission work with the formal care providers it funds to **set minimum outcomes expectations and ensure providers measure outcomes using emerging assessment tools**. Provide capacity building assistance where warranted, but ultimately provide direct financial support only to those providers who meet minimum quality thresholds

Recommendation 5: Promote a common "ready to learn" assessment at Kindergarten

- A common assessment at Kindergarten will enable the Commission to monitor how well it is achieving the "ready to learn" component of its mission overall, and help determine which Commission-funded programs are most effective

Key staff recommendations

To effectively implement the strategy, the Commission should strengthen its leadership team.

Recommendation 1: Strengthen the leadership team by identifying a Chief Program Officer & Director of Performance Management and Evaluation

- The assessment revealed that program management could be strengthened, particularly strategy setting and coordination across goal areas. As the ED is focused externally and on the organization as a whole, there is the need for a role that could focus on ensuring the objectives and principles were reflected in and across goal areas. Furthermore, all stakeholders expressed concerns about succession planning for the ED. Therefore, we recommend CFCOC **identify a Chief Program Officer** reporting to the ED
- A full time staff member is required to implement and manage the changes to CFCOC's evaluation system. We recommend CFCOC **identify a full time Director of Performance Management and Evaluation** reporting to the ED

Contents

- Assessment and recommendations summary (p. 4-6)
- Appendix A: Assessment and recommendations detail (p. 8-17)
- Appendix B: Project overview (p. 19-21)

Project focused on answering three questions and providing a recommendation for how CFCOC can maximize its impact

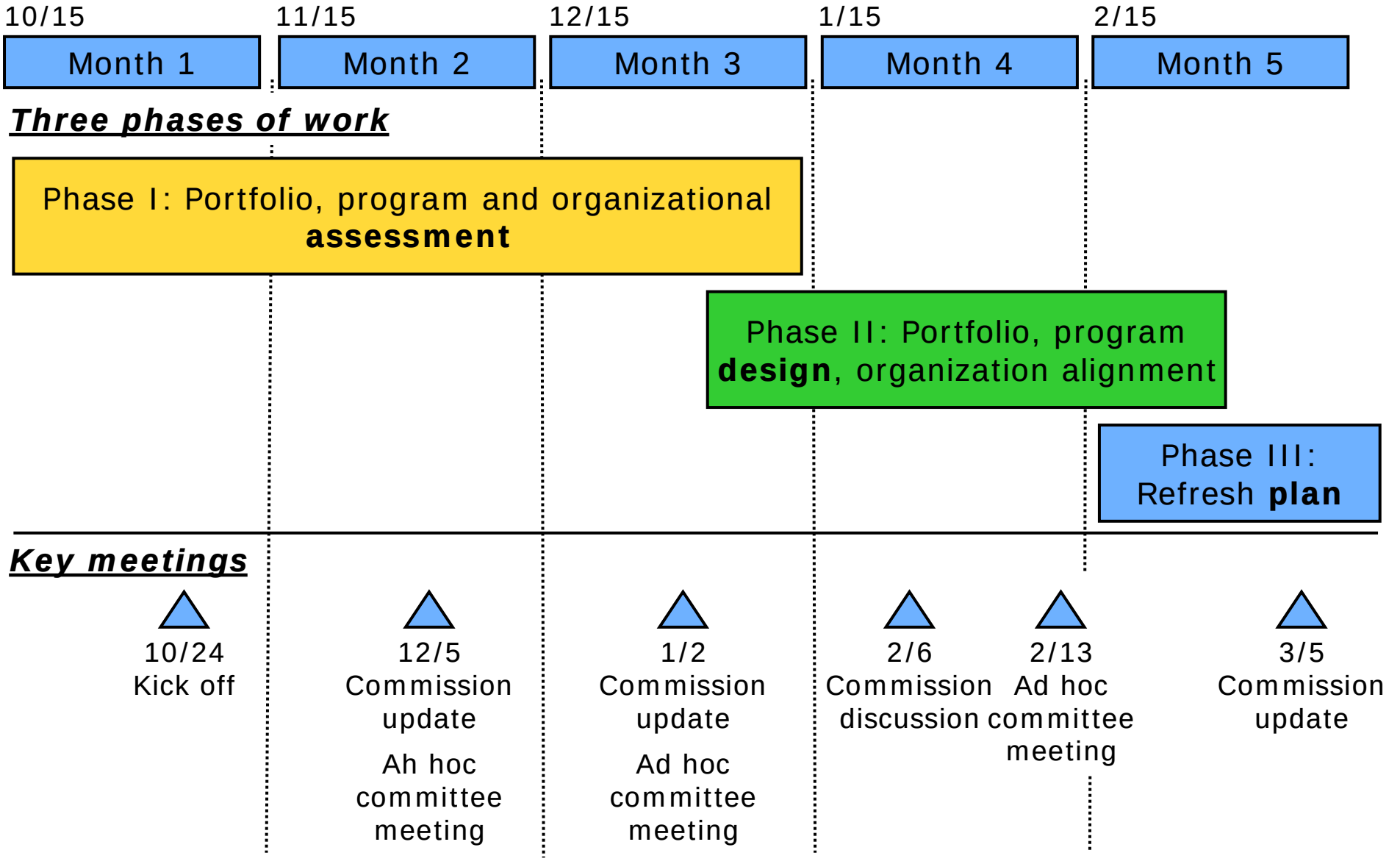
Key questions

1. Is the CFCOC **maximizing its impact** in Orange County? If not, what changes can be made to the strategic plan and business plan in order to have greater impact?
2. While continuing to focus direct efforts within Orange County, how can CFCOC best have beneficial impact on the lives of children and families **beyond Orange County**?
3. Are there ways that CFCOC can **improve its organizational effectiveness**?

Objectives

1. Provide an assessment of the **relative impact** of CFCOC various programs and services
2. Present an external perspective on the **effectiveness of the organization** relative to best practice organizations within, and outside, the sector
3. Collaboratively produce a **refreshed strategic plan**, with recommended changes to programs and the organization, to guide the next level and phase of impact

Project timeline



Project recommendations informed by input from multiple stakeholders, data analysis, and Commissioner discussions

Engaged **numerous stakeholders**

- Commissioner interviews
- Staff and key consultant interviews
- Interviews with 13 experts in the child development field
- Grantee interviews and focus groups with School Readiness Nurses, School Readiness Coordinators, Pediatric Health Services directors
- Site visits to Casa Teresa Homeless Shelter, Children's Health and Dental Center, Dorothy Von Der Ahe Infant Care Center, Girls and Boys Clubs of Garden Grove, HABLA, Santa Ana Child Guidance Center

Analyzed **external and internal data**, including

- Community demographics, health and learning outcomes of children birth to five
- Early care and education best practice programs
- CFCOC's programs and evaluation system

Held **discussions with Commissioners**

- 12/5 ad hoc committee and full Commission update
- 1/2 ad hoc committee and full Commission update
- 2/6 full Commission meeting
- 2/13 ad hoc committee meeting

The Bridgespan Group

PRITZKER

CHILDREN'S INITIATIVE

Photos: Ounce of Prevention Fund

Achieving Kindergarten Readiness for All Our Children

A Funder's Guide to Early Childhood Development from Birth to Five

Together, philanthropy, business and government can now expand early childhood opportunities so that all our children arrive at kindergarten ready to learn and achieve success throughout their lives.

Kindergarten readiness, a comprehensive measure of a child's development and readiness to learn, is a critical benchmark on the path to success for all children.

- Remarkably, **1 in 4 American children come from low-income families and enter kindergarten not ready to learn.**

  50% of all low-income children from birth to 5 are at risk of not being fully prepared for kindergarten

- Preparing a child for kindergarten requires a focus on five areas of development that begin at birth and are influenced by quality, early experiences:

  1. Physical well-being and motor development
  2. Social and emotional development
  3. Cognitive skills
  4. Language and developing literacy
  5. The ability to concentrate and follow directions

- Investments in early childhood development lay the foundation for school readiness by building these cognitive and character skills that children need to do well in school and in life, including attentiveness, persistence, impulse control and sociability.

- When a young child enters kindergarten ready for school, there is an

82% chance that child will master basic skills by age 11 compared with a **45%** chance for children who are not school ready.

Research shows the foundation for success in life begins during the critical period from pregnancy to age 5. Investing in early childhood development during this time makes a significant and lasting impact.

- From conception to the first day of kindergarten, **a child's brain develops more quickly and a greater amount** than at any other time.

- In the first three years of a child's life, **700 new connections between cells in the brain are formed each second,** so quality, responsive early experiences are incredibly important.

- Research from Nobel laureate economist James Heckman shows that investments in quality early childhood programs for disadvantaged children more than pay for themselves, with a

7-10% return on investment through better education, health, economic and social mobility outcomes.

- Programs for infants and toddlers from low-income families during **the first three years of life are most critical** in building a strong foundation for learning.

- Investments in the first three years of life are especially critical to prepare more children for kindergarten and lifelong success and provide the **greatest returns on investment**.

- When we choose not to invest in early childhood programs for low-income families, we eventually pay the price through larger taxpayer burdens in the education, health and criminal justice systems.

All data sources can be accessed at http://www.bridgespan.org/early-childhood-funder-guide-2015

We vastly underinvest in programs that work, and targeted public and private investments are needed to improve the patchwork delivery system of early childhood programs currently in place.

- Public education spending at the state and federal level for 6- to 18-year-olds is nearly **4 times** as high, per capita, as spending for children birth to 5.
- Effective parenting programs reached only 115,000 children in 2014, an estimated **2.5 percent of the need.**
- In 2013-14, only **29%** of 4-year-olds were enrolled in a state-funded pre-K program and only **5** states met all important quality benchmarks.
- Early Head Start reached only **4 percent** of eligible infants and toddlers as of 2012.
- Approximately **25 percent of low-income children** under 5 spend a significant portion of time in informal **family, friend and neighbor care**. These settings need support to improve quality.
- **Quality** at state-regulated **child-care**, **Head Start**, state-funded **pre-K** and other centers **varies widely**, and it falls short of its potential to prepare children for kindergarten. In most states, **basic training in child development is often not required**.

More investments in early childhood development are needed. This guide provides 13 specific, tested, early childhood investment opportunities donors can pursue immediately to make positive impacts.

Strengthen public systems of early care and education at state and local levels to ensure continuous quality improvements.

Option 1: Provide technical assistance for states to accelerate quality-improvement efforts.

Option 2: Fund training for providers pursuing quality improvements.

Scale health and developmental screenings to connect parents and families to resources to optimize their child's holistic development.

Option 3: Develop and share comprehensive screening and referral systems at the community level.

Option 4: Support pediatric practices to integrate screenings and referrals into well-child visits.

Option 5: Disseminate promising screening and assessment questionnaires and tools.

All data sources can be accessed at http://www.bridgespan.org/early-childhood-funder-guide-2015

Improve the training, continuing education, professional development and compensation of early childhood educators.

Option 6: Increase the availability of on-the-job coaching and development for early childhood educators.

Option 7: Fund research and technical assistance to promote fair compensation of early childhood educators.

Support greater access to high-quality, evidence-based programs that help parents and families to foster their children's development.

Option 8: Build the capacity of organizations implementing evidence-based programs to serve more children and families.

Option 9: Invest in innovative public-private financing mechanisms for evidence-based programs.

Option 10: Expand evidence-based programs for parents by advocating for increased state, local and federal funding.

Option 11: Simplify and disseminate information to assist parents in choosing high-quality care and education opportunities for their children.

Promote and share ongoing program innovation and improvement, especially for those programs supporting parents and informal caregivers.

Option 12: Promote quality-improvement efforts for family, friend and neighbor care.

Option 13: Foster innovation to achieve repeatable results.

To learn more, read The Bridgespan Group and the Pritzker Children's Initiative's "Achieving Kindergarten Readiness for All Our Children: A Funder's Guide to Early Childhood Development from Birth to Five."

http://www.bridgespan.org/early-childhood-funder-guide-2015

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Collaborating to accelerate social impact

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CHILDREN'S INITIATIVE

Photos: Ounce of Prevention Fund

Achieving Kindergarten Readiness for All Our Children

A Funder's Guide to Early Childhood Development from Birth to Five

By J.B. Pritzker, Jeffrey L. Bradach, and Katherine Kaufmann

About the Pritzker Children's Initiative

The Pritzker Children's Initiative (PCI) has been laser focused on a single, attainable goal: that all at-risk infants and toddlers in the United States will have access to high-quality early childhood development resources, increasing their likelihood of success in school and life. PCI is a project of the J.B. and M.K. Pritzker Family Foundation, which supports effective solutions to societal needs in four areas: early childhood, community healthcare and women's health, civil rights, and entrepreneurship. Our goal is to catalyze change that will fight poverty and promote equity and fairness nationally and in our immediate community of Chicago.

About The Bridgespan Group

The Bridgespan Group (www.bridgespan.org) is a nonprofit adviser and resource for mission-driven organizations and philanthropists. Bridgespan collaborates with social sector leaders to help scale impact, build leadership, advance philanthropic effectiveness, and accelerate learning. Through its work, Bridgespan focuses on issues related to society's most important challenges and breaking cycles of intergenerational poverty. Bridgespan's services include strategy consulting, leadership development, philanthropy advising, and developing and sharing practical insights.

Contributors

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Foreword

Smart investments in early childhood produce social benefits, cost savings, and economic returns for children, families, and society.

Economists such as Nobel Laureate James Heckman have demonstrated that investing in high-quality early childhood programs for disadvantaged children delivers a higher return on investment than social programs or education aimed at any other stage of life, through better education, health, social, and economic outcomes, increased productivity, and the reduced need for social spending. Scientific and educational research also demonstrates that the foundation for success in life begins during pregnancy and is built through age five. In sum, there is overwhelming evidence that high-quality early childhood interventions lead to measurable lifelong social and economic improvement.

In recent decades, pioneer investors and communities have seeded the field with experiments that have proven to have significant impact on child outcomes. Yet, although we know what works, we vastly underinvest in early childhood education. Annual philanthropic funding for birth to five is only a fifth of what is spent on K–12 education, and annual per capita government spending on early care and education is only a quarter of K–12 levels. As a result, very young children—particularly disadvantaged children—miss out on quality development opportunities, and the nation misses the opportunity to reap the strongest possible economic benefits from investing in children and families. These missed opportunities result in larger taxpayer burdens for the education, health, and criminal justice systems throughout these children's lives. As a nation, we must change how we think about and fund the early years—it's a matter of economic, fiscal, and common sense.

More than a decade ago, the J.B. and M.K. Pritzker Family Foundation began working to create substantial early learning opportunities for our nation's youngest children. Inspired and guided by mentors—especially Irving Harris and Barbara Bowman—and building on the work of national and local philanthropies that have been investing in early childhood development for decades, we invested in evidence-based programs, effective advocacy, and original research. Our research and experience, bolstered by emerging brain science, has deepened our belief in the importance of investing in our nation's youngest children, especially low-income children, who have the fewest resources and opportunities but who have equal potential for success.

We have made a long-term commitment to help ensure that all infants and toddlers in the United States, especially those most at risk, have access to high-quality development opportunities in early childhood, significantly increasing their likelihood of success in kindergarten and beyond.

In order to identify the greatest areas of need and points of leverage on which to focus our next phase of investment, we recently spent 18 months working to deepen our understanding of the early childhood field and either confirm or reject our assumptions. We asked questions that have been asked in decades past, but so much has been discovered in the last few years, we felt it was important to ask them again. We wanted to rely on the most recent data and the most modern and advanced research in the field.

Specifically, we asked four questions:

- What does the research tell us about the importance of early childhood development? What do we know about what works?
- What outcomes matter most for very young children, and to what extent are children in low-income families reaching these outcomes today?
- What are the immediate barriers to achieving better outcomes for low-income children?
- What are the most effective investments philanthropy can make to create meaningful impact for individual children and to achieve step-change improvements in the quality of the systems that surround them in their earliest years?

We embarked on this effort fully aware that private capital alone cannot achieve the outcomes we seek for our nation's youngest children. The need is too great for private philanthropy alone to meet. Much of the most effective work will be collaborative work that engages public and private stakeholders across a city, a state, or the nation. At the same time, philanthropic and business-led investments can play a critical role in demonstrating what works and encouraging government at all levels to make smarter and more cost-effective investments in early childhood.

Most fundamentally, our 18 months of work have highlighted *numerous* high-impact opportunities for investors to pursue *today* that can meaningfully increase kindergarten readiness beginning at birth. The "concept" has been proven—decades of research, program development, and evaluation have demonstrated strategies that work. While we will continue to learn more and refine these strategies, now is the time for philanthropy, business, and government to invest in expansion so that all our children arrive at school ready to learn.

This paper, prepared in partnership with The Bridgespan Group, summarizes what we have learned. We are sharing it broadly in hopes that it helps our colleagues in the donor community—particularly those new to the early childhood field—identify specific investments that they can make to ensure that young children reach their K–12 years ready to learn and thrive. While we do not expect or intend for this paper to change the priorities of funders who have worked tirelessly in this sector for years, we do hope the data and research presented here can help to inform our collective understanding of the issues facing our youngest children.

Our work has drawn on and builds upon the work of others to inform investments in early childhood, including: the White House; the Brookings Center on Children and Families (including key research on school readiness by Julia Isaacs and Katherine Magnuson); Child Trends; the Center for the Economics of Human Development at the University of Chicago; the Annie E. Casey Foundation and its KIDS COUNT project; the W.K. Kellogg Foundation; NIEER; the National Center for Children in Poverty; the New America Foundation; RAND; the Center for the Study of Social Policy; and the Center for High Impact Philanthropy at the University of Pennsylvania. This paper is neither an investment blueprint nor an exhaustive catalogue of public policy recommendations, but rather a menu of especially promising options for philanthropic investment to help prepare all of our nation's children for kindergarten. It is also very much a work in progress—there is so much more to learn about the most effective ways to influence early childhood outcomes, whether our focus is a single community, a state or region, or the nation as a whole.

We are at an exciting moment in time: while underinvestment persists, public and private momentum to invest is building. We hope that this report, in tandem with the continuing efforts of so many across the country, will contribute to conversation, spark new ideas and research, and convert the growing enthusiasm into actual investments that will significantly improve outcomes for very young children, ultimately strengthening the social and economic fabric of our nation.

J.B. and M.K. Pritzker

Highlighted Support for Early Childhood Investments

"Quality early childhood programs for disadvantaged children are not entitlements or bottomless wells of social spending. They are not government boondoggles. The early childhood investments we make today in disadvantaged young children promote social mobility, create opportunity, and foster a vibrant, healthy and inclusive society and economy."

JAMES J. HECKMAN, NOBEL LAUREATE IN ECONOMICS, HENRY SCHULTZ DISTINGUISHED SERVICE PROFESSOR OF ECONOMICS, UNIVERSITY OF CHICAGO

"Early childhood education is critical to a child's success in school and throughout life. Alabama's Voluntary Pre-K Program has been voted best in quality in the nation. We have prioritized funding for pre-K in Alabama and continue to expand access for all Alabama children whose parents want them to attend. Pre-K funding is an important investment that will benefit generations of children in the future."

GOV. ROBERT BENTLEY (R), ALABAMA

"This paper is an important catalyst for philanthropy in the early childhood field, offering a road map of areas for effective investments."

DIANA MENDLEY RAUNER, PH.D., PRESIDENT, OUNCE OF PREVENTION FUND (DEVELOPS INNOVATIVE PROGRAMS TO INCREASE HIGH-QUALITY EARLY CHILDHOOD EXPERIENCES) AND FIRST LADY OF ILLINOIS

"This well-researched guide shines a spotlight on the incredible importance of early childhood development and kindergarten readiness, the bright spots of effective efforts across the country, and a road map to high-impact opportunities that are ready for investment today. We need to pull together—across philanthropy, private and public sectors—to build on the momentum that exists to ensure that all of our country's children have the basic building blocks for a strong start in life."

CAROL LARSON, PRESIDENT AND CEO, THE DAVID AND LUCILE PACKARD FOUNDATION

"If indeed we are a nation at risk with our growing achievement and opportunity gap, this paper serves to raise awareness and inspire the commitment of public and private dollars where they can make the greatest difference—in our children's early years. Now we can only hope our leaders will read and respond."

MARGUERITE KONDRACKE, FORMER PRESIDENT AND CEO, AMERICA'S PROMISE ALLIANCE, CO-FOUNDER, BRIGHT HORIZONS FAMILY SOLUTIONS

"In recent years, extraordinary talent and resources have been allocated to improving America's K–12 educational system, but this study suggests that those efforts need to start much earlier to be successful. Giving all children equal opportunity, irrespective of the economic circumstances of their birth, is a profound moral obligation and the fundamental promise of America. This analysis provides useful guidance to government and philanthropy of the most effective interventions to help fulfill that promise."

GEORGE KAISER, PRESIDENT AND CEO, GBK CORPORATION, DONOR TO GEORGE KAISER FAMILY FOUNDATION

Please see page 47 for additional commentary.

Summary of Philanthropic Opportunities

We need to invest more money in early childhood, and we need to invest that money wisely. Thanks to decades of work by researchers, program developers and providers, foundations, and pioneering leaders, philanthropic investors today have many promising options. We can invest to expand approaches that have been proven effective (while recognizing the importance of continuous improvement) and also support ongoing research and innovation in targeted areas. The following list constitutes neither an investment blueprint nor an exhaustive catalogue of public policy recommendations, but rather a menu of high-impact options.

Strengthen public systems of early care and education at state and local levels to ensure continuous quality improvements.

Opportunity 1: Provide technical assistance for states to accelerate quality-improvement efforts.

Opportunity 2: Fund training for providers pursuing quality improvements.

Scale health and developmental screenings to connect parents and families with resources to optimize their children's holistic development.

Opportunity 3: Develop and propagate comprehensive screening and referral systems at the community level.

Opportunity 4: Support pediatric practices to integrate screenings and referrals into well-child visits.

Opportunity 5: Disseminate promising screening and assessment questionnaires and tools.

Improve the training, continuing education, professional development, and compensation of early childhood educators.

Opportunity 6: Increase the availability of on-the-job coaching and development for early childhood educators.

Opportunity 7: Fund research and technical assistance to promote fair compensation of early childhood educators.

Support greater access to high-quality evidence-based programs that help parents and families to foster their children's development.

Opportunity 8: Build the capacity of organizations implementing evidence-based programs to serve more children and families.

Opportunity 9: Invest in innovative public-private financing mechanisms for evidence-based programs.

Opportunity 10: Expand evidence-based programs for parents by advocating for increased state, local, and federal funding.

Opportunity 11: Simplify and disseminate information to assist parents in choosing high-quality care and education opportunities for their children.

Promote and share ongoing program innovation and improvement, especially for those programs supporting parents and informal caregivers.

Opportunity 12: Promote quality-improvement efforts for family, friend, and neighbor care.

Opportunity 13: Foster innovation to achieve repeatable results.

Part I: What does the research tell us about the importance of early childhood development? What do we know about what works?

The largest opportunities to improve the trajectory of a child's life happen during pregnancy and the earliest years of life, and continue through age five. Much of the critical development occurs before children enter the formal education system at kindergarten.

From the time of conception to the first day of kindergarten, a person's brain development proceeds at a faster pace than it will at any other stage of life.[1] Ninety percent of physical brain development occurs in the first three years of life, when a baby forms 700 new neural connections per second.[2,3] This building process is dramatically influenced by life experiences.[4] In particular, the quality of adult/child interaction strongly affects brain development and the cognitive and social-emotional skills that shape life outcomes.

Early childhood sets the course for what will happen in the first years of formal K-12 education and well beyond. When a young child enters kindergarten ready for school, there is an 82 percent chance that child will master basic skills by age 11, compared with a 45 percent chance for children who are not school ready.[5] Later in life, at-risk children who do not get high-quality early childhood experiences are 25 percent more likely to drop out of school, 40 percent more likely to become teen parents, and 60 percent less likely to attend college.[6] Further, early childhood development affects health and mental health. Comprehensive early interventions that combine health, nutrition, and learning have the potential to reduce risk factors associated with chronic diseases, such as hypertension and high blood sugar, well into adulthood.[7]

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1 Jack Shonkoff, and Deborah A. Phillips, eds., *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, D.C.: National Research Council and Institute of Medicine, National Academy Press, 2000), 386.

2 *Understanding the Effects of Maltreatment on Brain Development* Issue Brief (Washington, DC: Child Welfare Information Gateway, November 2009), 3.

3 Center on the Developing Child at Harvard University, "Five Numbers to Remember About Early Childhood Development," http://developingchild.harvard.edu/resources/multimedia/interactive_features/five-numbers/.

4 Jennifer Guerra, "Five Things to Know About Early Childhood Development," *State of Opportunity*, November 14, 2012.

5 Isabel V. Sawhill, Scott Winship, and Kerry Searle Grannis, *Pathways to the Middle Class: Balancing Personal and Public Responsibilities,* Washington, DC: Center on Children and Families at the Brookings Institution (September 20, 2012), 8.

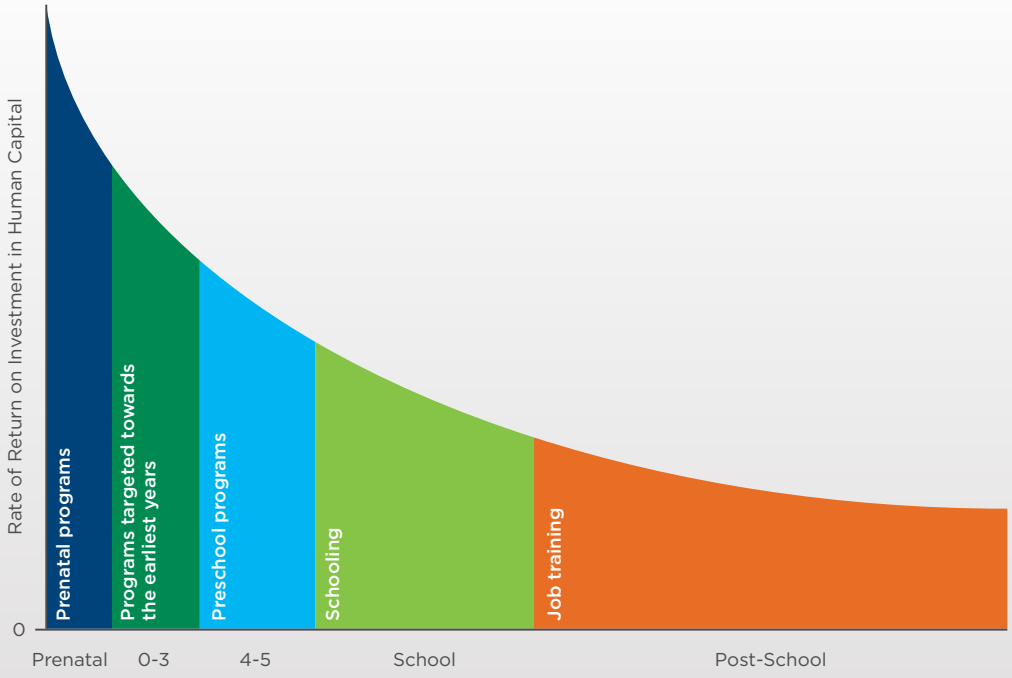
6 The Ounce of Prevention Fund, "Why Investments in Early Childhood Work," available at http://www.theounce.org/who-we-are/why-investments-in-early-childhood-work.

7 James J. Heckman, Francis Campbell, Gabriella Conte, Seong Hyeok Moon, Rodrigo Printo, Elizabeth Pungello, and Yi Pan, "Early Childhood Investments Substantially Boost Adult Health," *Science* 28, Vol. 343, No. 6178 (March 2014): 1478-1485.

Investing in early childhood development pays big dividends to society.

Investing in a full range of high-quality early childhood programs from birth to age five is one of the most economically efficient ways to create upward mobility, a capable and valued workforce, and a strong economy. Nobel Laureate Economist James Heckman has shown that investment in high-quality early childhood programs for at-risk children from birth to age five delivers a 7–10 percent return on investment through better education, health, social and economic outcomes, increased productivity, and the reduced need for social spending (Figure 1).[8] Investing in quality early childhood programs is a cost-efficient strategy for reducing deficits, improving K–12 achievement, creating jobs, and promoting economic growth.

Figure 1: Estimated rate of return on human capital investment[9]



Source: Heckman (2008) http://www.heckmanequation.org.

8 James J. Heckman, Seong Hyeok Moon, Rodrigo Pinto, Peter A. Savelyev, and Adam Yavitz, "The Rate of Return to the High/Scope Perry Preschool Program," NBER Working Paper No. 15471 (November 2009).

9 James J. Heckman, "Schools, Skills, and Synapses," *Economic Inquiry (2008)*, vol. 46, no. 3, 289-324. Chart presented as modified in James J. Heckman, "Invest in early childhood development: Reduce deficits, strengthen the economy," Chicago, IL: Heckman Equation, 2014.

A 2014 report from the White House Council of Economic Advisers[10] builds on the work of Heckman and others in finding that:

- expanding early learning initiatives could provide benefits to society worth roughly $8.60 for every $1 spent; and
- lifetime earnings gains from increased enrollment in early childhood education would outweigh the costs of these programs (the estimated gain in lifetime income per participant is $9,166 to $30,851 after subtracting the cost of the programs).

As Heckman has noted, "The longer society waits to intervene in the life cycle of a disadvantaged child, the more costly it is to remediate disadvantage."[11]

A vast body of research shows that disadvantaged children who receive quality early childhood education do better in school and have significantly better social and economic outcomes in life. However, a recent critique of investments in high-quality early childhood education programs is that the positive effects are believed to "fade out" by third grade.

While the Head Start Impact Study[12] is cited as proof of this purported "fade out," more current findings point to pollution in the study's treatment and control groups, resulting in an inaccurate assessment of the program's effectiveness. Two independent analyses by separate research teams controlled for this by dividing the children into three distinct groups according to their experience: Head Start attendees; other preschool attendees; and those who did not attend preschool. Both studies found that Head Start was as effective as other preschool programs and significantly more effective than no preschool at all.[13,14]

Moreover, the Impact Study provides no data for outcomes past third grade, while other rigorous studies of the long-term outcomes of Head Start have shown impacts on high school graduation, crime reduction, health outcomes, and wages.[15] Long-term randomized control trials of other early childhood programs such as Perry Preschool and Abecedarian track positive impacts on school, economic, and social outcomes well into adulthood (age 35).[16,17] Abecedarian's permanent gains

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10 The White House Office of the Press Secretary, "Fact Sheet: Invest in US: The White House Summit on Early Childhood Education," December 10, 2014, https://www.whitehouse.gov/the-press-office/2014/12/10/fact-sheet-invest-us-white-house-summit-early-childhood-education.

11 James J. Heckman, "The Case for Investing in Disadvantaged Young Children," in *Big Ideas for Children: Investing in Our Nation's Future*, 49-58. Washington, DC: First Focus, 2009.

12 M. Puma, S. Bell, R. Cook, C. Heid, G. Shapiro, P. Broene, F. Jenkins, P. Fletcher, L. Quinn, J. Friedman, et al., *Head Start Impact Study: Final Report*, Administration for Children & Families (2010).

13 A. Feller, T. Grindal, L. Miratrix, and L. Page, "Compared to What? Variation in Impacts of Early Childhood Education by Alternative Care-Type Settings," (December 30, 2014). Available at SSRN: http://ssrn.com/abstract=2534811.

14 P. Kline and C. Walters, "Evaluating Public Programs with Close Substitutes: The Case of Head Start," UC-Berkeley Institute for Research and Labor Employment Working Paper #123-14 (December 2014).

15 "Advisory Committee on Head Start Research and Evaluation: Final Report," submitted to the US Department of Health and Human Services, August 2012.

16 J.J. Heckman et. al., "Early Childhood Investments Substantially Boost Adult Health."

17 J.J. Heckman et. al., "The Rate of Return to the High/Scope Perry Preschool Program."

are attributed to the program starting from birth and incorporating all the elements of effective early childhood development: parental education, early health, nutrition, early learning, and preschool. Therefore, we would not conclude there is "fade out," but rather a strong "fade up" into better and more productive lives as children develop into adults.

Over the past few decades, we have gained a deep understanding of what works to improve child outcomes.

As this paper will describe in the sections that follow, research has identified the outcomes that matter most for young children. Research has also demonstrated the critical ingredient to achieving these outcomes: responsive, sensitive, and warm interactions between infants, toddlers, and preschoolers and the adults in their lives in all of the settings in which they learn and grow. Research and practice also have identified the barriers that make it difficult to realize those outcomes and the programmatic and systemic solutions to addressing these.

It became clear to us through our research that while research is still needed in many areas, there are numerous high–impact opportunities for investors to pursue today that can meaningfully improve child outcomes beginning at birth. The concepts have been proven—decades of research, program development, and evaluation have demonstrated strategies that work. While we will continue to learn more and refine these strategies, now is the time for philanthropy, business, and government to invest in expansion so that all our children arrive at school ready to learn.

We are not investing enough in early childhood.

Despite the evidence that investing in the early years is critically important and the existence of proven approaches, the United States severely underinvests in the development of children before they reach age five. Combined annual per capita public spending at the state and federal level on education for six- to eighteen-year-olds is nearly four times as high as spending on children from birth to five (Figure 2).[18] Philanthropic funding for K–12 education totals more than five times what is donated to early childhood causes.[19] While efforts to improve K–12 learning are much needed, they will have greater impact when we ensure that children enter the K–12 system ready to learn. Thus, we must work together, as philanthropists and local communities, to direct more spending towards the years before kindergarten—scaling what we know works and building more knowledge in areas where we know less.

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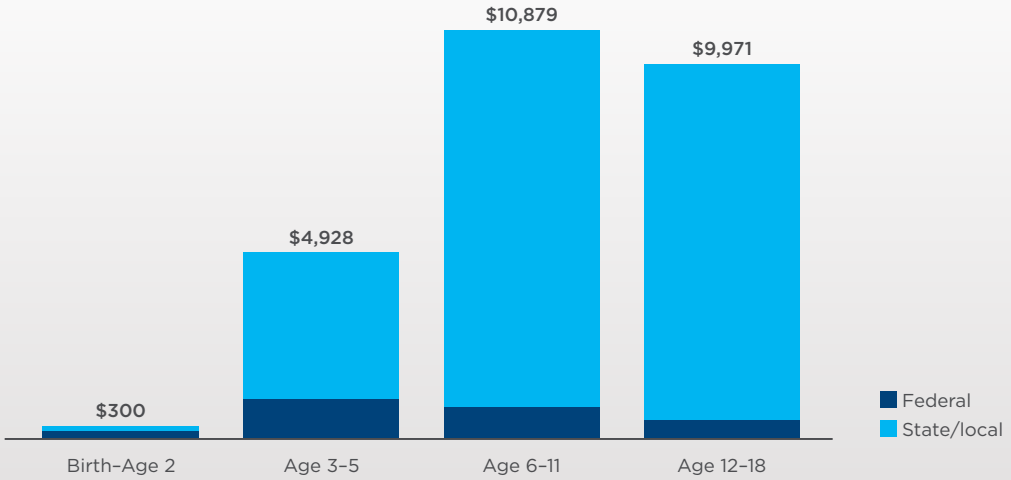
18 Sara Edelstein, Julia Isaacs, Heather Hahn, and Katherine Toran, "How Do Public Investments in Children Vary with Age? A Kid's Share Analysis of Expenditures in 2008 and 2011 by Age Group," The Urban Institute (October 2012), 11-12.

19 Based on analysis performed by The Bridgespan Group on data collected by The Foundation Center, 2009–2012. "Early childhood" includes all grants more than $50,000 tagged as early childhood education/child development, infant and prenatal health care, and parent education. "K–12" includes all grants more than $200,000 tagged elementary/secondary education, education services, and education technical assistance. Smaller grants were estimated by assuming the same distribution of grants below the cutoffs.

Figure 2: Estimated annual per child federal and state/local spending on education and early care, by age



Source: Edelstein et al. (2012); data is based on 2008 and 2011 expenditures.

Part II: What outcomes matter most for very young children?

Understanding a child's early development.

There is increasing consensus about the critical areas of development and the outcomes that matter most in the early years. Healthy development is commonly understood to include five dimensions:[20] (1) physical well-being and motor development; (2) social and emotional development (positive social behaviors when interacting with peers);[21] (3) cognitive skills (including numbers, patterns, and shapes); (4) language and emergent literacy; and (5) approaches to learning (the ability to concentrate and follow directions). These domains are, of course, interconnected: for example, children's ability to regulate emotions, thoughts, and behaviors can help them manage stress and control their impulses so that they learn more easily in school.[22]

These five domains simultaneously define healthy development of infants and toddlers and also comprise the key elements of "kindergarten readiness." Said another way, preparing a child for kindergarten—and, in turn, for success later in life—requires focusing on five areas of development that begin at birth. We have come to use kindergarten readiness as the single whole-child outcome towards which we direct our investments and attention. It is important to note that kindergarten readiness is not a simple yes/no switch. Rather, children may be more developed in some domains than in others. And their level of development can and does change over time, especially with the right kind of support.[23]

Kindergarten readiness could be a unifying goal for the early childhood field.

Today, multiple adults—parents, grandparents, physicians, child-care providers, and teachers—work to ensure that a young child has the supports he or she needs for healthy development. And multiple systems (health care, social services, education, child care) touch children and their families, and could potentially deliver those needed supports. However, without a shared focus on the same outcomes and developmental milestones, the efforts of these individuals and systems will remain disconnected and limited in effectiveness. We believe that kindergarten readiness

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20 *Getting Ready: Findings from the National School Readiness Indicators Initiative* (Rhode Island KIDS COUNT, February 2005), 13.

21 The social and emotional development component of kindergarten readiness is a similar to but separate concept from social and emotional learning, which is defined by the Collaborative for Academic, Social, and Emotional Learning as "the process through which children and adults acquire the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."

22 Collaborative for Academic, Social, and Emotional Learning, 2014.

23 Susan H. Landry, *Effective Early Childhood Programs: Turning Knowledge into Action*, Houston, TX: University of Texas Health Science Center (2005).

could be the unifying goal toward which all those who work to promote whole-child development of young children could align their efforts.

The Maryland Model for School Readiness is a case study in the power of unified focus on a set of common outcomes. While limited to pre-K and kindergarten, Maryland's universal assessment approach, the Work Sampling System, allows teachers to track children's knowledge and skills in seven areas of development at school entry and exit, as well as over the course of the year. This approach enables teachers to target resources to children in a way that could help them the most.[24] Maryland's experience demonstrates that implementing a unified and universal approach to assessing child outcomes is not without its challenges. For example, teachers were unable to assess children's progress and target resources earlier than school entry, and many expressed caution about using the results to evaluate children, rather than for the intended purpose of measuring progress.[25] However, this example illustrates the potential benefits of a shared focus on outcomes. In the 2013–2014 school year, 83 percent of the state's children entered kindergarten ready to learn, up from 49 percent in 2001.[26]

To what extent are children from low-income families reaching positive outcomes today?

As discussed above, there are limited data measuring how children are doing nationwide against developmental milestones. However, an analysis conducted by Julia Isaacs and Katherine Magnuson on a nationally representative, longitudinal data set collected by the National Center for Education Statistics (the Early Childhood Longitudinal Study–Birth Cohort, or ECLS-B) provides the basis for us to make some informed estimates.[27] The ECLS-B data set and the methods we used to analyze it have important limitations.[28] Because it is an observational data set, it cannot be used to establish causality between any childhood characteristics (e.g., demographic status, place of care, etc.) and outcomes. However, ECLS-B is the most comprehensive data set that allows us to understand the nature and magnitude of children's developmental needs. This data therefore is a useful complement to the observations and experience of practitioners and experts.

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24 National Conference of State Legislatures, "A Look at Maryland's Early Childhood Data System," Washington, DC, 2010.

25 Catherine Gewertz, "Kindergarten-Readiness Tests Gain Ground," *Education Week*, October 7, 2014.

26 Maryland State Department of Education, "Children Entering School Ready to Learn," http://www.marylandpublicschools.org/MSDE/divisions/child_care/early_learning/docs/2014MMSRTechnicalReport.pdf.

27 Responsibility for this analysis lies solely with The Bridgespan Group and the Foundation, and any conclusions drawn or errors made are entirely our own.

28 While it is the most recent study that tracks children from birth to kindergarten, ECLS-B tracks children born in 2001 who entered kindergarten in 2006 or 2007. See Appendix C for methods used to calibrate this data to reflect the 2012 population profile using the American Community Survey. Further limitations are discussed in Appendix C.

The ECLS-B data provides a picture of how a representative sample of American children performed in five areas relative to their peers. These areas roughly align with the kindergarten-readiness domains: math (cognitive skills), reading (language development), learning behaviors (approaches to learning), externalizing behaviors (social and emotional development), and health (physical well-being). ECLS-B measures age-appropriate development indicators in each of these five areas at ages nine months, two years, and four years, and at kindergarten entry.

Like most other national school-readiness assessments, the measure of school readiness we developed from ECLS-B does not measure children's performance against an absolute standard.[29] However, it does help us make a directional estimate that a significant number of children may not reach positive outcomes. We estimate that about half of the approximately 12 million low-income[30] children from birth to age five—5.8 million in all—are at risk of not being fully ready for kindergarten when they enter.[31] While there are children at all income levels who are also not ready, our analyses—and the opportunities in this paper—focus on low-income children.

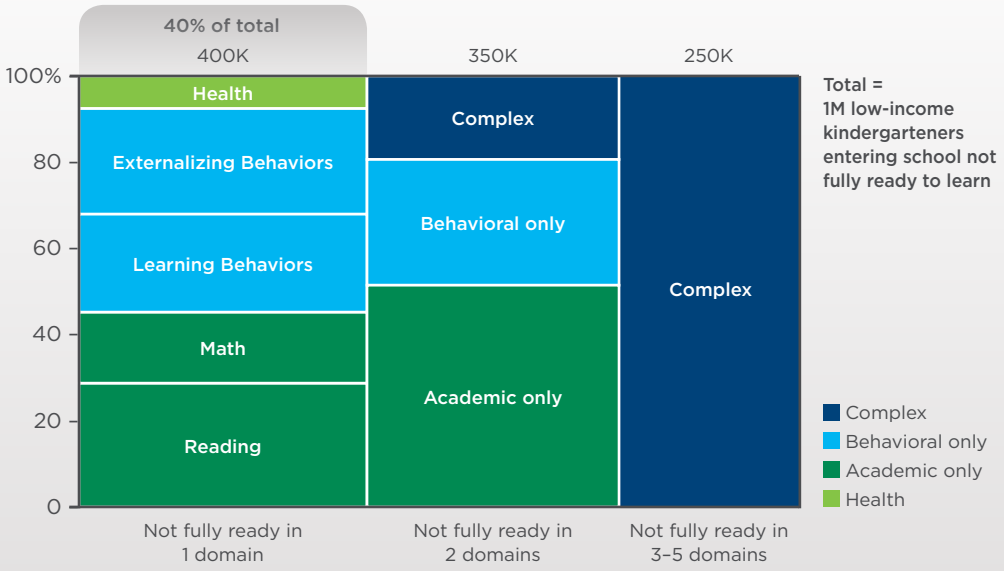
ECLS-B also tells us that children have a wide variety of needs and no one profile of need dominates. Some children are at risk of not keeping pace in cognitive and language domains, while others may not be developing positive social and emotional behaviors. As Figure 3 on the next page shows, a significant number of low-income children will likely struggle primarily in a single domain (e.g., learning behaviors). Almost the same number of children will likely need support in two related domains (e.g., both behavioral domains). And roughly a third of children will need support with both academic and behavioral development—labeled as "complex" gaps in Figure 3.

29 See Appendix C, Figure A-3 for comparison of ECLS-B to other national school-readiness assessments.

30 Throughout this paper, "low-income" refers to children living under 200 percent of the federal poverty line.

31 "Ready for kindergarten" is measured relative to peer performance and is not an absolute measure. The number of low-income children in 2012 is based on the American Community Survey (2012). According to ECLS-B data, The Bridgespan Group has estimated that close to half (49 percent) of low-income children are at risk of not being fully ready for kindergarten when they enter.

Figure 3: Low-income kindergarteners entering school not fully ready to learn, by domain of need[32]



Source: Analysis of ECLS-B (2006-7), American Community Survey (2012).

Why does it matter that there are diverse needs among this very large group of low-income children at risk for not being fully ready for kindergarten? We see four important implications. First, these data underscore the importance of equipping parents and caregivers with information about each child's specific developmental strengths and needs. Second, this diversity suggests that some of the most effective interventions may be those that identify and address specific needs and assets, rather than a one-size-fits-all approach.[33] Third, it illustrates that preparing all children for kindergarten will require developing and scaling solutions for each profile of need and ensuring that the right mix of solutions is available in every community. Finally, it reinforces the need for tools especially suited for infants and toddlers, population-level screenings of children at multiple points prior to kindergarten entry, and data management systems that enable communities to assess and act on data about child outcomes and needs in real time.

Our research on "how we are doing" also surfaced the importance of understanding—and ultimately addressing—a child's needs in the context of family

32 This chart is based on The Bridgespan Group's estimate of the percent of low-income children not ready for kindergarten in ECLS-B (2006–7), following methods used in Julia B. Isaacs and Katherine Magnuson, *Income and Education as Predictors of Children's School Readiness*, Washington, DC: Center on Children and Families at the Brookings Institution (December 14, 2011). The number of low-income children in 2012 is based on Bridgespan's estimates from the American Community Survey (2012).

33 National Association for the Education of Young Children, "Principles of child development and learning that inform developmentally appropriate practice," July 1996, https://oldweb.naeyc.org/about/positions/dap3.asp.

circumstances. For example, experts and data surfaced the particular needs of Dual Language Learners (DLLs).[34] These children often struggle with language and then are misdiagnosed as having learning disabilities.[35] The ECLS-B data add to this picture, suggesting that Hispanic children who are DLLs (or live in families where English is rarely spoken) are particularly likely to need primarily academic support.[36] Hispanic parents are less likely to enroll their children in public pre-K, instead making use of informal care arrangements.[37] Yet, when provided with high-quality early care and education, Hispanic children make significant gains and often surpass peers from other backgrounds.[38] For example, Hispanic children who experienced high-quality early education in Oklahoma's universal pre-K program increased their test scores by 54 percent.[39] These children and others, including immigrants from non-Hispanic countries, African Americans, and Native Americans, might benefit from culturally and linguistically tailored interventions.

Another group of children and families with unique circumstances are those facing multiple stressors, such as exposure to violence or maternal depression. Research has demonstrated that the negative effects of maternal depression on children's health and development can start before birth[40] and can impair the early parent-child relationship that forms the foundation of a high-quality early learning environment.[41] Research has also shown that long-lasting stress, which results from physical and emotional assault and exposure to violence, can disrupt healthy brain development and increase the risk of disease and cognitive impairment into the adult years.[42] The evidence of violence against children

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34 "Dual Language Learner" is used in this context to refer to students who are learning English as they continue to develop proficiency in their home language and who are generally eight years old or younger. Separately, "English Language Learner" refers to older students who have developed proficiency in another language and are learning English in school. Source: Conor P. Williams, *Better Policies for Dual Language Learners*, Washington, DC, New America Foundation (February 2015).

35 *Dual Language Learning: What Does It Take? Head Start Dual Language Report*, Washington, DC, Office of Head Start, Administration of Children and Families, US Department of Health and Human Services (February 2008), 22.

36 Please see Appendix C, Figure A-1 for domains of need for Hispanic children.

37 Sean Chalk and Holly Yettick, "Hispanic Preschool Participation Varies by State," *Education Week*, January 15, 2015.

38 Luis M. Laosa and Pat Ainsworth, *Is Public Pre-K Preparing Hispanic Children to Succeed in School?* New Brunswick, New Jersey, National Institute for Early Education Research (March 2007), 6-7.

39 William Gormley, Jr., Ted Gayer, Deborah Phillips, and Brittany Dawson, *The Effects of Oklahoma's Universal Pre-K Program on School Readiness*, Washington, DC, Center for Research on Children in the US, Georgetown University (2004), 4.

40 L. Bonari, N. Pinto, E. Ahn, A. Einarson, M. Steiner, and G. Koren, "Perinatal Risks of Untreated Depression During Pregnancy," *Canadian Journal of Psychiatry*, vol. 49 no. 11 (November 2004), 726-35.

41 Through ECLS-B and consistent with previous studies, Isaacs (2012) found that low-income mothers had a depression rate nearly twice that of more affluent mothers. Her analysis showed that depression has a significant impact on child development, as the likelihood of being school ready is 10 percentage points lower for children whose mothers score low in supportiveness during parent-child interactions.

42 Center on the Developing Child at Harvard University, "Key Concepts: Toxic Stress," http://developingchild.harvard.edu/key_concepts/toxic_stress_response/.

is sobering: a recent national survey of 4,500 children indicated that close to 10 percent of two- to five-year-olds were victims of maltreatment by a caregiver in the last year, and 15 percent have been indirect witnesses to violence.[43] Recent national statistics show that 75.7 percent of children who died as a result of abuse were younger than four years old.[44] Children can also be profoundly affected by witnessing violence against others: exposure to violence, particularly within the family, can alter a child's sense of trust and inhibit his or her autonomy and curiosity as he or she grows older.[45] This paper is focused primarily on opportunities that can improve outcomes for at-risk children, regardless of these risk factors. However, to ensure that children from the highest-risk families realize the full benefit of these programs, these solutions may also need to be coupled with targeted interventions addressing maternal depression, domestic violence, homelessness, and transience, the environmental factors that can so strongly influence children's development.

43 David Finkelhor, Heather A. Turner, Anne Shattuck, and Sherry Hamby, "Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth," *JAMA Pediatrics* vol. 167, no. 7 (July 2013), 614-21, Tables 3 and 5.

44 Ann T. Chu and Alicia F. Lieberman, "Clinical Implications of Traumatic Stress from Birth to Age Five," *Annual Review of Clinical Psychology*, vol. 6 (2010), 469-94.

45 Joy D. Osofsky, "The Impact of Violence on Children," *The Future of Children*, vol. 9, no. 3 (Winter 1999).

Part III: What are the immediate barriers to achieving better outcomes for low-income children?

Achieving positive child development outcomes requires improving the quality of children's interactions with adults across the settings where they spend time from birth to age five. Our research shows that responsive, sensitive, and warm interactions between infants, toddlers, and preschoolers and the adults in their lives are among the most important preparations for kindergarten.[46]

Experts widely agree that parents are the most influential adults in young children's lives, and their earliest teachers. Parenting explains 40 percent of the income-related cognitive differences between children at age four.[47] Research by Hart and Risley (2003) found high disparities between the number of words children hear by age three in high-income families versus those in low-income families (since labeled the "30 Million Word Gap"). This disparity, in turn, has a large effect on the size of children's vocabulary at age three, which influences school performance.[48] At the most basic level, overall well-being, including education and employment, also influence a parent's ability to support his or her child's development.[49] In sum, many parents—and especially those living in poverty—could benefit from extra support to ensure their children are achieving desired developmental milestones. Unfortunately, effective voluntary parenting programs are not reaching all those who need them.

The strongest parenting programs—including 16 federally approved home visitation programs[50]—can help parents form a secure attachment with their children and foster linguistic, cognitive, and social and emotional development. But despite $1.5 billion in federal funding over five years, these evidence-based home visitation programs reached only 115,000 children in 2014,[51] an estimated 2.5 percent of

46 These interactions improve children's social-emotional functioning and social competence skills. By kindergarten, these skills have been shown to be significantly associated with positive young adult outcomes across education, employment, criminal activity, substance use, and mental health. Source: Damon E. Jones, PhD, Mark Greenberg, PhD, and Max Crowley, PhD, "Early Social-Emotional Functioning and Public Health: The Relationship Between Kindergarten Social Competence and Future Wellness," *American Journal of Public Health*, published online ahead of print July 16, 2015: e1-e8.

47 Richard V. Reeves and Kimberly Howard, *The Parenting Gap*, Washington, DC, Center on Children and Families at the Brookings Institution (September 8, 2013), 3.

48 Betty Hart and Todd R. Risley, "The Early Catastrophe: The 30 Million Word Gap by Age 3," *American Educator* (Spring 2003), 8.

49 The Annie E. Casey Foundation, *Creating Opportunity for Families: A Two-Generation Approach*, 2014.

50 List available at Health Resources and Services Administration Maternal and Child Health, "Home Visiting Models," http://mchb.hrsa.gov/programs/homevisiting/models.html.

51 US Department of Health and Human Services Press Office, "HHS awards $386 million to support families through the home visiting program," February 19, 2015.

the need.[52] Early Head Start can reach parents through home-visiting or center-based models, or a combination of both. Early Head Start, however, was reaching only 4 percent of eligible infants and toddlers as of 2012.[53] Despite the variety of programs that have shown evidence of effectiveness, many are subscale and limited in geographic reach. As a result, many communities lack a full range of diverse and effective parenting programs and other supports for mental health, maternal depression, and domestic violence. Nor do many communities have a consistent way to match families to the supports that could help them most.

In addition to the critical time spent with parents in their earliest years, young children also spend time in the care of other adults. These adults are found in center-based care and education (e.g., private child-care centers, nurseries and preschools, state pre-K, Head Start centers), licensed family-based child-care centers, or informal family, friend, and neighbor (FFN) care provided in a home-based setting by a caregiver other than a child's parent. Care arrangements are dynamic, and young children move among these four settings. Generally speaking, most infants and toddlers spend the majority of their time with parents. As they get older, more children spend the majority of their time in a center-based setting, as illustrated on the following page in Figure 4 for the ECLS-B cohort that was in kindergarten when surveyed.[54] ECLS-B does not differentiate family or group child-care homes that care for groups of children in a home-based setting. Though this setting is different from FFN and center-based care in important ways described below, children in this setting may be included in either FFN care or center-based care in the ECLS-B analysis.

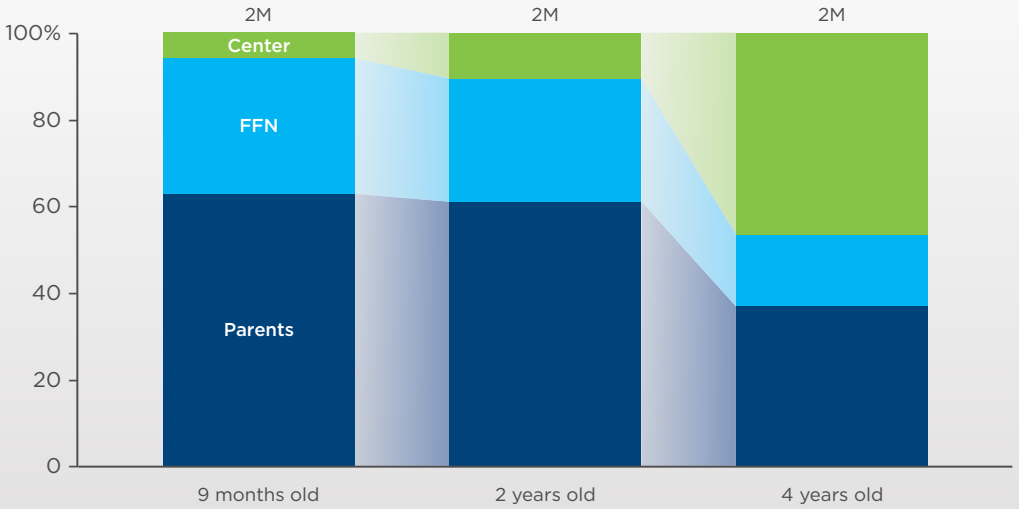
52 This proportion is based on Pew Center on the States's estimate of 4.5 million low-income infants and toddlers, in *States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line*, Washington, DC: Pew Charitable Trusts (August 2011), 23.

53 Stephanie Schmit and Danielle Ewen, *Supporting Our Youngest Children: Early Head Start Programs in 2010*, Washington, DC: Center for Law and Social Policy (March 2012), 11.

54 Children often spend time in multiple settings. For the purposes of this figure, children in the "parents" setting spend less than 10 hours a week in either FFN or center-based care. Children in FFN and center-based care spend more time in those settings than in any other setting. Please see Appendix C for detailed definition of settings.

Figure 4: Estimated primary care setting for low-income kindergarteners, by age[55]

% Low-income (<200% Federal Poverty Line) children in kindergarten, at three ages



Source: Analysis of ECLS-B (2006-7) and American Community Survey (2012).

Given the fluidity of where children spend their time before age five, it is important to invest in programs that help improve the quality of adult-child interactions across all settings. There is value in building formal systems that give parents high-quality child-care and education options for all ages. In addition, parents and FFN caregivers will continue to play a major role in individual children's development and should also receive evidence-based voluntary supports. This is particularly true of children in immigrant families, who have lower rates of participation in nonparental care of any type, due in part to language barriers and cultural preferences for child care at home.[56]

55 Based on analysis performed by Bridgespan on the ECLS-B (2006–7). Please see Appendix C for detailed definition of settings. While place of care is not measured nationwide by systematic methods, several surveys confirm these estimates. Halle et al. (2009) findings from the 2005 National Household Education Survey indicate that approximately 40 percent of nine-month-old infants are in some form of nonparental care at least once a week, and that FFN is the most common arrangement for those infants who are living below 150 percent of the federal poverty line. The National Institute of Child Health and Human Development (NICHD) (2006) uses the Study of Early Child Care and Youth Development (SECCYD) to show that approximately 50 percent of all six-month-olds (not just low-income) are in parental care, 42 percent in FFN (relative or other home-based care), and 9 percent in centers, and 23 percent of four-and-one-half year-olds are in parental care, 23 percent in FFN, and 54 percent in centers.

56 Lynn A. Karoly and Gabriella C. Gonzalez, *Early Care and Education for Children in Immigrant Families*, (Princeton, NJ: The Future of Children, Spring 2011), vol. 21, no. 1, 71-101.

Family, friend, and neighbor (FFN) care

We estimate that approximately 25 percent of low-income children under the age of five are spending a significant portion of their time in FFN care.[57] In the years before age three, more children are in FFN care than in center-based care. The millions of FFN providers, many of them grandparents and other family members, are often unpaid, unregulated, and difficult to involve in quality-improvement efforts. Many care for fewer than five children, which may mean they are not subject to licensing and state child-care requirements in some states. Furthermore, approximately half of unlisted[58] home-based providers (1.7 million) have no more than a high school education.[59] Given that many of these providers operate outside of the licensing and regulatory system, identifying and reaching this population is very challenging. However, many experts we interviewed agreed that, given the number of children in FFN care, even a small average improvement in the quality of FFN care would better prepare many young children for kindergarten.

Family or group child-care homes

Families seeking nonparental arrangements choose among a variety of options. Some children are in the care of an adult other than their parent in the caregiver's home. These settings vary greatly from one to the next, including a mix of: regulated/licensed child care and regulation-exempt care, paid and unpaid providers, and care by both relatives and nonrelatives delivered in a home-based setting. These family or group child-care homes vary by level of regulation and licensing status, depending on their state's cutoff for the number of children that can be cared for before that home-based setting must be licensed/regulated. While quality data on this setting is limited, there is a general belief that it varies dramatically across family child-care providers.[60]

Center-based care and education

By age four, about half of low-income children are estimated to be spending a significant amount of their time in some form of center-based care or education.[61]

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57 This number is estimated from Bridgespan's analysis of ECLS-B (2006–7), based on where low-income kindergarteners spent more than 10 hours per week under the age of five. Please see Appendix C for detailed definition of settings.

58 "Unlisted" caregivers are those who have not taken steps to secure licensing, apply for exempt status, or participate in Head Start.

59 National Survey of Early Care and Education Project Team, *Number and Characteristics of Early Care and Education (ECE) Teachers and Caregivers: Initial Findings from the National Survey of Early Care and Education (NSECE)*, OPRE Report #2013–38, (Washington, DC: Office of Planning, Research and Evaluation, Administration of Children and Families, US Department of Health and Human Services, October 2013), 16.

60 Bruce Fuller, Sharon Lynn Kagan, Susanna Loeb, and Yueh-Wen Chang, "Child Care Quality: Centers and Home Settings that Serve Poor Families," *Early Childhood Research Quarterly*, vol. 19 (2004), 505-527.

61 This number is estimated from Bridgespan's analysis of ECLS-B (2006–7), based on where low-income kindergarteners spent more than 10 hours per week under the age of five. Please see Appendix C for detailed definitions of settings.

These centers include state-regulated child care, Head Start, state-funded pre-K, and other centers that may not be regulated by the federal government. Quality varies widely across each of these centers. Barriers to higher quality include: the lack of incentives and resources for improving quality; the challenges to hiring, training, and developing quality staff; and some of the lowest levels of compensation in the US economy.

Experts define "quality" care and education as including a set of conditions and practices that include: sufficient teacher qualifications, appropriate child-teacher ratios and overall number of children in a group, quality materials and/or curriculum, teacher attention to fostering development and learning, and supportive and nurturing teacher-child interactions.[62] Research has also demonstrated the positive impact of quality child care and illustrated wide variation in quality across centers.[63] In addition, research suggests that many center-based programs, including child care, Head Start, and pre-K, are falling short of their potential to help get children ready for kindergarten. Simply finding recent national surveys that measure the quality of child care is a challenge. However, one national longitudinal study from the early 2000s showed that only 26 percent of the child-care centers observed met guidelines for child/staff ratios (at age two), and only 39 percent of children in observed child-care settings received "a fair amount" of positive caregiving (the rest were worse).[64] With well over one million children in 18,000 centers across the nation,[65] Head Start is by far the largest early education program. However, despite an average annual federal investment of $8,000 per child,[66] studies indicate that the Head Start network's quality and impact are not consistent across sites, and that there is potential to improve outcomes.[67] There are also publicly funded pre-K programs in many states, but their quality is also mixed and access is often limited. In the 2013-2014 school year, only 29 percent of four-year-olds were enrolled in a state-funded pre-K program, and only five states met all benchmarks for teacher quality, class size, and teacher/student ratios.[68]

The experts we interviewed suggested that one barrier to increasing the quality of these centers is that there are few incentives or resources available to improve

62 National Institute of Child Health and Human Development, *The NICHD Study of Early Child Care and Youth Development: Findings for Children up to Age 4 ½ Years,* NIH Pub. No. 05-4318, Washington, DC: US Department of Health and Human Services National Institutes of Health (January 2006), 8–10.

63 Ibid., 12.

64 Ibid., 9, 11.

65 Administration for Children and Families, "FY 2014 Head Start Program Fact Sheet," 2014, http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/2014-hs-program-factsheet.html.

66 US Department of Health and Human Services, Administration for Children and Families, "Head Start Program Facts Fiscal Year 2013," obtained by dividing total federal funding of $7.28 billion by total enrollment of 903,000.

67 Sara Mead, *Renewing Head Start's Promise: Invest in What Works for Disadvantaged Preschoolers*, Bellwether Education Partners (July 2014), iv.

68 W. Steven Barnett, Megan E. Carolan, James H. Squires, Kirsty Clarke Brown, and Michelle Horowitz, *The State of Preschool 2014: State Preschool Yearbook*. New Brunswick, NJ: National Institute for Early Education Research (2015).

the conditions and practices that result in positive child outcomes. In most states, child-care centers become eligible for funding from the Child Care and Development Block Grants just by meeting health and safety standards—basic training in child development is not required in many cases.[69] Clearly, high standards for health and safety are essential, but they are not sufficient on their own to promote child development. In many states, child-care centers are subject to even less regulation than beauty salons and tattoo parlors.[70] Research has suggested that centers should be held accountable for maintaining conditions for learning and upholding quality professional practices that are tied to quality child outcomes.[71]

To increase accountability for quality, many states have implemented Quality Rating and Improvement Systems (QRIS). However, our interviews revealed that these systems are not yet reaching their potential. QRIS today are typically voluntary (which results in low participation) and do not yet consistently evaluate the presence (or absence) of quality conditions and practices. Moreover, states are evaluating and assessing programs without consistently investing in resources to help them improve, and funding is not linked to quality standards (so there are few incentives to participate). In a similar vein, the federal Head Start funding stream does not consistently reward high performance. In the last few years, the lowest-performing Head Start providers have been required to re-compete for funding, which is an important step to increasing quality across the program.

Given the importance of positive adult-child interactions, experts agreed that another barrier to improving center quality is the difficulty of hiring and training qualified staff who can engage in stimulating and supportive interactions with children.[72] Infants have been shown to have better expressive language skills when their caregivers are better educated,[73] and preschoolers' language comprehension skills are higher when their caregivers have at least an associate of arts degree in a child-related field.[74] However, the experts we interviewed agreed that a number of barriers—including lack of state regulation, low salaries, poor working conditions, and limited professional development opportunities—hinder the recruitment, training, and retention of a high-performing early childhood workforce.

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69 *We Can Do Better: 2013 Update*, Arlington, Virginia: Child Care Aware of America (2013).

70 Maryam Adamu, "New Child Care Regulations Are a Step in the Right Direction," *Center for American Progress*, Sept. 17, 2014.

71 Elliot Regenstein and Rio Romero-Jurado, *A Framework for Rethinking State Education Accountability and Support from Birth Through High School*, Chicago, IL: The Ounce of Prevention Fund, June 3, 2014.

72 Hirokazu Yoshikawa et al., *Investing in Our Future: The Evidence Base on Preschool Education*, New York, NY: Foundation for Child Development (October 2013).

73 Margaret R. Burchinal, Joanne E. Roberts, Laura A. Nabors, and Donna M. Bryant, "Quality of Center Child Care and Infant Cognitive and Language Development," *Child Development,* vol. 67, no. 2 (April 1996), 606–620.

74 Carollee Howes, "Children's Experiences in Center-Based Child Care as a Function of Teacher Background and Adult : Child Ratio," *Merrill-Palmer Quarterly,* vol. 43, no. 3 (July 1997), 404-425.

Finally, a third related barrier to quality center-based care is poor compensation for teachers. While research has consistently demonstrated the link between teacher compensation and program quality,[75] we aren't paying early childhood teachers nearly enough to attract the right people with the right educational qualifications. In 2013, child-care workers (who were not pre-K or Head Start teachers) were in the third earnings percentile of occupations in terms of mean annual salary (along with parking lot attendants). Pre-K teachers earn more but are still paid only 60 percent of a kindergarten teacher's salary.[76] Early childhood salaries are not commensurate with education: teachers with a bachelor's degree or higher earn, on average, only 55 percent the wages of their peers with the same education level in other professions.[77] These low salaries lead to high turnover rates—as high as 27 percent in for-profit centers.[78] Professional development efforts may therefore achieve limited impact if salaries in the early childhood teaching profession cannot attract and retain qualified workers.

Across settings, we lack sufficient capital to invest in both existing programs and innovation, and we lack data that can tell us where to invest.

Federal and state spending on children is largely directed at school-age children. The United States ranks 31st in a group of 32 developed nations in the percentage of public education dollars allocated to early childhood.[79] According to experts we interviewed, we also are underinvesting in innovation to address several early childhood challenges, including engaging FFN caregivers, reaching early childhood teachers with effective professional development, developing curricula that increase learning in center-based care, and developing lower-cost parenting and family engagement models that might be the easiest to scale.

Across the sector, data and measurement are limited and are not consistently aligned with the same outcomes, so it is hard to know what is working, what is not, and where to best direct resources. In our research, the most promising approach involved implementing developmental screenings from birth to age five across the five kindergarten-readiness domains, which some communities are doing using tools like the Ages and Stages Questionnaire®. However, population-wide screenings before kindergarten are difficult to implement, given that children are in different settings and can be challenging to reach. An alternative approach would be to assess child development at age four in pre-K, with such tools as the Early Development Instrument (the EDI), to create a neighborhood-level snapshot of child needs and inform where interventions could help children at

75 Leone Huntsman, *Determinants of Quality in Child Care: A Review of the Research Evidence*, New South Wales, Australia: Centre for Parenting and Research, NSW Department of Community Services, April 2008.

76 Ibid., 16-17.

77 Ibid., 21.

78 Ibid., 30.

79 Eduardo Porter, "Investments in Education May Be Misdirected," *The New York Times*, Economic Scene, April 2, 2013.

earlier ages. Some states, private funders (e.g., the Commonwealth Fund), and independent child-care providers (e.g., Head Start grantees) have undertaken initiatives to expand developmental screenings to more children.[80] However, we are not yet deploying these tools systematically to assess a child's development prior to entering the school system. While tools like the EDI are commonly used in other countries such as Australia and Canada, these metrics are not systematically assessed and collected across the United States for children before age five.

Assessment prior to kindergarten is critical, given that so much brain development occurs before age five. We must have data on individual children to help parents and caregivers intervene at the point in a child's life where these interventions can do the most good. In addition, population-level assessments can help communities decide when and how much to invest in child development. Those interviewed agreed that ideally tools like Kindergarten Entry Assessments would be consistent across the nation and measure all five domains of kindergarten readiness, and child development would be measured at regular intervals throughout children's early years.

To state the obvious, the early childhood field is a complex one. Figure 5 on the next page has helped us make sense of this field by illustrating the systems, organizations, and individuals operating at federal, state, and local levels that must join forces in order to promote healthy whole-child development, working towards a unifying goal of preparing children for kindergarten, school, and life. This unified picture has informed our choices about where to invest by illustrating the many potential areas of investment, how each might—and might not—contribute to the outcomes we seek, and where collaboration with other efforts will be needed.

80 Christine Johnson-Staub, *First Steps for Early Success: State Strategies to Support Developmental Screening in Early Childhood Settings*, Washington, DC, CLASP (October 2014).

Figure 5: Components of an effective ecosystem for children from birth to five

Part IV: What are the most effective investments philanthropy can make?

In our search for investment opportunities, we asked: *Within a complex early childhood system in which many stakeholders play a role, and where a significant portion of funding will ultimately come from the public sector, where might philanthropic investments have the most impact? How can philanthropy catalyze efforts to tackle the barriers to kindergarten readiness?*

We went looking for opportunities that have the potential to improve kindergarten readiness for a significant number of at-risk children and offer a high return on investment. Given that our focus is primarily on philanthropy, the opportunities presented here are not a blueprint for public policy or funding, nor is this a comprehensive literature review. Instead, we have identified areas where there is a clear role for private investment in helping to improve the quality of largely public programs.

Our research surfaced 13 concrete opportunities within five broad categories.

In the discussion below, we describe each opportunity and name a number of specific organizations and initiatives that philanthropy could support. We do so not so much to suggest that these are the only organizations worthy of investment, but to offer concrete examples of how donors have invested for maximum impact to improve outcomes for America's young children. Some of these opportunities are earlier stage than others, but each offers a pathway for philanthropic investment.

Strengthen public systems of early care and education at state and local levels to ensure continuous quality improvements.

Often compared to market-based approaches like hotel star ratings, state Quality Rating and Improvement Systems (QRIS) summarize the quality of early child-care and education providers across categories such as child/staff ratios, teacher credentials, and teacher-child interactions.[81] As of February 2015, nearly all states were planning or implementing some type of QRIS,[82] but our research revealed three barriers to its intended impact on quality: participation is low, funding is not linked to QRIS ratings, and higher quality standards can actually be disincentives if the system doesn't give providers the financial resources they need to improve.

81 QRIS National Learning Network, "Glossary of Terms," 2013–15, http://qrisnetwork.org/glossary.

82 BUILD Initiative, "Quality Rating and Improvement Systems (QRIS)," http://www.buildinitiative.org/TheIssues/EarlyLearning/QualityQRIS.aspx.

Most experts we interviewed agreed that every state should have a QRIS that not only assesses child-care and education programs (including Head Start and publicly-funded pre-K), but that also provides clear financial incentives to improve quality, as well as a pathway and resources for moving from one level of quality to the next. Some states offer models worth emulating. For example, Pennsylvania's QRIS, Keystone STARS, requires all state pre-K providers to achieve at least a two-star rating and ties reimbursement levels to higher ratings. As a result, Keystone STARS covered nearly 70 percent of centers, which serve 170,000 children across the state, as of March 2012.[83] Over the 2011–12 school year, the proportion of children in three- and four-star centers with age-appropriate skills increased from 33 percent to nearly 66 percent.[84]

In states where a QRIS does not yet exist, such systems should be developed. In states where there is a "first generation" QRIS in place (particularly those that have received Race to the Top—Early Learning Challenge funding for QRIS), experts agreed that systems should be improved to measure learning outcomes, better disseminate ratings information to parents, and offer incentives for meeting quality standards. Philanthropic investment in state quality-improvement systems can help to drive efficiency, accountability, and transparency for parents in choosing quality child-care and education options for their children. There are two opportunities for philanthropy to support such state-level quality-improvement efforts.

Opportunity 1: Provide technical assistance for states to accelerate quality-improvement efforts.

One example of an intermediary providing technical assistance for statewide systems is the BUILD Initiative, created in 2002 by the Early Childhood Funders Collaborative.[85] BUILD provides support to reform statewide systems, strengthen local programs, and test new models, with a strong focus on QRIS. Other intermediaries might also be in a position to contribute to expanded and enhanced QRIS. For example, the Alliance for Early Childhood Finance helps states design QRIS that include incentives for provider participation.[86] The Administration for Children and Families recently produced a research brief to guide states in implementation of "next generation" QRIS models that may be of use to states in building their systems.[87] The organization also has created a

83 Pennsylvania Early Learning, "Children's Progress Update: Keystone STAR 3 and 4 Programs, 2011–12," 2012, https://www.pakeys.org/uploadedContent/Docs/Early%20Learning%20Programs/Keystone%20STARS/Keystone_STARS_progress_11-12.pdf.

84 Ibid.

85 BUILD Initiative, "BUILD's Mission and History," 2015, http://www.buildinitiative.org/AboutUs/MissionHistory.aspx.

86 Alliance for Early Childhood Finance, "Aligning Finance with Common Standards," 2010, http://www.earlychildhoodfinance.org/downloads/2010/Aligning%20Finance%20with%20Common%20Standards.pptx.

87 Martha Zaslow and Kathryn Tout, *Reviewing and Clarifying Goals, Outcomes and Levels of Implementation: Toward the Next Generation of Quality Rating and Improvement Systems (QRIS)*, OPRE Research Brief #2014-75, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services (October 2014).

guide for helping states validate that their QRIS are measuring quality effectively and leading to meaningful quality improvements.[88]

Philanthropists can also directly fund capacity within state agencies to implement plans for quality improvement, thereby catalyzing action and spurring collaboration. The Bill & Melinda Gates Foundation, through its direct support of Washington State's Department of Early Learning (DEL) and Thrive Washington, is doing just that. Thrive and DEL will manage Washington State's 10-year Early Learning Plan, which includes implementing QRIS and child-care licensing policies, in addition to many other strategies to expand access to quality programs.[89] In this case, the Gates' support also has enabled a formal partnership between DEL, Thrive, and the state departments of education and health to share accountability for the plan. Thrive Washington and DEL are long-term partners of the Gates Foundation in helping to create Washington's high-quality early learning system and forming public-private partnerships.

Opportunity 2: Fund training for providers pursuing quality improvements.

As mentioned, providers face challenges in getting the training, technical assistance, and funding they need to improve quality and achieve higher QRIS ratings. Funders can work with policy makers to provide and disseminate these resources. For example, in North Carolina, the W.K. Kellogg Foundation and others helped the state's Smart Start initiative to improve the quality of early care and education—including supporting child-care programs in achieving higher QRIS ratings. Over the years, Smart Start helped achieve outstanding results: in fiscal year 2012-13, 84 percent of children receiving subsidies for care and education attended four- and five-star centers (compared to only 30 percent in 2001).[90]

Scale health and developmental screenings to connect parents and families with resources to optimize their children's holistic development.

As described above, many communities do not have the infrastructure or tools to universally and regularly screen children from birth to five years old across the five kindergarten-readiness domains. Further investment is needed to ensure that children are screened from birth to five and directly linked to appropriate high-quality services. Philanthropy can help catalyze this investment.

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88 Kathryn Tout and Rebecca Starr, *Key Elements of a QRIS Validation Plan: Guidance and Planning Template*, OPRE 2013-11, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services.

89 Washington State Department of Early Learning, "Washington State Early Learning Plan: Executive Summary," September 2010.

90 Smart Start, "Why Smart Start Works: The North Carolina Partnership for Children and Local Smart Start Partnerships," January 2015, http://ivdesignhouse.com/smartstart/wp-content/uploads/2015/01/Why-Smart-Start-Works-2013.pdf.

Through our conversations with experts, we realized that an ideal coordinated local solution would provide universal screening and intake, invest in expanding the menu of parenting interventions, and help parents understand their choices and connect to the program that is right for them. It also would help communities understand how much of the need for quality programs is being met, and what additional investment is warranted.

A great example is the Healthy Beginnings program run by the Children's Services Council (CSC) of Palm Beach County,[91] which screened close to 90 percent of newborns in 2012.[92] It also screens children throughout the early years for developmental, social, and behavioral issues using tools like the Ages and Stages Questionnaire. Healthy Beginnings helps connect parents to one or more of a wide array of interventions through its strong network of organizational partners. Available interventions include Triple P, Incredible Years, Parent-Child Home Program, Nurse-Family Partnership, Centering Pregnancy, and Healthy Steps, as well as some promising local programs. Healthy Beginnings includes an integrated data system that tracks individual children as they move between providers in the Healthy Beginnings network. Between 2007 and 2012, Palm Beach County's rates for infant mortality, low-weight births, and prematurity improved, and are now better than Florida's as a whole.[93]

Though there would be great benefit to using a consistent developmental screening (ideally based on the five kindergarten-readiness domains) across the country, there is no obvious role for philanthropy to help this happen at the national level. However, here are three promising opportunities for philanthropy to support expanded screening and referral tools at the community level. Two of these involve building the infrastructure for screening and referrals, and one involves further developing existing tools. These opportunities are particularly relevant in the states that have received Race to the Top—Early Learning Challenge funding and Enhanced Assessment Grants.[94]

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91 The Children's Services Council of Palm Beach County, a special district of government that is primarily supported with public funding through taxing authority, has developed a system of care for children and families with four goals: healthy births, keeping children free from child abuse and neglect, getting children ready to start school, and providing access to quality after-school programs. The system of care features three strategic components: individual child and family services through the *Healthy Beginnings* System; quality child-care and after-school programs through the *Strong Minds Network*; and targeted place-based programs in ten low-income communities through *Bridges*.

92 Interview with Lisa Williams Taylor, Children's Services Council of Palm Beach County, October 16, 2013.

93 *Healthy Babies 2014 Palm Beach County*, Boynton Beach, Florida, Children's Services Council of Palm Beach County (2014).

94 The Enhanced Assessment Grants program is a federal initiative focused more tightly on assessments than Race to the Top. It has awarded $15 million to 17 states. Source: Catherine Gewertz, "Kindergarten-Readiness Tests Gain Ground," *Education Week*, October 7, 2014.

Opportunity 3: Develop and propagate comprehensive screening and referral systems at the community level.

Philanthropy can play a role in creating and supporting local agencies and staff needed to conduct universal screenings and referrals, ensuring access to an array of quality programs, data systems, screening tools, and more.

For example, philanthropy has provided key strategic support to the CSC of Palm Beach County (described on the previous page) in the early development of the critical components of its system of care. The Quantum Foundation partnered with CSC to provide local private-public funding to attract and match a Robert Wood Johnson Foundation (RWJF) grant, through RWJF's Local Initiative Funding Partners Program. This funding supported development of CSC's Maternal Child Health Network (which ultimately evolved into Healthy Beginnings). The Picower Foundation was also an important private strategic funding partner on a number of other initiatives at CSC, including funding the initial design, start-up, and early implementation of a quality child-care initiative that, ultimately, became a model for other communities in Florida.[95]

The CSC is a special district of government that is primarily supported with public funding through taxing authority. When a referendum on CSC funding was recently up for a vote in Florida, it passed with 85 percent of the vote. Private funding (not philanthropy) supported a successful campaign to renew its funding authority.

In other communities across the nation, philanthropies and public agencies are working in long-term partnerships to provide access to high-quality birth-to-five programs and infrastructure for connecting families to those resources. Exemplars include Greater Cleveland (supported by the George Gund Foundation, the Cleveland Foundation, and others), Detroit (supported by the Kresge Foundation and the W.K. Kellogg Foundation), and Pittsburgh (supported by the Heinz Endowments). The Duke Endowment has worked for years in partnership with Durham County, NC, to fund Durham Connects, a universal newborn screening and referral system that has demonstrated a $3 return on every $1 invested in the program.[96]

There are also technical assistance organizations that help states identify at-risk children and connect families to community-based programs. The Help Me Grow National Center is active in over 20 states performing that specific function and is funded in part by the Kellogg Foundation.[97] Local funders, such as the Health Foundation of Western and Central New York and the Community Foundation of Greater Birmingham, have funded Help Me Grow affiliates to spread developmental screenings in their communities.

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95 Correspondence with Tana Ebbole and Michael Levine, March 5, 2015.
96 Durham Connects, "Results," 2015, http://www.durhamconnects.org/results/.
97 Help Me Grow National Center, "What is the *Help Me Grow* National Center?" http://www.helpmegrownational.org/pages/hmg-national/what-is-hmg-national.php.

Opportunity 4: Support pediatric practices to integrate screenings and referrals into well-child visits.

The great majority of low-income children from birth through age three see pediatricians and other health providers regularly.[98] Pediatric practices could be excellent places to engage the parents and caregivers of young children, identify parenting challenges, and help parents develop skills and strategies to overcome those challenges. In this setting, parents are attuned to the healthy development of their young children and may be most open to getting support. For these reasons, it seems that pairing early screening with integrated behavioral and mental health services, along with referrals to parenting supports, may be a powerful combination for promoting child development.

There are signs that pediatric practice is shifting towards such a holistic approach. Under the Affordable Care Act, insurance companies now must cover the cost of developmental screenings.[99] Other trends in healthcare payment structures may also be moving the system toward greater financial reward for such preventative measures. In concert with these changes, there is an opportunity for philanthropy to help further demonstrate the value of developmental screenings for very young children.

Philanthropists can act on this opportunity either by funding programs that work with pediatric providers, or by funding pediatric providers directly. For example, the Montefiore Children's Hospital in the Bronx screens infants and toddlers every six months for signs of stress and maladaptive social and emotional development, providing the Healthy Steps intervention to those who need it. The Altman Foundation provided funding for Healthy Steps Specialists[100] (psychologists, social workers, or nurses), who screen children to identify developmental or behavioral problems, coach parents, and provide referral services. Montefiore also has integrated Healthy Steps into its residency training program, helping the next generation of physicians understand the importance of child and family development as an essential element in good pediatric care.[101] Philanthropy could support the expansion of Healthy Steps or similar programs (like Project DULCE in Boston, which pairs family specialists with access to legal services), either by funding programs directly or by supporting a provider like Montefiore in implementing the program.

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98 David Murphey, Mae Cooper, and Nicole Forry, *The Youngest Americans: A Statistical Portrait of Infants and Toddlers in the United States*, Chicago, IL: The McCormick Foundation and Child Trends (2013), 100.

99 Help Me Grow Orange County, "Developmental Screening and Monitoring," http://www.helpmegrowoc.org/healthcare_screening.html.

100 Laurie Tarkan, "For Mother and Child at Risk, Care that Includes a Psychologist," *The New York Times* Health section, February 14, 2009.

101 Healthy Steps for Young Children, "Residency Training," http://healthysteps.org/about/healthy-steps-sites/residency-training.

Opportunity 5: Disseminate promising screening and assessment questionnaires and tools.

Several holistic development measures exist, but they are not in sufficiently wide use across the country. Philanthropy can help spread the use of these valuable tools. For example, the Center for Healthier Children, Families, and Communities in Los Angeles is expanding implementation of the Early Development Instrument (EDI) in cities and communities across Los Angeles County.[102] It is producing citywide data and maps showing children's health and development across multiple domains and fostering collaboration to test local strategies for addressing variations in developmental outcomes. As discussed before, though the EDI can be administered in school as early as pre-K, its use can help direct resources to children in higher-needs neighborhoods at earlier ages. The EDI is also easy for teachers and other administrators to use. While it measures across five domains, it only takes 10–15 minutes to implement.[103] Philanthropy could support communities in pursuing such initiatives elsewhere in the country, with particular attention to screening children at a number of points from birth to five, not solely at preschool or kindergarten entry.

Improve the training, continuing education, professional development, and compensation of early childhood educators.

A resounding theme of our research was the critical importance of improving the effectiveness of early childhood educators, including child-care providers, FFN providers, pre-K teachers, Head Start, and Early Head Start providers. There are multiple efforts underway, including the recent $500 million federal appropriation for Early Head Start-Child Care Partnerships.[104] These are promising steps towards promoting high quality. But these efforts remain at a fairly early stage, with more progress needed to identify scalable, effective solutions that can be implemented by each type of provider. A study from the National Academies, which supports these efforts, details the knowledge, skills, and abilities that educators need to support children's health and development.[105] Two critical barriers facing the early childhood workforce today are limited professional development opportunities and low compensation, both of which are opportunities that philanthropy can address.

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102 UCLA Center for Healthier Children, Families and Communities, "Systems Innovation and Improvement," http://www.healthychild.ucla.edu/ourwork/edi.

103 Dr. Lisa Stanley, "A Community Level Index of Children's Health, Developmental, and School Readiness," UCLA.

104 Administration for Children and Families, "Early Head Start-Child Care Partnerships," December 2014, http://www.acf.hhs.gov/programs/ecd/early-learning/ehs-cc-partnerships.

105 Institute of Medicine of the National Academies, "Transforming the Workforce for Children Birth through Age 8: A Unifying Foundation," April 2015, http://iom.nationalacademies.org/Reports/2015/Birth-To-Eight.aspx.

Opportunity 6: Increase the availability of on-the-job coaching and development for early childhood educators.

Philanthropists have helped to create and support institutes for formal early childhood certification and training (e.g., the Buffett Early Childhood Institute at the University of Nebraska, the Erikson Institute in Chicago, and the Early Childhood Education Institute at the University of Oklahoma). These institutes have a clear role to play in promoting educator excellence and supporting research. However, research has demonstrated the importance of ongoing coaching and professional development that occurs in the classroom and that can meet teachers, caregivers, and program leaders where they are. We see a role for philanthropy in helping to reach educators with these solutions.

Philanthropists could support coaching and development efforts in two ways: at the individual provider level and at the program level. At the individual level, philanthropy can help scale coaching and development programs to reach more teachers. For example, MyTeachingPartner offers on-site training and remote video coaching based on CLASS (Classroom Learning and Assessment Scoring System), a tool designed to measure the quality of teacher-child interactions. The McCormick Foundation has provided longtime support for the Erikson Institute's Early Math Collaborative, which provides a year-long professional development program in early mathematics instruction. Students of pre-K teachers who received this program advanced their math skills by three months, compared with similar students whose teachers did not receive the program.[106]

At the school level, philanthropy can support technical assistance providers that work with the directors of individual programs (including Head Start and Early Head Start) to help raise the effectiveness of the program's entire workforce. Two examples are the Ounce of Prevention Fund's Lead. Learn. Excel. program, which provides training, technical assistance, and peer learning resources to program directors to help them embed professional development opportunities for their teaching workforce, and Acelero Learning, a for-profit company that works specifically with Head Start providers. The $500 million federal appropriation for Early Head Start-Child Care Partnerships[107] can be leveraged to fund this type of technical assistance. This funding seeks to raise the quality of non–Early Head Start providers by pairing them with Early Head Start programs for training and professional development. Recipients must meet Early Head Start standards in order to receive funding.[108] Philanthropy can augment the resources available by providing matching funds to local agencies who receive Early Head Start-Child Care Partnerships grants, as the Heising-Simons Foundation is doing in California.

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106 Robert R. McCormick Foundation, "Early Math," http://mccormickfoundation.org/page.aspx?pid=611.

107 Administration for Children and Families, "Early Head Start-Child Care Partnerships," December 2014, http://www.acf.hhs.gov/programs/ecd/early-learning/ehs-cc-partnerships.

108 Maria V. Mayoral, "Fact Sheet: Building Partnerships Between Early Head Start Grantees and Child Care Providers," Zero to Three National Center for Infants, Toddlers, and Families (March 2014).

Opportunity 7: Fund research and technical assistance to promote fair compensation of early childhood educators.

Every expert we spoke with agreed that a major barrier to attracting talented individuals to the early childhood field is low compensation (which leads to high turnover). Without addressing compensation, investments in professional development may have limited impact if qualified individuals are leaving the workforce. Though opportunities for philanthropy to help address this barrier may not be as obvious, philanthropy has a critical role to play in setting public policy priorities around compensation. It can help do this at the national and local levels.

At the national level, philanthropy can fund research to document the existing wages, education, and turnover in the early childhood care and education workforce. This research can be used to advocate for sustainable, dedicated sources of funding for early childhood programs. For example, the Foundation for Child Development is funding the Center for the Study of Child Care Employment (CSCCE) at UC-Berkeley to collect state-by-state data on early childhood compensation and policy initiatives to address wages. This project, the State of the Early Childhood Workforce Biennial Report, can help policy makers identify best practices in improving compensation.[109] Funders can also support organizations like the CSCCE to directly advise local, state, and federal advocates and policy makers on how to address compensation issues.

At the local level, philanthropy can fund technical assistance for state agencies to improve workers' wages. For example, the W. Clement & Jessie V. Stone Foundation, the Kresge Foundation, and many others support the T.E.A.C.H. Early Childhood National Center. T.E.A.C.H., which is implemented through local early childhood agencies, provides scholarships to early childhood educators so they can graduate debt-free from college and certificate courses. It also improves compensation through bonuses or raises for scholarship recipients who complete their education on time. These programs are being implemented in 24 states and have helped program participants achieve 8 percent wage increases, on average.[110]

109 Correspondence with Marcy Whitebook, March 2015.

110 Child Care Services Association, "T.E.A.C.H. Early Childhood National," http://www.childcareservices.org/ps/teach_ta_qac/teac-early-childhood-national/.

Support greater access to high-quality evidence-based programs that help parents and families to foster their children's development.

There are a range of effective programs for parents, but they touch only a fraction of those who could benefit from them. Examples include:

- Home-visiting and center-based parent education programs: The 16 programs approved by the federal home visiting initiative (MIECHV) include Nurse-Family Partnership[111] and Early Head Start.
- Pregnancy-focused programs: Centering Pregnancy provides prenatal care to groups of 8–12 women in physician settings; HealthConnect One places community-based doulas with women from pregnancy through the early months of parenting.
- Mental health-related programs: Child First is a home visitation program that pairs a mental health clinician with a care coordinator to visit high-needs families; the New Haven MOMS Partnership coordinates multiple agencies in reaching and helping mothers experiencing poverty, high levels of maternal stress, and social isolation; the Fussy Baby Network at the Erikson Institute offers home visiting, support groups, and a hotline to parents under stress.
- Programs that work through the pediatric system: Reach Out and Read is a low-cost intervention that helps pediatricians provide information to parents about the importance of reading aloud and encourages parents to read to their children more often by providing a book at each regular checkup. Healthy Steps, mentioned above, is another example.
- Programs with particular focus on Hispanic families: AVANCE, Abriendo Puertas (Opening Doors), and HIPPY are family engagement programs that help Spanish-speaking children develop language skills and improve parental confidence.

Some of these programs, including Child First, New Haven MOMS Partnership, and Abriendo Puertas, also incorporate "two-generation" elements that work to provide benefits directly to parents as well as to children (e.g., adult literacy education, stress management, mental health treatment). In order to ensure that evidence-based programs have the resources they need to collectively reach all families who would benefit from their services, there are four ways in which philanthropists can help.

Opportunity 8: Build the capacity of organizations implementing evidence-based programs to serve more children and families.

Investments in core organizations can help these programs scale much faster. For example, RWJF has supported Child First with capacity-building grants.

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111 List available at Health Resources and Services Administration Maternal and Child Health, "Home Visiting Models," http://mchb.hrsa.gov/programs/homevisiting/models.html.

These grants have helped it develop a web-based data and measurement system, a quality-improvement and certification process, a funding-sustainability plan, and randomized controlled trials to build their evidence base.[112] The program has been expanded throughout Connecticut by the state's Department of Children and Families and plans to expand to two new states in 2015.[113]

Philanthropists can also aggregate pools of growth capital to help increase the scale of proven interventions. The Edna McConnell Clark Foundation (EMCF) has done just that with the Nurse-Family Partnership (NFP) home visiting program. Since 2002, EMCF has awarded $23.3 million to NFP and helped aggregate an additional $38 million in growth capital through its Growth Capital Aggregation Pilot.[114] Five coinvestors[115] and the NFP Board of Directors committed these growth capital funds to help NFP grow from reaching 13,484 mothers in 2007 to a goal of reaching 60,000 mothers by 2018. As of 2013, NFP had nearly doubled its reach to 26,350 mothers.[116] EMCF's investment has shown that infusions of growth capital can help propel interventions with strong evidence bases and business cases for obtaining public funding.[117]

Opportunity 9: Invest in innovative public-private financing mechanisms for expanding evidence-based programs.

As a tool to encourage federal investments in evidence-based interventions, pay-for-success models such as social impact bonds (SIBs) are gaining traction. These models harness private and philanthropic capital to invest in social programs with long-term benefits. The government repays private investors as those benefits are realized. If no benefits are realized, private investors assume the risk of non-performance, which could result in the loss of principal. We believe that the real potential of pay-for-success in early childhood is not to substitute for public money, but to demonstrate what works to increase kindergarten readiness, and perhaps even change the way government invests in these programs.

Such innovative funding models will likely require a pool of philanthropic funds with the goal of establishing successful proof points to attract private capital and expand pressure for public investment in improving access to and quality of early childhood programs. As an example, private capital from the Goldman Sachs Social

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112 Grants listed on Robert Wood Johnson Foundation website, http://www.rwjf.org.

113 Child First, "Replication," http://www.childfirst.com/our-network/replication.

114 Edna McConnell Clark Foundation, "Nurse-Family Partnership: Overview," 2012–15, http://www.emcf.org/our-grantees/our-grantee-portfolio/nurse-family-partnership/overview/.

115 Coinvestors are Bill and Melinda Gates Foundation, Robert Wood Johnson Foundation, W.K. Kellogg Foundation, The Kresge Foundation, The Picower Foundation. Source: EMCF, "An Experiment in Coordinated Investment," October 2008, http://www.emcf.org/fileadmin/media/PDFs/gcap_progressreportOct08.pdf.

116 Edna McConnell Clark Foundation, "Nurse-Family Partnership: Performance," http://www.emcf.org/our-grantees/our-grantee-portfolio/nurse-family-partnership/performance/#families-enrolled.

117 Edna McConnell Clark Foundation, "Nurse-Family Partnership: Overview," http://www.emcf.org/our-grantees/our-grantee-portfolio/nurse-family-partnership/overview/.

Impact Fund, Northern Trust Financial Services, and a program-related investment from the J.B. & M.K. Pritzker Family Foundation will finance an expansion of the evidence-based Child-Parent Center preschool program to 2,600 children over four years in Chicago. Although the programs would be run by Chicago Public Schools, three nonprofit groups will coordinate, fund, and evaluate the program. Payments to investors will come from savings for each student who avoids placement in special education as a result of attending the program.[118]

Pay-for-success models also hold promise for expanding parenting support programs that reach younger children. Nurse-Family Partnership's national office is exploring potential SIBs in several states in partnership with commercial investors, philanthropy, and third-party intermediaries. Payments to investors could be tied to public savings resulting from a number of outcomes that NFP has demonstrated through randomized controlled trials, such as reductions in preterm births, child maltreatment, and need for remedial language services.[119]

In addition to investing directly in pay-for-success contracts, philanthropy can fund technical assistance for the nonprofits and public agencies that are implementing these models. The Rockefeller Foundation helped to establish the Harvard Kennedy School's Social Impact Bond Technical Assistance Lab, which provides pro bono assistance to state and local governments pursuing such bonds.[120] Social Finance, Nonprofit Finance Fund, Third Sector Capital Partners, the Institute for Child Success in South Carolina, and the James Lee Sorenson Global Impact Investing Center at the David Eccles School of Business at the University of Utah provide similar technical assistance to governments and nonprofits, helping to conduct feasibility studies, structure complicated pay-for-success contracts, and advise implementing agencies. All of these organizations have been funded by philanthropy in the past. For example, the Laura and John Arnold Foundation has leveraged public funding from the federal Social Innovation Fund to support the Nonprofit Finance Fund in providing technical assistance to governments and nonprofits.[121]

Opportunity 10: Expand evidence-based programs for parents by advocating for increased state, local, and federal funding.

Continued and expanded funding for high-quality initiatives at the federal and state levels is essential if we are to prepare all at-risk children for kindergarten. Advocacy organizations play an important role in this effort. Two examples are the Alliance for Early Success and the First Five Years Fund, both of which

118 City of Chicago Mayor's Press Office, "Mayor Emanuel Announces Expansion of Pre-K to More than 2,600 Chicago Public School Children," October 7, 2014.

119 Nurse-Family Partnership, "Social Impact Bonds," 2014, http://www.nursefamilypartnership.org/assets/PDF/Policy/NSO-SIBS-Overview.aspx.

120 Harvard Kennedy School, "The SIB Lab," http://siblab.hks.harvard.edu/sib-lab.

121 Nonprofit Finance Fund, "Nonprofit Finance Fund Receives $3.6 million from Social Innovation Fund to Accelerate 'Pay for Success' Projects," October 1, 2014.

are supported by coalitions of funders.[122] There are also numerous state-based advocacy organizations that philanthropists can support in their own communities, such as Early Edge California and Pennsylvania Partnerships for Children, among many others. California's Strong Families, Strong Children Act (SB 1123) is an example of the type of policy that can result from such advocacy. The bill proposes $350 million in funding to raise quality standards for child care, scale parenting resources, and develop new standards for Early Head Start.[123] This bill was supported by community advocacy organizations and philanthropy, including Next Generation and Californians Together.[124]

At the municipal level, philanthropy also can play a role in advocating for communities to commit to making quality early childhood experiences a priority. The Bezos Family Foundation catalyzed the unanimous adoption at the 2014 US Conference of Mayors annual meeting of a resolution to support building an Early Learning Nation by 2025.[125] This resolution already has helped build on existing community-level momentum. Since the resolution, communities such as Kent County, MI, and Seattle, WA, are designing and implementing universal pre-K, training early learning providers, and building gateways for families to access early childhood services in their communities.[126] In addition, new cities and counties are stepping up to create action plans, which the Bezos Family Foundation will support through technical assistance grants in order to spur adoption of what works in communities across the nation.

Supporting flagship models for achieving quality outcomes is another way to apply pressure for increased funding for early care and education. The George Kaiser Family Foundation, the Buffett Early Childhood Fund, the Irving Harris Foundation, the Bill & Melinda Gates Foundation, the Kellogg Foundation, and the J.B. & M.K. Pritzker Family Foundation (among others) all support local efforts across the United States to replicate Educare schools, which provide high-quality care and education for children from six weeks to five years old, as well as wraparound services for parents. The schools achieve impressive outcomes: higher rates of school readiness, better vocabulary development, and better

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122 Funders of both organizations include the Buffett Early Childhood Fund, the Bill and Melinda Gates Foundation, the Irving Harris Foundation, Heising-Simons Foundation, the George Kaiser Family Foundation, the W.K. Kellogg Foundation, the J.B. and M.K. Pritzker Family Foundation, and the David and Lucile Packard Foundation. The Richard W. Goldman Foundation and the Annie E. Casey Foundation also support the Alliance for Early Success. Source: Alliance for Early Success, "Funding Partners," http://earlysuccess.org/partnerships/funding-partners and First Five Years Fund, "Leaders and Partnerships," http://ffyf.org/who-we-are/leaders-and-partnerships/.

123 Alliance for Early Success, "Success Stories," retrieved January 23, 2015, from http://earlysuccess.org/partnerships/success-stories.

124 *SB 1123: Early Learning: The Strong Families, Strong Children Act*, Early Edge California, April 3, 2014.

125 Paul Nyhan, "Mayors Endorse New Movement to Create an Early Learning Nation by 2025," Thrive by Five Washington, June 26, 2014.

126 Early Learning Nation 2025, "Steps to Building an Early Learning Nation," http://eln2025.org/steps-to-building-an-early-learning-nation.

classroom quality scores than their peers.[127] However, Educare's value is not only in scaling best practices—its schools also serve as a platform for demonstrating the value of early childhood investment, especially to public policy makers. For example, Educare of Tulsa helped inspire a $25 million public-private pilot program for children from birth to three throughout Oklahoma, and Educare of Omaha helped spur a Nebraska State Constitution amendment creating a $60 million endowment for birth-to-three services for low-income children.[128]

At the national level, philanthropy can support research on the costs and benefits of high-quality early childhood programs. The Center for the Economics of Human Development (CEHD) at the University of Chicago, directed by Professor James Heckman, conducts such research. CEHD's research on the long-term impact of programs like the Perry Preschool Project and the Carolina Abecedarian Project can be used to quantify the economic impacts of investing in many of the high-quality programs and approaches mentioned throughout this paper. CEHD has also helped determine the specific components of these programs that lead to high quality, which can help fuel investment in the right supports for children at the right time.

Opportunity 11: Simplify and disseminate information to assist parents in choosing high-quality care and education opportunities for their children.

All families benefit from good, easily accessible information on high-quality programs, yet our research showed that this information is more often than not hard to come by. Compiling this information and disseminating it widely to parents and caregivers is one way to increase the demand for higher-quality programs, which could in turn strengthen efforts to expand them. One such example is the Chicago Early Learning Portal, launched by Mayor Rahm Emanuel in 2012 and funded by the J.B. and M.K. Pritzker Family Foundation. The portal allows parents to search for and compare quality programs by zip code while also providing them with information about enrollment deadlines and requirements. It will eventually link programs to the ratings they receive from Illinois's QRIS.[129]

Providing parents with information on high-quality education and care providers is especially important for Hispanic families. High-quality pre-K has particularly positive effects on Hispanic children's cognitive and language skills, but Hispanic children have the lowest preschool participation rates of any major ethnicity or race in the United States.[130] Experts suggest that there are four ways to improve participation by immigrant children, including Hispanics: outreach, enrollment

127 UNC Frank Porter Graham Child Development Institute, "Educare Implementation Study Findings," August 2012, http://www.educareschools.org/about/pdfs/Demonstrating-Results.pdf.

128 Tulsa Educare, "Platform," http://www.tulsaeducare.org/platform/.

129 City of Chicago Mayor's Press Office, "Mayor Emanuel Unveils Online Early Learning Portal to Help Parents and Families Find Quality Programs for Children in Their Neighborhoods," November 29, 2012.

130 Luis M. Laosa and Pat Ainsworth, "Is Public Pre-K Preparing Hispanic Children to Succeed in School?" New Brunswick, New Jersey: National Institute for Early Education Research (March 2007).

assistance, building relationships with parents, and building immigrant-friendly pre-K programs.[131] Voter registration and health insurance enrollment campaigns might serve as models for an enrollment campaign targeting Hispanic parents. The National Council of La Raza and other Hispanic organizations have helped lead successful campaigns to register voters and enroll people in health plans. Philanthropy could support the application of these approaches to enrollment in pre-K and other high-quality programs.

Promote ongoing program innovation and improvement, especially for those programs supporting parents and informal caregivers.

Finally, there are barriers mentioned in this paper that do not align with immediate investment opportunities, but for which research and development might provide scalable solutions. Given that philanthropy is the primary engine of research and development in the social sector, there is a role for philanthropy in finding these new solutions, particularly in the challenging area of effectively supporting informal caregivers.

Opportunity 12: Promote quality improvement efforts for family, friend, and neighbor child care.

Philanthropists can fund the capacity of organizations that reach family, friend, and neighbor (FFN) caregivers, specifically for program experimentation and impact measurement, to better understand what features of their programs work in each context and how they can be scaled effectively. Funders like the David and Lucile Packard Foundation have acknowledged that, while informal care is not a system, very little is known about how children are cared for in these settings, and an experimental strategy is needed. Therefore, Packard's main objective is to research FFN communities and networks to better understand their demographics, the motivations of individual providers, and the resources and community institutions they may already be accessing. Packard expects this experimentation phase to last from 2-3 years, with a higher percentage of smaller grants. The ultimate goal of this research is to gain a better understanding of the needs of these communities and to test ways to provide them with resources and support that can be scaled over time.[132]

Organizations like All Our Kin provide training and business consultation to all types of community child-care providers, including unlicensed caregivers, licensed family caregivers, and Early Head Start providers. Providers who graduate from these programs report higher earnings and a greater knowledge and understanding of child development.[133]

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131 Julia Gelatt, Gina Adams, and Sandra Huerta, *Supporting Immigrant Families' Access to Prekindergarten*, Washington, DC: The Urban Institute (March 2014).

132 Correspondence with Meera Mani of the David and Lucile Packard Foundation, March 2015.

133 All Our Kin, "Our Impact," http://www.allourkin.org/our-impact.

Another promising program called Tutu and Me has been developed in Hawaii, and a similar approach was developed and piloted by the YMCA in cities like Oklahoma City, Chicago, and Austin.[134] Tutu and Me is a traveling pre-K program that engages grandparents in meeting the developmental needs of young children in their care. Teaching teams conduct the program, which is organized around values specific to the culture and community.

Opportunity 13: Foster innovation to achieve repeatable results.

Overall, the early childhood sector lacks the processes that enable the kind of continuous research and development found in many parts of the for-profit sector. Such a research and development effort could advance the science of child development, develop promising early childhood interventions that have yet to be scaled, and fund well-established interventions that might benefit from continued innovation. Given our rapidly evolving understanding of brain development, we believe it is imperative that we fuel experiments to apply these learnings and develop more effective interventions and approaches.

One immediate opportunity is for philanthropists to fund research and development through existing early childhood-focused research institutes, such as the Center on the Developing Child at Harvard University and the Center for Child & Family Policy at Duke University. The Center for the Economics of Human Development produces research that helps identify components of quality that could be scaled across different types of programs. In addition to funding research institutes, we have identified three ways for philanthropy to lead innovation through investments to create new initiatives—while also recognizing that these opportunities are less "shovel-ready" than others we have surfaced. First, funders could create a consortium to set a common research agenda and carry out rapid cycle experimentation across a number of communities. Second, funders could create an "accelerator" that identifies and attracts high-potential ideas and supports their creators with mentoring, seed funding, and connections to a strong network. Finally, funders could support strong organizations with R&D "line items" to encourage them to set aside internal capacity for testing and evaluating new ideas and applications of existing models.

134 Campaign for Grade-Level Reading, "Bright Spots: YMCA of the USA, Chicago, Illinois," July 2011, http://www.gradelevelreading.net/wp-content/uploads/2011/07/Bright-Spot-Programs-YMCA-July-11.pdf; YMCA of Austin, "Early Learning Readiness," http://www.austinymca.org/sites/default/files/Adopt%20A%20Program%20-%20Early%20Learning%20Readiness%20FINAL.pdf.

Postscript

We believe that increased private and public investment in helping low-income young children prepare for kindergarten is one of the smartest investments that we can make. These investments should support the outcomes that matter most—those that allow children to enter kindergarten ready to learn.

This paper has not been intended as a road map either for our own investments or those of others. As the range and diversity of the opportunities described here make clear, there is no single path toward the outcomes we all seek. Rather, we have tried to highlight both the importance of promoting kindergarten readiness for our nation's children and the variety of opportunities available to donors who want to invest wisely towards this end. It is our hope that this paper will help reverse the pattern of systematic underinvestment by surfacing tangible high-impact opportunities that private philanthropists and their public-sector partners can pursue today.

Philanthropy will never have the resources to invest in early childhood that government does. But what we in philanthropy can and must do is to highlight and demonstrate what works to improve kindergarten readiness for low-income children in a way that will encourage local, state, and federal policy change—and smarter public investments in early childhood.

In sharing this paper, we hope to stimulate increased investment in early childhood in states and communities, targeted toward the interventions and efforts with the very best chance of moving the needle on kindergarten readiness.

Acknowledgments

This has been a truly collaborative project. We had the chance to learn and share experience with some of the leading funders in the early childhood field, including the Buffett Early Childhood Fund, the David and Lucile Packard Foundation, the Edna McConnell Clark Foundation, the Bill & Melinda Gates Foundation, the George Kaiser Family Foundation, the Irving Harris Foundation, the Robert R. McCormick Foundation, and the W.K. Kellogg Foundation.

We are indebted to Professor James Heckman at the University of Chicago, whose work has inspired and guided our own. Julia Isaacs at the Urban Institute and Katherine Magnuson at the University of Wisconsin–Madison, through their research at the Brookings Center on Children and Families, helped us better understand the existing data on kindergarten readiness and its socioeconomic determinants. Experienced policy makers and analysts—Libby Doggett, Shannon Rudisill, and Sara Mead, among many others—helped us identify promising local, state, and national intervention models. Elise Tosun, Christina Triantaphyllis, Chris Addy, Mike Levine, and Bradley Seeman at The Bridgespan Group provided invaluable help as thought partners, data analysts, and editors. We owe very special thanks to Joan Lombardi, Diana Rauner, and Phyllis Glink, who have lent their expertise, wisdom, and deep experience in the field throughout this project. A full list of individuals who contributed to this work is provided in Appendix A. Finally, Jeff Schoenberg helped to guide and shape this research from its earliest days. We are grateful for his expertise throughout and for helping us to see this work to its fullest potential.

At the same time, the paper itself, especially the conclusions that it draws about investment opportunities, are ours alone and do not necessarily reflect the views of any of the individuals or organizations that we consulted in our research.

Additional Commentary

"Knowing that we need more investments in early childhood development does not necessarily tell us how to invest. This paper is based on the best research and best practices in the early development field, and it helps to illuminate what works and where funding can be most effective. It is a blueprint for potential investors, public as well as private, and is a must-read for both."

ARTHUR ROLNICK, PH.D., SENIOR FELLOW, UNIVERSITY OF MINNESOTA; FORMER SENIOR VICE PRESIDENT AND DIRECTOR OF RESEARCH, FEDERAL RESERVE BANK OF MINNEAPOLIS; AUTHOR OF LANDMARK STUDY DEMONSTRATING RATE OF RETURN FOR HIGH-QUALITY EARLY CHILDHOOD PROGRAMS

"Science, economics, and common sense tell us that investing in the earliest years of life is critical to the well-being of children, families, communities, and countries. This report sends an important message about the role the private sector can play in supporting expanded public investments."

JOAN LOMBARDI, PH.D., FORMER DEPUTY ASSISTANT SECRETARY AND INTERAGENCY LIAISON FOR EARLY CHILDHOOD DEVELOPMENT, US DEPARTMENT OF HEALTH AND HUMAN SERVICES

"When hard-headed economists and businessmen endorse early education, we can be sure it is not only right, but right for our economy. This paper makes the case for supporting early care and education abundantly clear."

BARBARA T. BOWMAN, M.A., CO-FOUNDER, THE ERIKSON INSTITUTE GRADUATE SCHOOL IN CHILD DEVELOPMENT; FORMER CHIEF EARLY CHILDHOOD EDUCATION OFFICER FOR CHICAGO PUBLIC SCHOOLS

"We at the Edna McConnell Clark Foundation believe that our nation can change the life trajectories of disadvantaged children and youth by developing a deeper understanding of 'what works' and expanding programs that have demonstrated their effectiveness. This report is an example of the tools philanthropists need to identify opportunities for greater impact and make smarter investments in early childhood."

NANCY ROOB, PRESIDENT, THE EDNA MCCONNELL CLARK FOUNDATION

"We are at a pivotal moment in the growing Early Childhood Movement. The wisdom of investing wisely in the early years is gaining traction. More people 'get it,' but they're wondering what to do. This paper is a valuable tool, especially if you are a philanthropist looking to make smart investments in this highly under-invested field."

SUSAN A. BUFFETT, BUFFETT EARLY CHILDHOOD FUND

"Impact investors and philanthropists should look to this paper for smart ideas on how to invest in social programs, like early childhood development, that have long-term benefits to those in need and to society at large. Supporting the expansion of early childhood programs, especially through innovative funding models like Pay for Success, can have a high social impact while also being a worthwhile investment."

JAMES LEE SORENSON, CHAIRMAN, SORENSON MEDIA, INC., AND FOUNDER, JAMES LEE SORENSON GLOBAL IMPACT INVESTING CENTER AT THE ECCLES SCHOOL OF BUSINESS AT THE UNIVERSITY OF UTAH

“As demonstrated page after page, when we provide children with access to high-quality early learning opportunities, we ensure that children start out on an equal playing field. Our country’s ability to address systemic social and economic problems starts with early childhood education, and I hope philanthropists and policy makers use the report to make progress for all children.”

NEERA TANDEN, PRESIDENT, CENTER FOR AMERICAN PROGRESS

“This paper is a powerful tool for generating greater investments in children zero to five. This will accelerate the work of garnering permanent, sustainable solutions for funding early childhood education to prepare children for competition as early as kindergarten. This guide works not only with investors but with advocates, parents, and [care] providers of young children who want to make an impact at the local, state, and national level.”

KRIS PERRY, EXECUTIVE DIRECTOR, THE FIRST FIVE YEARS FUND (WORKS WITH POLICY MAKERS, BUSINESS LEADERS, EXPERTS, AND ADVOCATES TO ADVANCE INVESTMENT IN QUALITY EARLY CHILDHOOD EDUCATION FROM BIRTH TO FIVE)

“Every child is full of potential and deserves to realize it. The best way to tap into this potential is to invest during the first five years of life, when brain development is the most rapid. This paper makes it abundantly clear that we all have an opportunity to change lives and transform our collective future for the better.”

JACKIE BEZOS, PRESIDENT, BEZOS FAMILY FOUNDATION

“This paper provides a road map for philanthropists who want to maximize their grants to high-quality early childhood services and to the development of leadership in the field. J.B. and M.K. clearly understand the value of investing in the earliest years of life.”

JOAN HARRIS, PAST CHAIRMAN, THE IRVING HARRIS FOUNDATION

“Indianapolis just launched our first ever Preschool Scholarship Program utilizing a public-private partnership because high-quality early learning opportunities are beneficial for children’s lives and neighborhood health. These children are more likely to graduate and get a job, which is imperative for the economic vitality of our city.”

GREGORY A. BALLARD (R), MAYOR, INDIANAPOLIS, IN

Appendix A: List of Interviewees

W. Steven Barnett, National Institute for Early Education Research (NIEER)

David Bley, Bill & Melinda Gates Foundation

Eva Tansky Blum, formerly of PNC Foundation

Jeanne Brooks-Gunn, National Center for Children & Families at Columbia University

Laurie Miller Brotman, ParentCorps and NYU School of Medicine

Roger Brown, Bright Horizons

Miriam Calderon, BUILD Initiative

Sarah Clabby, Little Sprouts

Harriet Dichter, formerly of the Delaware Office of Early Learning

Libby Doggett, US Department of Education

David Fleming, formerly of Seattle King County Public Health Department

Phyllis Glink, Irving Harris Foundation

Sandra Gutierrez, Abriendo Puertas

Tamara Halle, Child Trends

James Heckman, University of Chicago

Julia Isaacs, Urban Institute

Jane Isaacs Lowe, Robert Wood Johnson Foundation

Wendy Lewis Jackson, Kresge Foundation

Jeffrey Liebman, Harvard Kennedy School

Joan Lombardi, Early Opportunities LLC

Rhett Mabry, Duke Endowment

Meera Mani, The David and Lucile Packard Foundation

Virginia Mann, UC Irvine

Sara Mead, Bellwether Education Partners

Anne Mitchell, Early Childhood Policy Research and Alliance for Early Childhood Finance

Molly O'Connor, Thrive Washington

Kris Perry, First Five Years Fund

Toni Porter, Bank Street College of Education

Sylvia Puente, Latino Policy Forum

Jessie Rasmussen, Buffett Early Childhood Fund

Diana Rauner, Ounce of Prevention Fund

Elliot Regenstein, Ounce of Prevention Fund

Arthur Reynolds, University of Minnesota

Shannon Rudisill, Administration for Children and Families, Department of Health and Human Services

David Sciarra, Education Law Center

Jill Stamm, New Directions Institute for Infant Brain Development

Carla Thompson, W.K. Kellogg Foundation

Kathryn Tout, Child Trends

Annie Van Hanken, George Kaiser Family Foundation

Sara Watson, ReadyNation

Sarah Weber, Bill & Melinda Gates Foundation

Gerrit Westervelt, WestEd (formerly of BUILD Initiative)

Lisa Williams Taylor, Children's Services Council of Palm Beach County

David Willis, Division of Home Visiting and Early Childhood Systems, Health Resources and Services Administration

Marcy Whitebook, Director of the Center for the Study of Child Care Employment at the University of California-Berkeley

Megan Wyatt, Bezos Family Foundation

Appendix B: Sources

101: Early Head Start-Child Care Partnerships, Washington, DC: Administration for Children and Families, US Department of Health and Human Services (2014).

Adamu, Maryam, "New Child Care Regulations Are a Step in the Right Direction," *Center for American Progress*, Sept. 17, 2014.

Administration for Children and Families, "Early Head Start-Child Care Partnerships," December 2014, http://www.acf.hhs.gov/programs/ecd/early-learning/ehs-cc-partnerships.

Administration for Children and Families, "FY 2014 Head Start Program Fact Sheet," http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/2014-hs-program-factsheet.html.

"Advisory Committee on Head Start Research and Evaluation: Final Report," submitted to the US Department of Health and Human Services, August 2012.

All Our Kin, "Our Impact," http://www.allourkin.org/our-impact.

Alliance for Early Success, "Success Stories," retrieved January 23, 2015, from http://earlysuccess.org/partnerships/success-stories.

Barnett, W. Steven, Megan E. Carolan, James H. Squires, Kirsty Clarke Brown, and Michelle Horowitz. *The State of Preschool 2014: State Preschool Yearbook.* New Brunswick, NJ: National Institute for Early Education Research (2014).

Bonari, L., N. Pinto, E. Ahn, A. Einarson, M. Steiner, and G. Koren, "Perinatal Risks of Untreated Depression During Pregnancy," *Canadian Journal of Psychiatry*, vol. 49, no. 11 (November 2004): 726-35.

Bornfreund, Laura, Clare McCann, Conor Williams, and Lisa Guernsey, *Beyond Subprime Learning: Accelerating Progress in Early Education,* Washington, DC: New America Foundation (July 2014). Retrieved from https://static.newamerica.org/attachments/743-beyond-subprime-learning/Beyond_Subprime_Learning_by_Bornfreund-et-al_New_America_Jul2014.pdf.

Bornfreund, Laura, Clare McCann, Conor Williams, and Lisa Guernsey, *Subprime Learning: Early Education in America Since the Great Recession,* Washington, DC: New America Foundation (January 2014). Retrieved from http://www.newamerica.org/downloads/NewAmerica_SubprimeLearning_Release.pdf.

BUILD Initiative, "BUILD's Mission and History," http://www.buildinitiative.org/AboutUs/MissionHistory.aspx.

BUILD Initiative, "Quality Rating and Improvement Systems (QRIS)," http://www.buildinitiative.org/TheIssues/EarlyLearning/QualityQRIS.aspx.

Burchinal, Margaret R., Joanne E. Roberts, Laura A. Nabors, and Donna M. Bryant, "Quality of Center Child Care and Infant Cognitive and Language Development," *Child Development,* vol. 67, no. 2 (April 1996): 606–620.

Center on the Developing Child at Harvard University, "Five Numbers to Remember about Early Childhood Development," http://developingchild.harvard.edu/resources/multimedia/interactive_features/five-numbers/.

Center for High Impact Philanthropy at the University of Pennsylvania, "Invest in a Strong Start for Children: A Toolkit for Donors," 2014, http://www.impact.upenn.edu/toolkits/early-childhood-toolkit/.

Chalk, Sean and Holly Yettick, "Hispanic Preschool Participation Varies by State," *Education Week*, January 15, 2015.

Child Care Aware of America, *We Can Do Better: 2013 Update*, Arlington, VA, 2013.

Chu, Ann T. and Alicia F. Lieberman, "Clinical Implications of Traumatic Stress from Birth to Age Five," *Annual Review of Clinical Psychology*, vol. 6 (2010): 469–94.

City of Chicago Mayor's Press Office, "Mayor Emanuel Announces Expansion of Pre-K to More than 2,600 Chicago Public School Children," October 7, 2014.

City of Chicago Mayor's Press Office, "Mayor Emanuel Unveils Online Early Learning Portal to Help Parents and Families Find Quality Programs for Children in Their Neighborhoods," November 29, 2012.

Collaborative for Academic, Social, and Emotional Learning (CASEL), "What is Social and Emotional Learning?" http://www.casel.org/social-and-emotional-learning/.

Dual Language Learning: What Does It Take? Head Start Dual Language Report, Washington, DC: Office of Head Start, Administration of Children and Families, US Department of Health and Human Services (February 2008).

Edelstein, Sara, Julia Isaacs, Heather Hahn, and Katherine Toran, *How Do Public Investments in Children Vary with Age? A Kid's Share Analysis of Expenditures in 2008 and 2011 by Age Group*, Washington, DC: The Urban Institute (October 2012).

Feller, A, T. Grindal, L. Miratrix, and L. Page, "Compared to What? Variation in Impacts of Early Childhood Education by Alternative Care-Type Settings," (December 30, 2014). Available at SSRN: http://ssrn.com/abstract=2534811.

Finkelhor, David, Heather A. Turner, Anne Shattuck, and Sherry Hamby, "Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth," *JAMA Pediatrics*, vol. 167, no. 7 (July 2013): 614–21.

Fuller, Bruce, Sharon Lynn Kagan, Susanna Loeb, and Yueh-Wen Chang, "Child Care Quality: Centers and Home Settings that Serve Poor Families," *Early Childhood Research Quarterly*, vol. 19 (2004): 505–527.

Gelatt, Julia, Gina Adams, and Sandra Huerta, *Supporting Immigrant Families' Access to Prekindergarten*, Washington, DC: The Urban Institute (March 2014).

Getting Ready: Findings from the National School Readiness Indicators Initiative (Rhode Island KIDS COUNT, February 2005). Retrieved from http://www.rikidscount.org.

Gewertz, Catherine, "Kindergarten-Readiness Tests Gain Ground," *Education Week*, October 7, 2014.

Gormley, William, Jr., Ted Gayer, Deborah Phillips, and Brittany Dawson, *The Effects of Oklahoma's Universal Pre-K Program on School Readiness*, Washington, DC: Center for Research on Children in the US, Georgetown University (2004).

Guerra, Jennifer, "Five Things to Know About Early Childhood Development," *State of Opportunity*, Nov. 14, 2012.

Halle, Tamara G., Elizabeth C. Hair, Margaret Burchinal, Rachel Anderson, and Martha Zaslow, *In the Running for Successful Outcomes: Exploring the Evidence for Thresholds of School Readiness*, Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (2012).

Halle, Tamara, Elizabeth Hair, Mirjam Nuenning, Debra Weinstein, Jessica Vick, Nicole Forry, and Akemi Kinukawa, *Primary Child Care Arrangements of US Infants: Patterns of Utilization by Poverty Status, Family Structure, Maternal Work Status, Maternal Work Schedule, and Child Care Assistance*, Washington, DC: US Department of Health and Human Services, Office of Planning, Research, and Evaluation (June 2009).

Hart, Betty and Todd R. Risley, "The Early Catastrophe: The 30 Million Word Gap by Age 3," *American Educator* (Spring 2003): 4–9.

Health Resources and Services Administration Maternal and Child Health, "Home Visiting Models," http://mchb.hrsa.gov/programs/homevisiting/models.html.

Healthy Babies 2014 Palm Beach County, Boynton Beach, FL: Children's Services Council of Palm Beach County (2011).

Heckman, James J., "The Case for Investing in Disadvantaged Young Children," *Big Ideas for Children: Investing in Our Nation's Future*, 49-58. Washington, DC: First Focus (2009). Retrieved January 23, 2015, from http://www.heckmanequation.org.

Heckman, James J., "Schools, Skills, and Synapses," *Economic Inquiry*, vol. 46, no. 3 (2008): 289–324.

Heckman, James J., Francis Campbell, Gabriella Conte, Seong Hyeok Moon, Rodrigo Printo, Elizabeth Pungello, and Yi Pan, "Early Childhood Investments Substantially Boost Adult Health," *Science* 28, Vol. 343, No. 6178 (March 2014): 1478–1485.

Heckman, James J., Seong Hyeok Moon, Rodrigo Pinto, Peter A. Savelyev, and Adam Yavitz, "The Rate of Return to the High/Scope Perry Preschool Program," NBER Working Paper No. 15471 (November 2009).

Help Me Grow National Center, "What is the *Help Me Grow* National Center?" http://www.helpmegrownational.org/pages/hmg-national/what-is-hmg-national.php.

Howes, Carollee, "Children's Experiences in Center-Based Child Care as a Function of Teacher Background and Adult : Child Ratio," *Merrill-Palmer Quarterly,* vol. 43, no. 3 (July 1997): 404–425.

Huntsman, Leone, *Determinants of Quality in Child Care: A Review of the Research Evidence*, New South Wales, Australia: Centre for Parenting & Research, NSW Department of Community Services, April 2008.

Institute of Medicine of the National Academies, edited by LaRue Allen and Bridget B. Kelly, *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation*, April 1, 2015, http://www.iom.edu/Reports/2015/Birth-To-Eight.aspx.

Isaacs, Julia B., *Starting School at a Disadvantage: The School Readiness of Poor Children,* Washington, DC: Center on Children and Families at the Brookings Institution (March 19, 2012). Retrieved from http://www.brookings.edu.

Isaacs, Julia B. and Katherine Magnuson, *Income and Education as Predictors of Children's School Readiness*, Washington, DC: Center on Children and Families at the Brookings Institution (December 14, 2011). Retrieved from http://www.brookings.edu.

Johnson-Staub, Christine, *First Steps for Early Success: State Strategies to Support Developmental Screening in Early Childhood Settings*, Washington, DC: CLASP (October 2014). Retrieved from http://www.clasp.org.

Kagan, Sharon Lynn and Elizabeth Rigby, *Improving the Readiness of Children for School*, Washington, DC: Center for the Study of Social Policy (February 2003). Retrieved from http://www.policyforchildren.org.

Karoly, Lynn A. and Gabriella C. Gonzalez, "Early Care and Education for Children in Immigrant Families," Princeton, NJ: *The Future of Children*, v. 21, no. 1 (Spring 2011): 71-101.

Karoly, Lynn A., M. Rebecca Kilburn, and Jill S. Cannon, *Early Childhood Interventions: Proven Results, Future Promise*, Santa Monica, CA: RAND Corporation (2005). Retrieved from http://www.rand.org.

Kitzman, H., D.L. Olds, et al. Enduring effects of prenatal and infancy home visiting by nurses on children: follow-up of a randomized trial among children at age 12 years, *Arch Pediatr Adolesc Med* 2010: vol. 164, no. 5, 412-18.

Klein, Lisa G. and Jane Knitzer, *Promoting Effective Early Learning: What Every Policymaker and Educator Should Know*, New York, NY: National Center for Children in Poverty at the Mailman School of Public Health, Columbia University (January 2007).

Kline, P. and C. Walters, "Evaluating Public Programs with Close Substitutes: The Case of Head Start," UC-Berkeley Institute for Research and Labor Employment Working Paper #123-14 (December 2014).

Landry, Susan H., *Effective Early Childhood Programs: Turning Knowledge into Action*, Houston, TX: University of Texas Health Science Center (2005). Retrieved from http://www.childrenslearninginstitute.org.

Laosa, Luis M. and Pat Ainsworth, *Is Public Pre-K Preparing Hispanic Children to Succeed in School?* New Brunswick, NJ: National Institute for Early Education Research (March 2007).

Lowell, D.I., A.S. Carter, L. Godoy, B. Paulicin, M.J. Briggs-Gowan, "A Randomized Controlled Trial of Child First: A Comprehensive, Home-Based Intervention Translating Research into Early Childhood Practice," *Child Development*: vol. 82, no. 1 (2011): 193-208.

Maryland State Department of Education, "2012-2013 Maryland School Readiness Report," 2013, http://marylandpublicschools.org/NR/rdonlyres/BCFF0F0E-33E5-48DA-8F11-28CF333816C2/35515/MMSR_ExecutiveSummaryReport20122013_.pdf.

Mayoral, Maria V., "Fact Sheet: Building Partnerships between Early Head Start Grantees and Child Care Providers," Zero to Three National Center for Infants, Toddlers, and Families (March 2014).

Mead, Sara, *Renewing Head Start's Promise: Invest in What Works for Disadvantaged Preschoolers*, Bellwether Education Partners (July 2014). Retrieved from http://bellwethereducation.org/publication/RenewingHeadStartsPromise.

Merzer, Martin, *The Billion-Dollar Bet on a Community's Future*, Miami, FL: The Children's Trust. Retrieved January 2015 from http://www.thechildrenstrust.org.

Murphey, David, Mae Cooper, and Nicole Forry, *The Youngest Americans: A Statistical Portrait of Infants and Toddlers in the United States*, Chicago, IL: The McCormick Foundation and Child Trends (November 2013). Retrieved from http://www.mccormickfoundation.org.

National Association for the Education of Young Children (NAEYC), "Principles of child development and learning that inform developmentally appropriate practice," July 1996, https://oldweb.naeyc.org/about/positions/dap3.asp.

National Institute of Child Health and Human Development, *The NICHD Study of Early Child Care and Youth Development: Findings for Children up to Age 4½ Years*, NIH Pub. No. 05-4318, Washington, DC: US Department of Health and Human Services National Institutes of Health (January 2006).

National Survey of Early Care and Education Project Team, *Number and Characteristics of Early Care and Education (ECE) Teachers and Caregivers: Initial Findings from the National Survey of Early Care and Education (NSECE)*. OPRE Report #2013-38, Washington, DC: Office of Planning, Research and Evaluation, Administration of Children and Families, US Department of Health and Human Services (October 2013).

Nonprofit Quarterly, "Edna McConnell Clark Foundation's Growth Capital Aggregation Pilot: A Bold Philanthropic Innovation," August 17, 2013.

Osofsky, Joy D., "The Impact of Violence on Children," *The Future of Children*, vol. 9, no. 3 (Winter 1999).

Pennsylvania Early Learning, "Children's Progress Update: Keystone STAR 3 and 4 Programs, 2011-12," 2012, https://www.pakeys.org/uploadedContent/Docs/Early%20Learning%20Programs/Keystone%20STARS/Keystone_STARS_progress_11-12.pdf.

Pew Center on the States, *States and New Federal Home Visiting Initiative: An Assessment from the Starting Line*, Washington, DC: Pew Charitable Trusts (August 2011).

Playbook for Becoming an Early Learning Community, Washington: DC, Executive Office of the President of the United States (December 2014). Retrieved from http://www.whitehouse.gov.

Porter, Eduardo, "Investments in Education May Be Misdirected," *The New York Times*, Economic Scene, April 2, 2013.

Preskill, Hallie, Nathalie Jones, and Afi Tengue, *Markers That Matter: Success Indicators in Early Learning and Education*, FSG, July 17, 2013. Retrieved from http://www.fsg.org.

Puma, M., S. Bell, R. Cook, C. Heid, G. Shapiro, P. Broene, F. Jenkins, P. Fletcher, L. Quinn, J. Friedman, et al., *Head Start Impact Study: Final Report*, Administration for Children & Families (2010).

Quinton, Sophie, "The Accountability Revolution Comes to Head Start," *National Journal*, April 23, 2014.

Reeves, Richard V., and Kimberly Howard, *The Parenting Gap*, Washington, DC: Center on Children and Families at the Brookings Institution (September 8, 2013).

Regenstein, Elliot and Rio Romero-Jurado, *A Framework for Rethinking State Education Accountability and Support from Birth Through High School*, Chicago, IL: The Ounce of Prevention Fund (June 3, 2014).

Reynolds, Arthur J., "One Year of Preschool Intervention or Two: Does It Matter?" *Early Childhood Quarterly* 10, no. 1 (January 1995): 1–31.

Sawhill, Isabel V., Scott Winship, and Kerry Searle Grannis, *Pathways to the Middle Class: Balancing Personal and Public Responsibilities,* Washington, DC: Center on Children and Families at the Brookings Institution (September 20, 2012). Retrieved from http://www.brookings.edu.

SB 1123: Early Learning: The Strong Families, Strong Children Act, Early Edge California, April 3, 2014. Retrieved from http://www.earlyedgecalifornia.org.

Schmit, Stephanie and Danielle Ewen, *Supporting Our Youngest Children: Early Head Start Programs in 2010*, Washington DC: CLASP (March 2012).

Schmit, Stephanie, Hannah Matthews, Sheila Smith, and Taylor Robbins, *Investing in Young Children: A Fact Sheet on Early Care and Education Participation, Access, and Quality*, New York, NY: National Center for Children in Poverty at the Mailman School of Public Health, Columbia University (November 2013).

Schweinhart, Lawrence J., Jeanne Montie, Zongping Xiang, W. Steven Barnett, Clive R. Belfield, and Milagros Nores, *Lifetime Effects: The High/Scope Perry Preschool Study Through Age 40*. Ypsilanti, MI: High/Scope Press (2005). Retrieved from http://www.highscope.org.

Shonkoff, Jack P. and Deborah A. Phillips, eds., *From Neurons to Neighborhoods: The Science of Early Childhood Development*, Washington, D.C.: National Research Council and Institute of Medicine, National Academy Press (2000).

Smart Start, "Why Smart Start Works," January 2015, http://ivdesignhouse.com/smartstart/wp-content/uploads/2015/01/Why-Smart-Start-Works-2013.pdf.

Stebbins, Helene and Jane Knitzer, *State Early Childhood Policies*, New York, NY: National Center for Children in Poverty at the Mailman School of Public Health, Columbia University (June 2007).

Tarkan, Laurie, "For Mother and Child at Risk, Care that Includes a Psychologist," *The New York Times* Health section, February 14, 2009.

The Annie E. Casey Foundation, *Creating Opportunity for Families: A Two-Generation Approach*, 2014.

The Annie E. Casey Foundation, *The First Eight Years: Giving Kids a Foundation for a Lifetime of Success*, 2013, http://www.aecf.org/resources/the-first-eight-years-giving-kids-a-foundation-for-lifetime-success/.

The Economic Promise of Investing in High-Quality Preschool: Using Early Education to Improve Economic Growth and the Fiscal Sustainability of States and the Nation, Washington, DC: Committee for Economic Development (June 26, 2006). Retrieved from http://www.ced.org.

The Economics of Early Childhood Investments, Washington, DC: Executive Office of the President of the United States (December 2014). Retrieved from http://www.whitehouse.gov.

The Rockefeller Foundation, "State and Local Governments Receive Assistance to Launch Social Impact Bond Projects Across the Country," June 10, 2013, http://www.rockefellerfoundation.org/about-us/news-media/state-and-local-governments-receive-assistance-to-launch-social-impact-bond-projects-across-the-country/.

The White House Office of the Press Secretary, "Fact Sheet: Invest in US: The White House Summit on Early Childhood Education," December 10, 2014, http://www.whitehouse.gov/the-press-office/2014/12/10/fact-sheet-invest-us-white-house-summit-early-childhood-education.

Tout, Kathryn and Rebecca Starr, *Key Elements of a QRIS Validation Plan: Guidance and Planning Template*, OPRE 2013–11, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services.

Understanding the Effects of Maltreatment on Brain Development, Issue Brief, Washington, DC: Child Welfare Information Gateway (November 2009). Retrieved from http://www.childwelfare.gov.

Whitebook, Marcy, Deborah Phillips, and Carollee Howes, *Worthy Work, STILL Unlivable Wages: The Early Childhood Workforce 25 Years After the National Child Care Staffing Study*, Berkeley, CA: Center for the Study of Child Care Employment, University of California, Berkeley, 2014.

Williams, Conor P., *Better Policies for Dual Language Learners*, Washington, DC: New America Foundation, February 2015.

Yoshikawa, Hirokazu, Christina Weiland, Jeanne Brooks-Gunn, Margaret R. Burchinal, Linda M. Espinosa, William T. Gormley, Jens Ludwig, Katherine A. Magnuson, Deborah Phillips, and Martha J. Zaslow, *Investing in Our Future: The Evidence Base on Preschool Education*, Foundation for Child Development, New York, NY: October 2013.

Zaslow, Martha, and Kathryn Tout, *Reviewing and Clarifying Goals, Outcomes and Levels of Implementation: Toward the Next Generation of Quality Rating and Improvement Systems (QRIS)*, OPRE Research Brief #2014-75, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services (October 2014).

Appendix C: ECLS-B Technical Appendix

Technical Appendix for the Pritzker-Bridgespan Analysis of the Early Childhood Longitudinal Study–Birth Cohort (ECLS-B)

In an effort to provide philanthropists with rough estimates of the number of children who are at risk of entering kindergarten not ready to learn and the types of barriers they face to achieving kindergarten readiness, we built directly off of the work of Julia Isaacs and Katherine Magnuson as published in a series of papers from the Brookings Institution.[135] We drew extensively on appendix materials from their work as well as personal communication with Julia Isaacs. We are grateful for Isaacs's helpful comments; her assistance implies no responsibility for the final product, which rests solely with Bridgespan and the Pritzker Children's Initiative.

Data

In this paper, we use the Early Childhood Longitudinal Study–Birth Cohort (ECLS-B), released by the National Center for Education Statistics (NCES). ECLS-B began with 10,688 unique births in 2001. Children's parents were interviewed in a series of four waves, corresponding with ages of nine months, two years, four years, and kindergarten.[136] Our final study sample includes roughly 4,600 children whose families remained in the survey and whose readiness for kindergarten was assessed. We use NCES-derived weights that correct for attrition bias that occurred over the course of the study.[137] Nonetheless, if sample attrition was systematically associated with the likelihood that a child was ready for kindergarten, our estimates of kindergarten readiness will be biased.

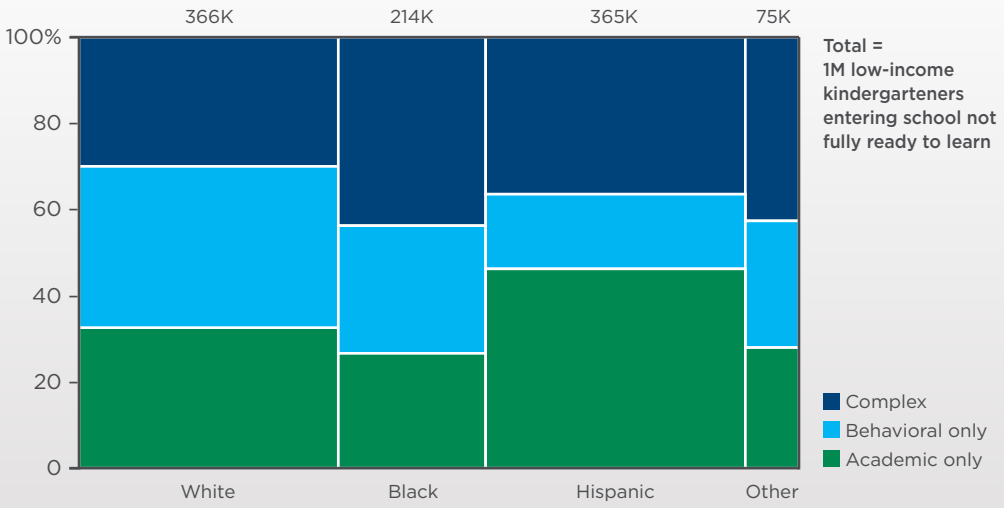
135 See Julia Isaacs and Katherine Magnuson, "Income and Education as Predictors of Children's School Readiness," Brookings Center on Children and Families at the Brookings Institution, December 2011, and Julia Isaacs, "Starting School at a Disadvantage: The School Readiness of Poor Children," Brookings Center on Children and Families at the Brookings Institution, March 2012.

136 Some children who attended kindergarten in 2007 were interviewed in a fifth wave.

137 Specifically, we use WK45T0 to calculate summary measures related to kindergarten readiness.

Additional analytical findings

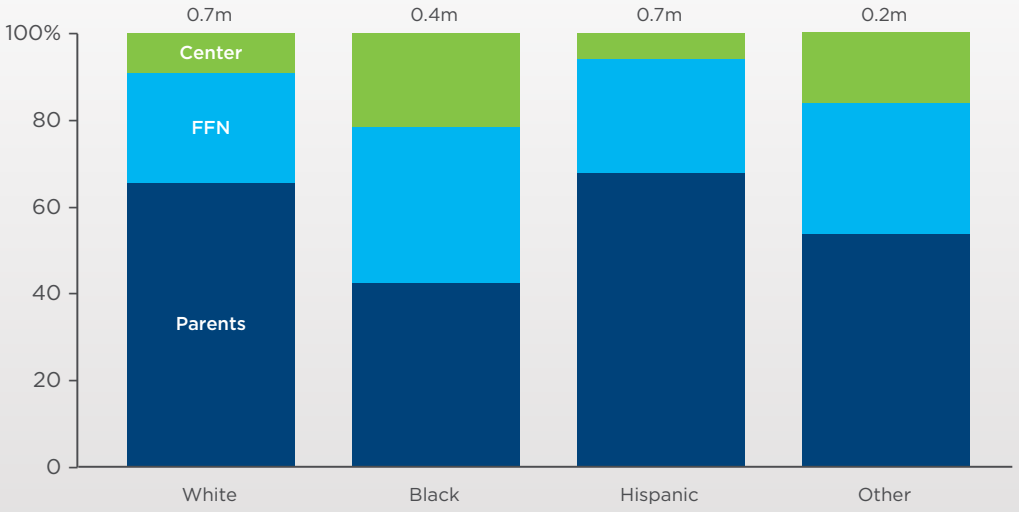
Figure A-1: Low-income kindergarteners entering school not fully ready to learn, by ethnicity



Source: Analysis of ECLS-B (2006-7) and American Community Survey (2012).

Figure A-2: Estimated primary care setting for low-income kindergarteners at age 2, by ethnicity

Low-income (<200% federal poverty line) children in kindergarten, by place of care at age 2



Source: Analysis of ECLS-B (2006-7) and American Community Survey (2012).

Creating the measure of kindergarten readiness

We measure each child's readiness for kindergarten based on the results from assessments of his or her abilities relative to those of peers, consistent with the approach in Isaacs and Magnuson (2011). In the domains of math, reading, learning-related behaviors, and externalizing problem behaviors, we followed three steps:

1. Create a continuous measure of each child's readiness.
2. Normalize that measure across all kindergarteners.
3. Identify children who were more than one standard deviation below the mean in at least one category, labeling them "not ready."

Table A-1 summarizes the variables and methods used to construct the continuous measure of readiness within each domain:

Table A-1. Variables and methods used to create continuous measure of child's readiness within domains

Domain	Variable(s)	Description	Method
Math	X*MSCR2	IRT composite score	Excluded missing values
Reading	X*RSCR2	IRT composite score	Excluded missing values
Learning-related behaviors	T*PAYATT, T*CONCEN, T*FIDGET, T*SHWIMG, T*EAGER, T*NDEPND, T*FINISH	Teacher-rated behavioral characteristics (on a 1-5 scale)	Sum values of variables after reverse-coding T*CONCEN and T*FIDGET
Externalizing problem behaviors	T*TEMPER, T*AGRESS, T*ANNOYS, T*ACTIVE, T*MPULSV, T*DISRPT	Teacher-rated behavioral characteristics (on a 1-5 scale)	Sum values of variables after reverse-coding all variables

* Refers to the wave in which the child first entered kindergarten (either four or five)

For the fifth domain, the child's health, we used the parents' report of the child's health. Children who were reported to be in "excellent," "very good," or "good" health were ready for kindergarten (if they were proficient in each of the other four domains) and those reported as being in "fair" or "poor" health were not ready for kindergarten. Only 2 percent of kindergarteners were judged to be in "fair" or "poor" health by their parents.

Reflections on our measure of kindergarten readiness

As the focus on kindergarten readiness has grown among both researchers and policy makers, measures of readiness have proliferated. There are two broad parameters that differentiate measures of readiness:

1. The "domains" of readiness, or skills, in which a child must achieve "proficiency" in order to be kindergarten ready.
   a. Domains cover academic as well as physical, social, and emotional readiness.
2. The metric by which "proficiency" is defined.
   a. Measures are *criterion-based* if children are judged against an absolute threshold of ability.
   b. Measures are *norm-based* if children's abilities are judged relative to those of other children.

The domains we use to assess kindergarten readiness among subjects in ECLS-B are conceptually similar to those identified by the National Education Goals Panel (NEGP), a working group whose findings have been validated by others since their publication in 1995.[138] The NEGP identified 1) physical well-being and motor development, 2) language development, 3) cognition and general knowledge, 4) social-emotional development, and 5) approaches to learning. In an effort to estimate children's abilities in these domains using information available in ECLS-B, our measure incorporates children's assessed abilities to perform math and reading tasks (relevant to NEGP domains 2 and 3), learning-related behaviors (domain 5), externalizing problem behaviors (domain 4), and parent-reported physical health (domain 1). Of the five domains used in our measure of readiness, the parent-reported physical health of the child probably approximates the NEGP domains with the least fidelity; parents of ECLS-B subjects appear to have highly optimistic views of their children's health.

Like most measures of readiness that are based on nationally representative surveys of young children, our measure is norm-based; children are deemed not ready for kindergarten if they fall one standard deviation or more below the mean in any one of the four non-health domains. This cutoff point is widely used by researchers, and there is some evidence that being more than one standard deviation below mean performance carries statistically meaningful implications for a child's subsequent achievement in school.[139] However, this norm-based approach has three important limitations:

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138 S.L. Kagan, E. Moore, and S. Bradekamp, *Reconsidering children's early development and learning: Toward common views and vocabulary,* Washington, DC: National Education Goals Panel Goal 1 Technical Planning Group, (1995).

139 See Tamara Halle, Elizabeth Hair, Margaret Burchinal, Rachel Anderson, and Martha Zaslow, "In the Running for Successful Outcomes: Exploring the evidence for thresholds of school readiness," December 2012. Prepared for Laura Radel, Office of the Assistant Secretary for Planning and Evaluation, HHS.

1. The resulting estimate of the rate of kindergarten readiness among American children is sensitive to the somewhat arbitrary assignment of one standard deviation as the key threshold; though there may not be an important difference between two children who are 0.9 and 1.1 standard deviations below the mean in a given domain of readiness, our decision to assign one of those children as ready and the other as unready affects our count of children who are not ready.

2. This measure could not be relied upon to track improvements in kindergarten readiness over time, as it reports the share of children in a certain portion of the distribution of all children's skills. That is, if all children improved incrementally (i.e. the mean of the distribution shifted) but the shape of the distribution of skills remained the same, then the number of children estimated to be ready for kindergarten would not change.

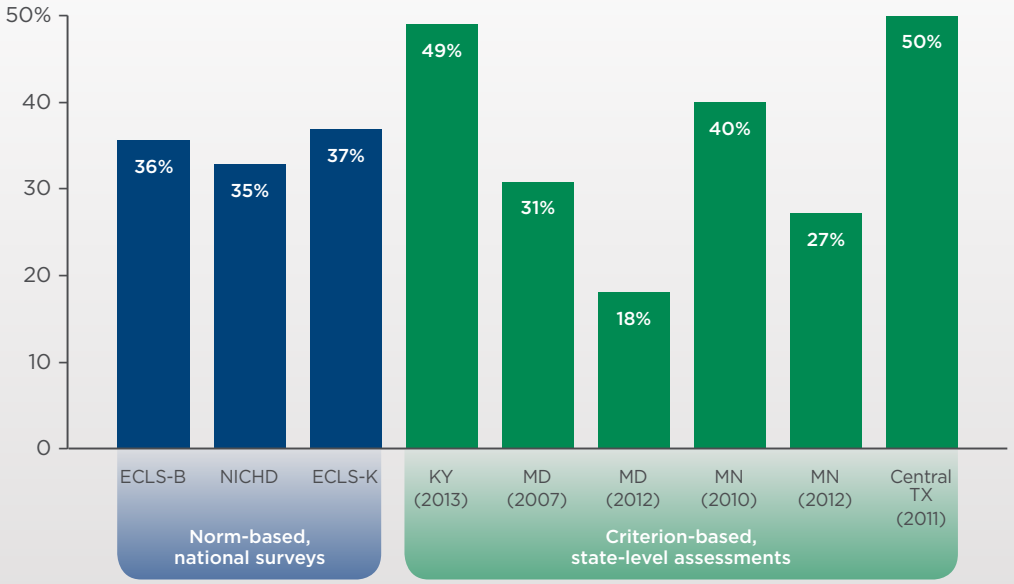
3. Most states that assess kindergarteners' readiness use criterion-based measures, increasing the need to benchmark our findings in ECLS-B to reported rates of readiness in states.

Keeping these limitations in mind, the lack of well-evidenced, widely agreed-upon criterion-based thresholds for kindergarten readiness suggests that the measure presented here is appropriate for presenting rough estimates of the number of American children at risk of entering kindergarten not ready to learn.

Figure A-3 compares several norm-based and criterion-based measures, with the consensus that about one in three kindergarteners do not enter school ready to learn (across all income levels).

Figure A-3: Comparison of norm-based national measures of kindergarten readiness and criterion-based state measures of kindergarten readiness

Percent of kindergarteners not fully ready



Source: State and national kindergarten-readiness measures.

Coding observable characteristics of children and their families in ECLS-B

Some of the characteristics by which we categorize children are time invariant, such as race/ethnicity and mother's birth age. When assigning kindergarteners to categories on the basis of an observable characteristic that could change over time (poverty status, mother's marital status, mother's educational attainment, and mother's employment status), we reported the modal value of the variable across the four waves in which the child's family was interviewed. In instances where there was no mode, we used the value from the child's first interview (at nine months).

Table A-2 summarizes the variables and methods used to construct each variable.

Table A-2. Variables and methods used to categorize children based on observable characteristics

Domain	Variable(s)	Notes
Poverty status	X*HTOTAL, X*INCOME, P*HHINCY	Imputed exact dollar income assuming random uniform distribution within income band in X*INCOME (except for low-income families with exact income provided in P*HHINCY). Compared to poverty thresholds corresponding with number of family members (in X*HTOTAL).
Race/ ethnicity	Y1CHRACE	Categories "White," "Black," and "Other" include only non-Hispanic children.
Maternal education	Y1MOMED	
Primary place of care	X*PRIMNW, P*PRTYPE, P*CHRS, P*CHROTH, P*RHRS, P*RHROTH, P*NHRS, P*NHROTH, P*HSHRS	Begin with ECLS coding of child's "primary" place of care (X*PRIMNW). Recategorize as "parental" care if the total number of hours/week in center-based care (P*CHRS + P*CHROTH + P*HSHRS) is less than 10 and if the total number of hours in FFN care (P*RHRS + P*RHROTH + P*NHRS + P*NHROTH) is less than 10. Recategorize as FFN care if the total number of hours/week in FFN care is greater than 10 and greater than the total number of hours/week in center-based care. Recategorize as center-based care if the total number of hours/week in center-based care is greater than 10 and is greater than or equal to the number of hours spent in FFN care.
Mother's marital status	Y1MARSTA	Only distinguish between married and not married.
Mother's age at birth	BCMOMAGE	

* Refers to the wave in which place of care is being observed

Estimating the number of children currently not ready for kindergarten

In order to arrive at estimates of the *number* of kindergarteners who are not ready for kindergarten today, we applied the percentage likelihoods that any given type of child would be ready for kindergarten (estimated in the Early Childhood Longitudinal Study) to the number of kindergarteners matching that description in the 2012 American Community Survey (ACS).[140] For instance, 82 percent of non-Hispanic White kindergarteners whose families had incomes above 350 percent of the federal poverty line (FPL) in the Early Childhood Longitudinal Study—Birth Cohort (ECLS-B) were ready for kindergarten—we assumed that this within-segment rate has not changed since 2006–7. In order to estimate the number of non-Hispanic White kindergarteners who are today ready for kindergarten, we applied that 82 percent rate to the number of non-Hispanic White kindergarteners with family incomes above 350 percent FPL (estimated to be about 825,000) living in the United States from the ACS.

In order to estimate the number of children ages birth to five who are at risk of entering kindergarten not ready to learn, we used a similar approach as described above, applying rates calculated in ECLS-B for a given type of child (e.g., child of a single mother in poverty) to the number of children ages birth to five estimated to have those traits in 2012. The assumption underlying these estimates is that children with certain observable characteristics will, in the absence of intervention, be ready for kindergarten at the same rate as kindergarteners with those same characteristics.

In general, we only rescaled the segments of population of children by poverty status and race/ethnicity. For instance, we assumed that the percent of children in poverty who received primarily parental care at two years remained at 61 percent; however, the share of all children who were both in poverty and receiving primarily parental care grew because we scaled up the share of all children in poverty. Therefore, if parents' educational attainment, child-care choices, marital statuses, or other variables of interest systematically changed within income or racial categories between 2007 and 2012, our estimates may be biased.

Finally, in calibrating our estimate of the likelihood that the average American kindergartener is ready, we applied the readiness rates for each poverty/race cell from ECLS-B to the population estimates from the ACS. Summing across the cells, we calculated the number of kindergarteners who would not have been ready in 2012 (roughly 1.5 million) and divided that number by the number of kindergarteners in the ACS in 2012 (roughly 4.2 million) to estimate the likelihood that the average American kindergartener was ready in 2012 (36 percent).

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140 This approach is especially important because it incorporates two important trends that have changed the profile of infants and toddlers in the US since the end of the ECLS-B data collection period: the rise of childhood poverty and the increased share of children who are Hispanic. The share of children ages birth to five in poverty was 21 percent in 2007 and 26 percent in 2012. Similarly, the share of children birth to five who were Hispanic was 26 percent in 2012.

Note on the precision of estimates

When calculating standard errors for estimates of kindergarten-readiness rates for a particular group, we account for complex survey design by calculating jackknife standard errors.

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Children & Families
Commission
of Orange County

SUPPLEMENT TO ORANGE COUNTY'S ANNUAL REPORT TO THE STATE FOR FISCAL YEAR 2014/15

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CHILDREN AND FAMILIES COMMISSION OF ORANGE COUNTY (COMMISSION) SUPPLEMENT TO THE ANNUAL REPORT TO THE STATE JULY 1, 2014 – JUNE 30, 2015

This supplemental report describes the Commission's investments in the programs it funds and the outcome of those investments. It also documents barriers to young children and the Commission's actions, programs and recommendations to advance the Commission's vision of an Orange County in which all young children are healthy and ready to learn.

Background

California voters passed Proposition 10, the California Children and Families First Act (The Act), in 1998. The Act provided for a 50 cent per pack excise tax on cigarettes. The monies collected are restricted to funding parent education, health, and early care programs that promote early childhood development from the prenatal stage through age five.

The Act enabled the Board of Supervisors in each county to establish its own Commission. On December 15, 1998, the Orange County Board of Supervisors adopted County Ordinance No. 98-18, creating the Children and Families Commission of Orange County (Commission).

In February 2000, the Children and Families Commission of Orange County adopted its Strategic Plan to become eligible for Proposition 10 tobacco tax revenue allocations. The Strategic Plan outlined the Commission's goals, outcomes, indicators and objectives, and guides its funding decisions. In May 2006, the Commission adopted an update to the Strategic Plan, highlighting linkages between the Strategic Plan and other planning efforts and expanded program-specific measures to better reflect the diverse services the Commission funds. In October 2014, the Commission approved revisions to the Strategic Plan to align with current priorities and strategies. The Strategic Plan is reviewed annually in a public hearing.

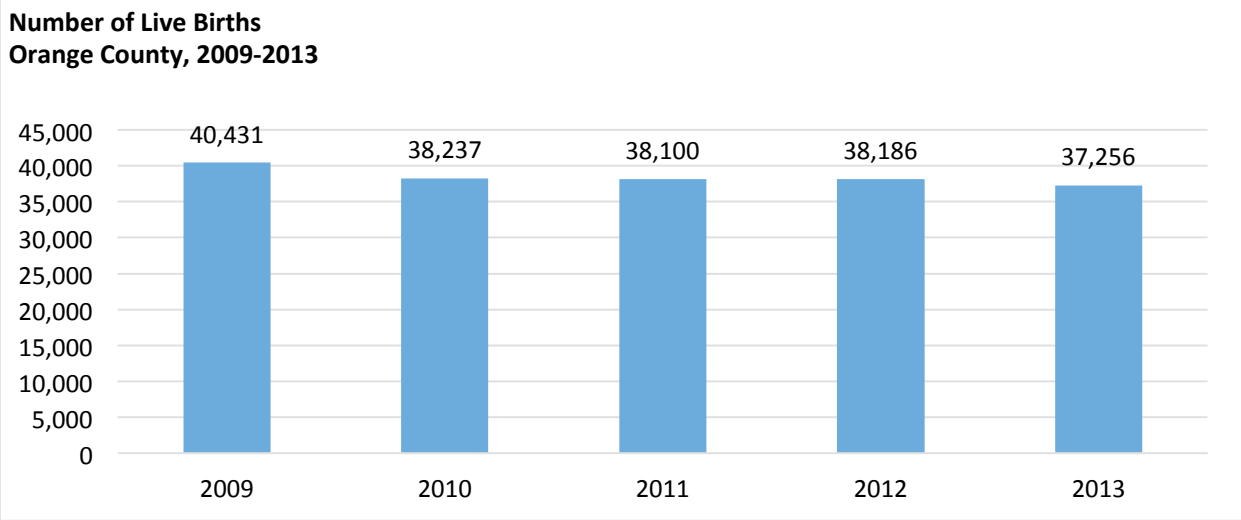
The Commission's mission is to: Provide leadership, funding and support for programs that achieve the vision that all children are healthy and ready to learn. The Commission defines four goals in its Strategic Plan:

1. *Healthy Children*: Promote the overall physical, social, emotional and intellectual health of young children.
2. *Strong Families*: Support and strengthen families to promote good parenting for the optimal development of young children.
3. *Early Learning*: Provide early learning opportunities for young children to maximize their potential to succeed in school.
4. *Capacity Building*: Promote an effective and quality delivery system for young child and their families.

Orange County Demographics and Trends

There has been a steady decrease in the number of births and number of children ages five years and younger living in Orange County. Despite the decrease in the young population, there is growing need as the percentage of families living in poverty increased in the past five years, from less than 10% to over 13%. Measures that have improved in the past five years include an increase in the percentage of children who have public health insurance, an increase in the percentage of children who are up to date on their immunizations at kindergarten entry, and a decrease in the rate of substantiated child abuse in the county.

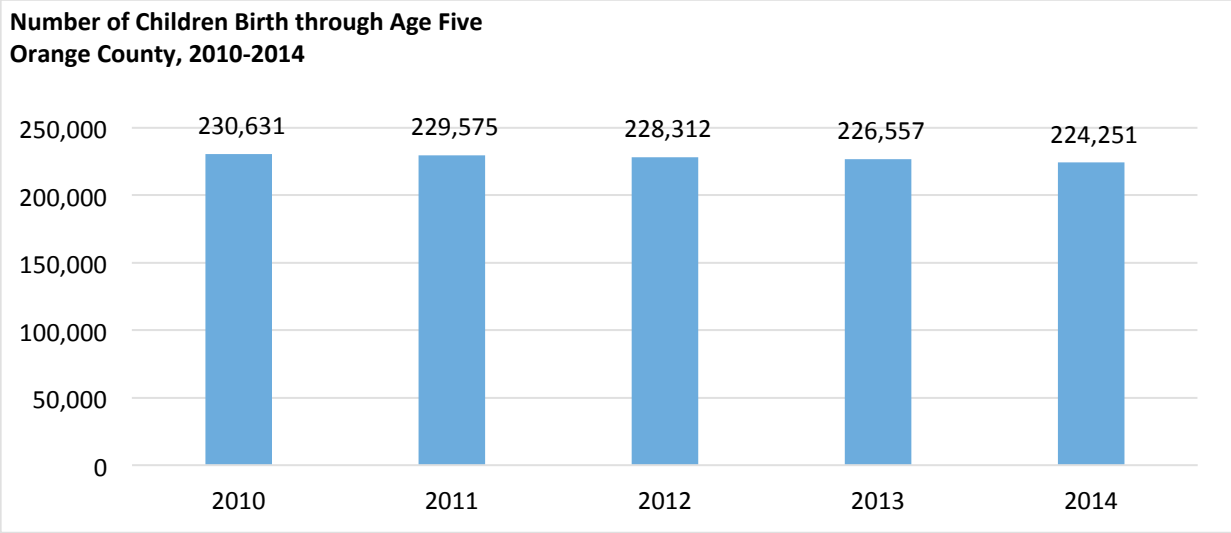
Births



Source: California Department of Public Health

- There were 37,256 live births in Orange County in 2013.
- This represents a five-year decrease of 8% in the number of live births in the county.

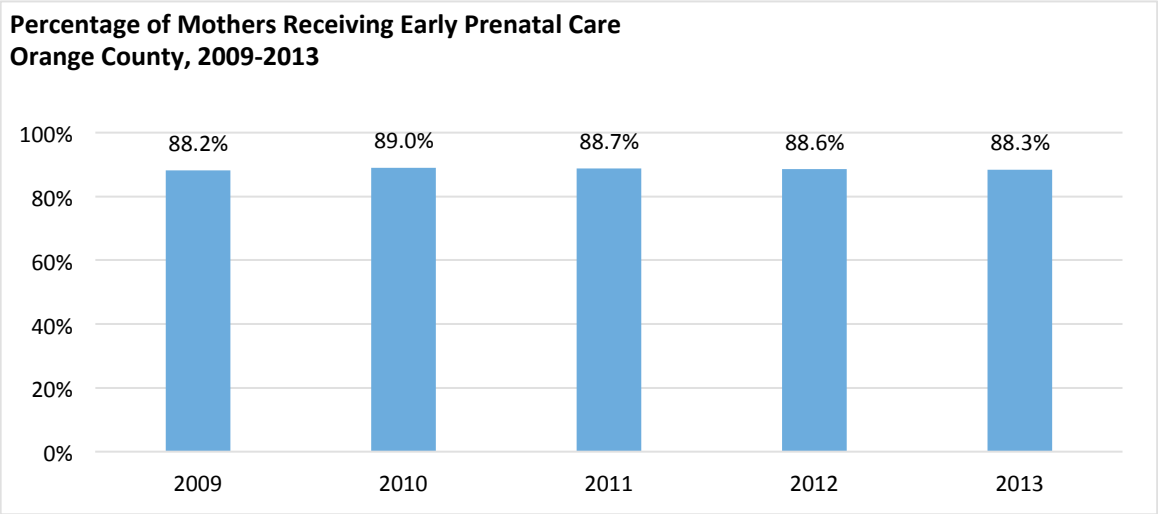
Children under Age Six



Source: California Department of Finance, Demographic Research Unit, Report P-3

- In 2014, there were 224,251 children ages five years and younger in Orange County.
- This represents a five-year decrease of 3%.
- In 2014, 7.2% of the total population in Orange County were ages five years or younger.

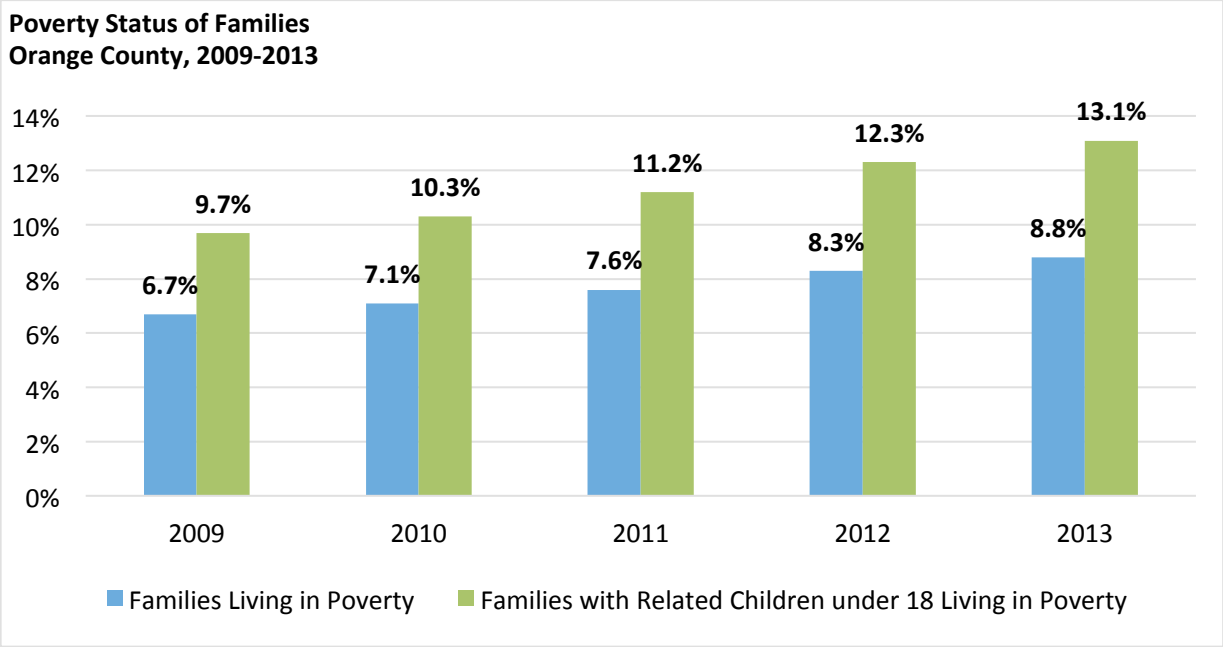
Early Prenatal Care



Source: California Department of Public Health

- In 2013, 88.3% of mothers received early prenatal care (care during the first trimester)
- This figure has remained relatively stable in the past five years.

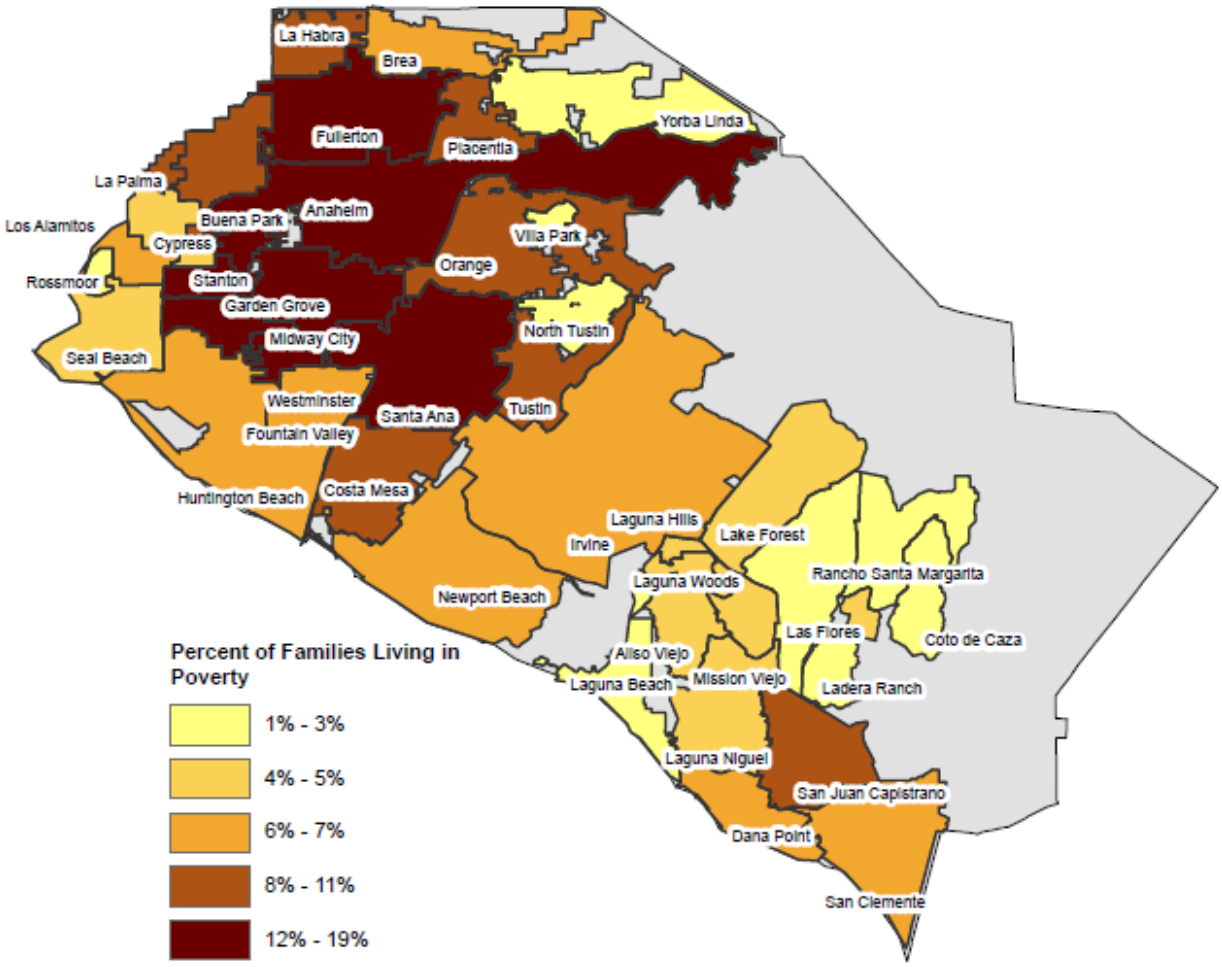
Poverty



Source: American Community Survey, 5-Year Estimates

- In 2013, 8.8% of families in Orange County were living below the official (federal) poverty line.
- The official poverty rate in Orange County is even higher for families who have related children under age 18 (13.1%).
- At 18.5% and 16.2%, the cities of Santa Ana and Stanton have the highest rate of families living in poverty, respectively.
- The California Poverty Measure, which has a broader definition of family and makes geographic adjustment for housing costs, estimates that 24.3% of Orange County's residents are living below the poverty line (Public Policy Institute of California).

Percentage of Families Living in Poverty
Orange County, 2013

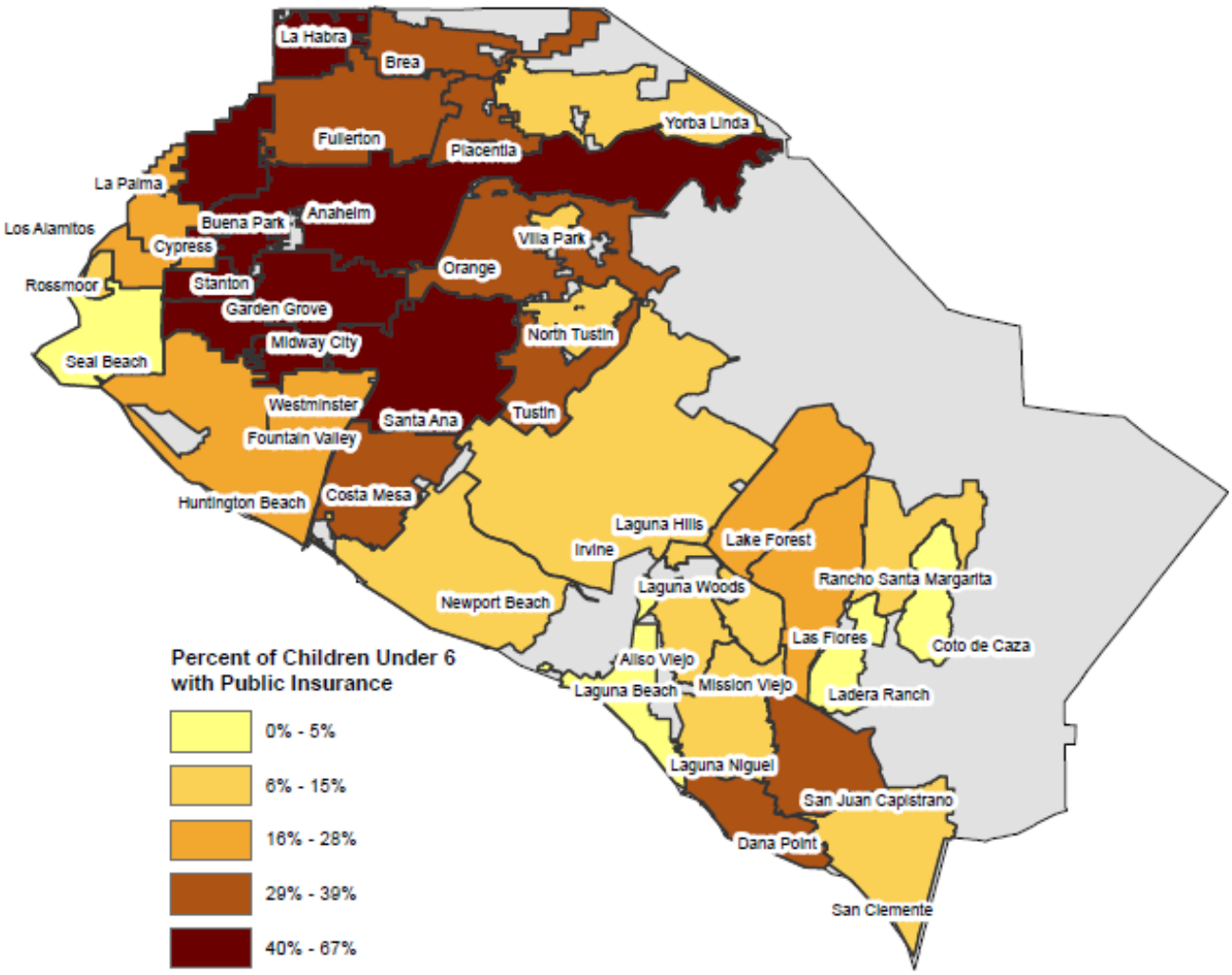


Source: American Community Survey, 5-Year Estimates

Public Health Insurance

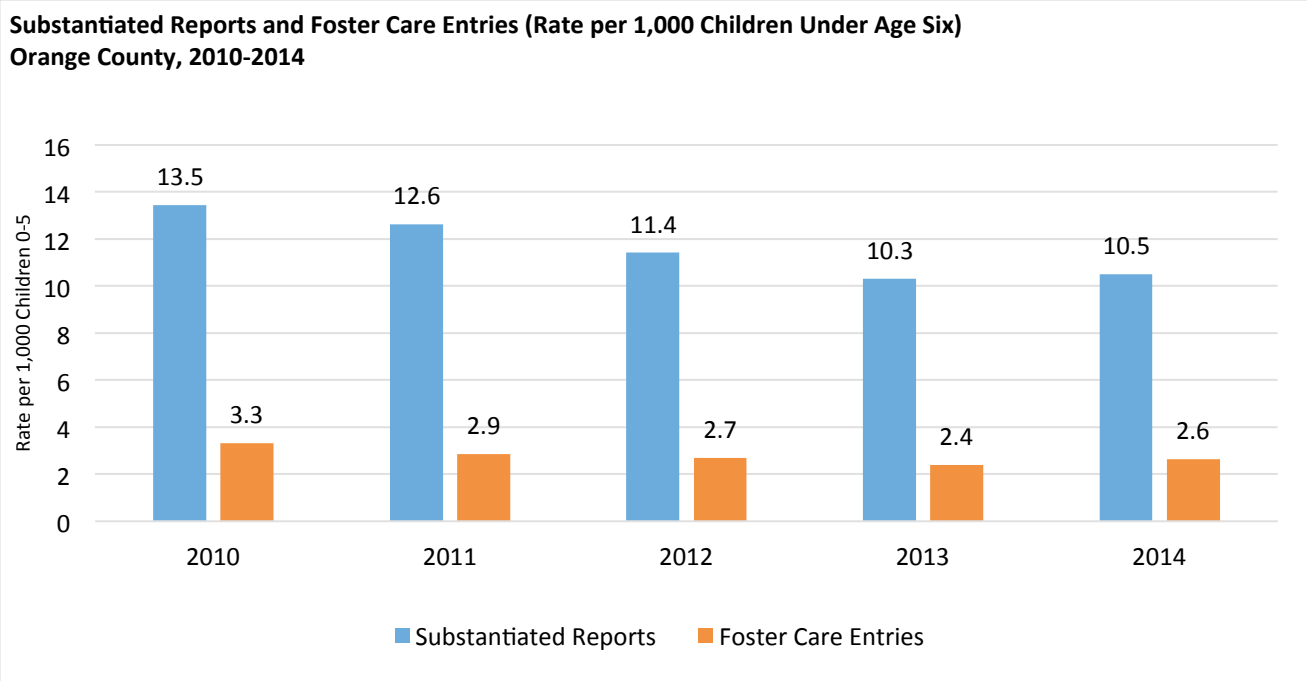
- In 2013, 38.0% of children birth through age five in Orange County had public health insurance.
- This is an increase from 2012, when 36.1% of children birth through age five had public health insurance.
- The cities of Santa Ana, Anaheim, and Garden Grove have the highest percentage of children birth through age five receiving public insurance (67%, 54%, and 54%, respectively).

Percent of Children under Age Six with Public Insurance
Orange County, 2013



Source: American Community Survey, 5-Year Estimates

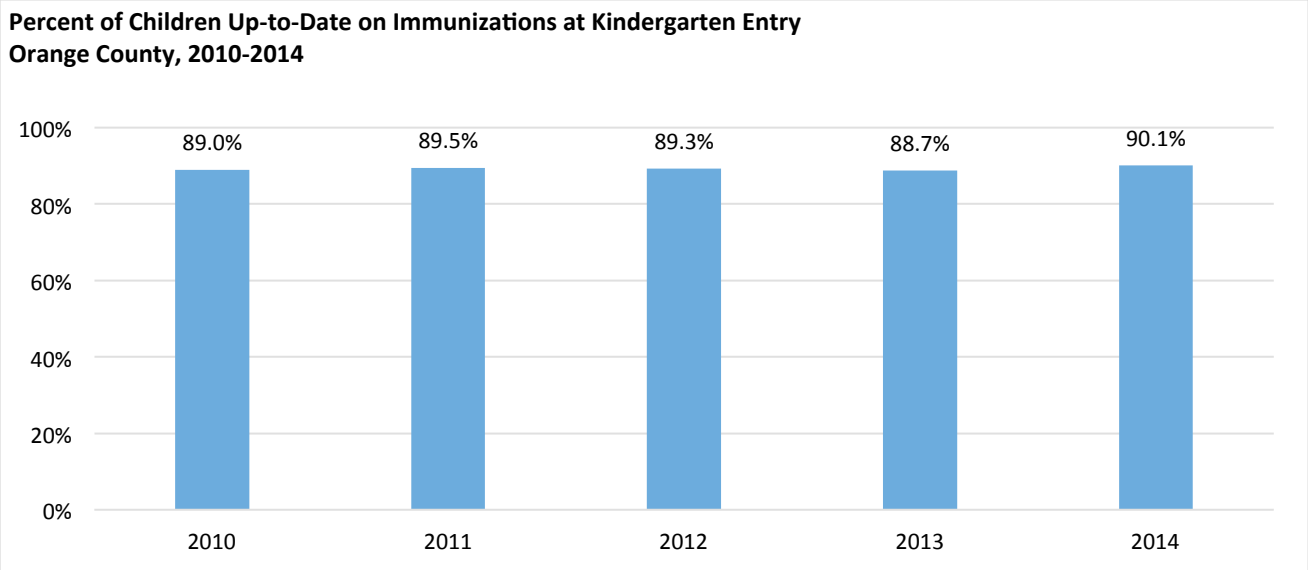
Child Abuse and Foster Care



Source: University of California Berkeley, Center for Social Services Research, Child Welfare Research Center

- In 2014, there were 10.5 substantiated abuse/neglect reports per 1,000 children birth through age five in Orange County.
  - This marks a five-year drop of 22%.
- In 2014, there were 2.6 foster care entries per 1,000 children birth through age five in Orange County.
  - This is a five-year decrease of 20% in the rate of foster care entries.

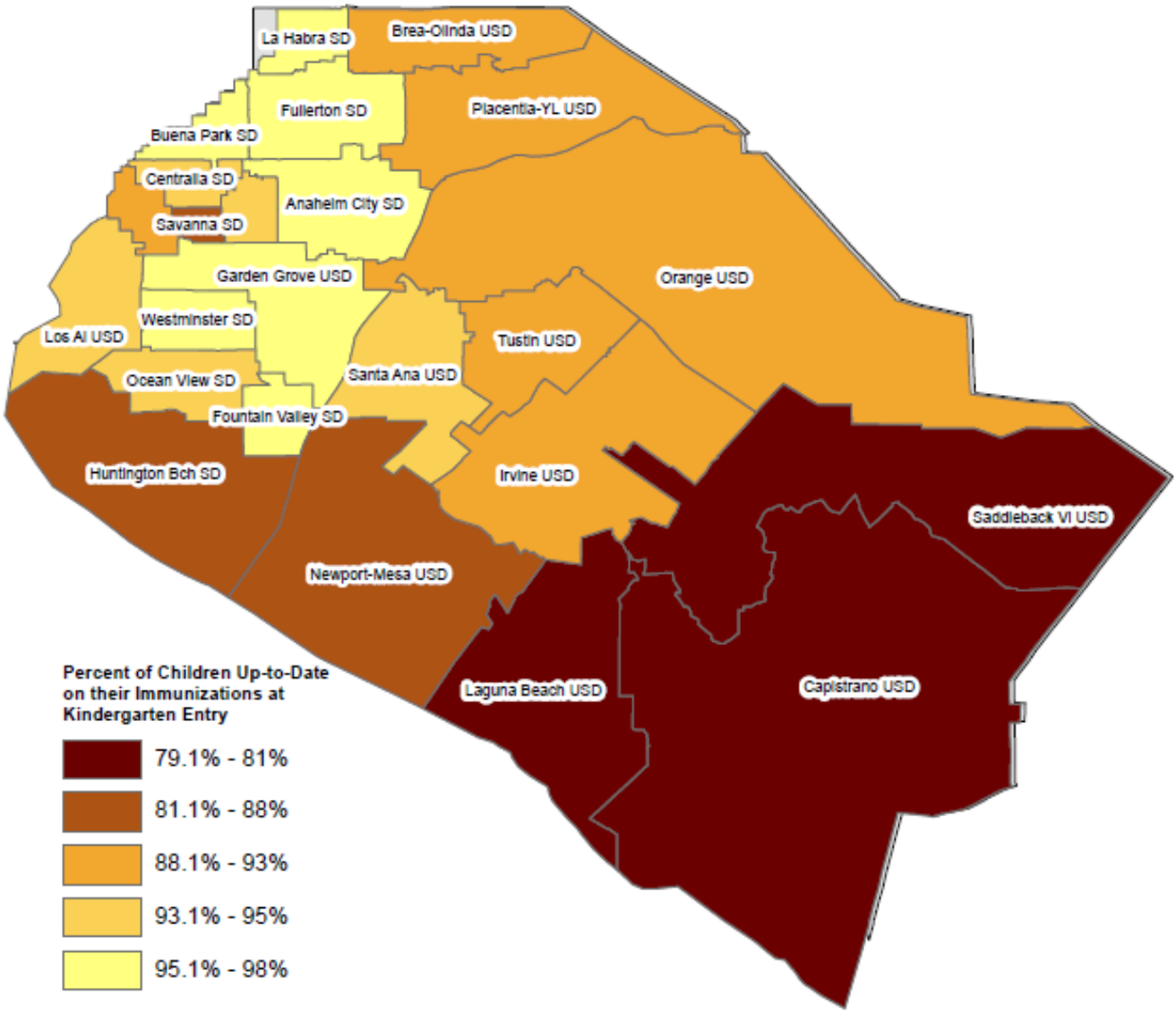
Immunizations



Source: California Department of Public Health

- In 2014, fully 90.1% of children had all the required immunizations upon kindergarten entry.
- This is an increase of more than one percentage point since 2010.
- The school districts of Capistrano, Laguna Beach, and Saddleback had the lowest rate of children up-to-date on their immunization at kindergarten entry (79%, 80%, and 81%, respectively).

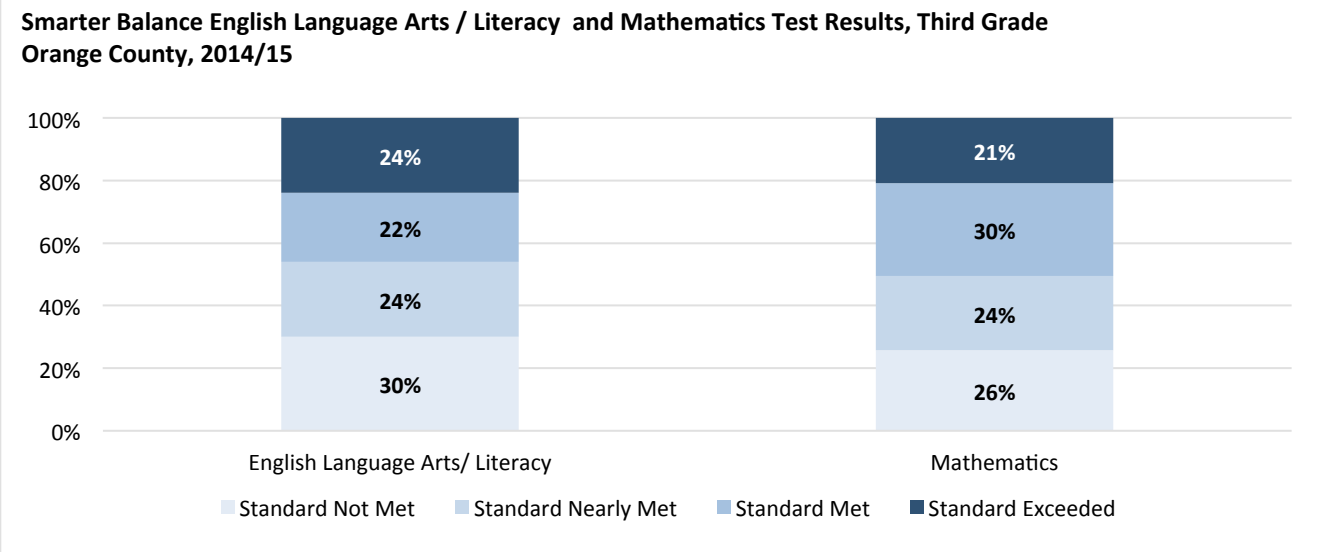
Percent of Children Up-to-Date on their Immunizations at Kindergarten Entry
Orange County, 2014/15 School Year



Source: California Department of Public Health

Third Grade English Language Arts and Mathematics

The California Department of Education has adopted new, online, end-of-year assessments of grade-level learning that measure progress toward college and career readiness. This *Smarter Balance Assessment* is aligned with the Common Core State Standards. 2014/15 is the first year data are available.

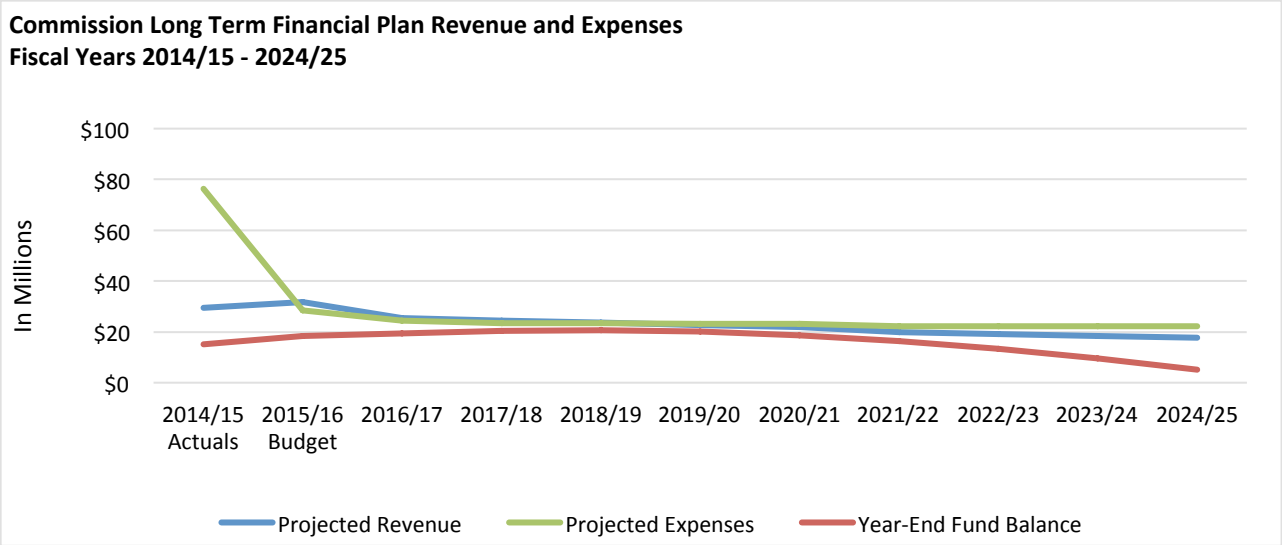


Source: California Department of Education, DataQuest

- Less than half (46%) of third graders in Orange County met or exceeded standards in English Language Arts/ Literacy.
- Slightly more than half (51%) of third graders met or exceeded standards in Mathematics.
- Third grade test results vary significantly by district:
    - English Language Arts/Literacy:
        - Laguna Beach and Los Alamitos school districts had the highest rate of third graders meeting or exceeding standards (77% and 75%, respectively)
        - Anaheim City and Santa Ana school districts had the lowest proportion of third graders meeting or exceeding standards (18% each)
    - Mathematics:
        - Los Alamitos and Irvine school districts had the highest rate of third graders meeting or exceeding standards (82% and 77%, respectively)
        - Anaheim City and La Habra school districts had the lowest proportion of third graders meeting or exceeding standards (23% and 26%, respectively)

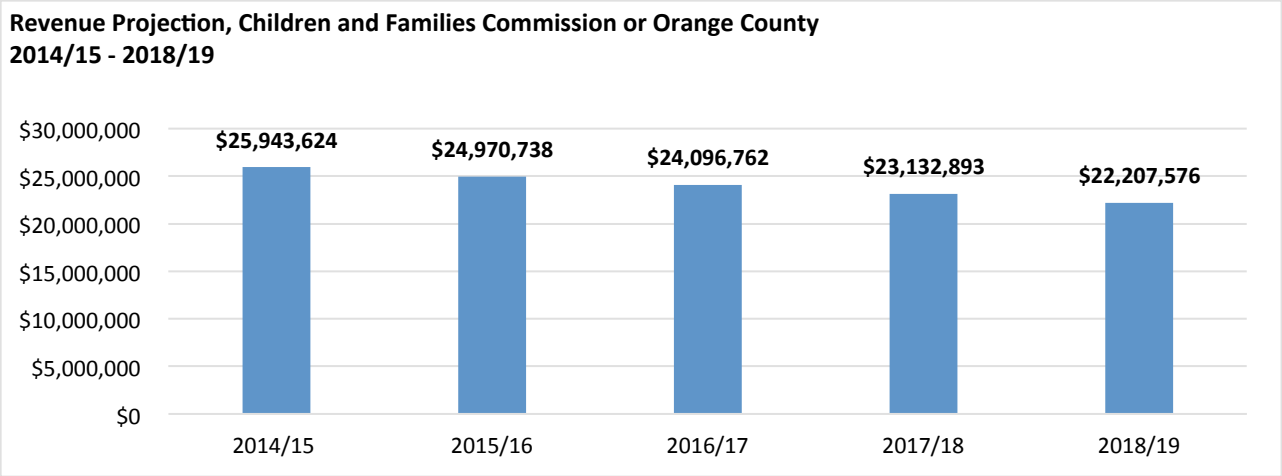
Financial

Commission revenue is projected to decrease steadily in the next ten years, as tobacco consumption declines, from $31,842,738 in annual revenues in fiscal year 2015/16 to $17,708,153 projected annual revenue by fiscal year 2024/25. While actual revenue declined only 1.7% in fiscal year 2014/15, Proposition 10 tobacco tax revenue is projected to decline annually at an average annual rate between 3.5% and 4%. The Commission supplements the decline in annual revenue through annual withdrawals from its Long Term Commitment account. This account, however, is expected to be fully exhausted within the next eight years.



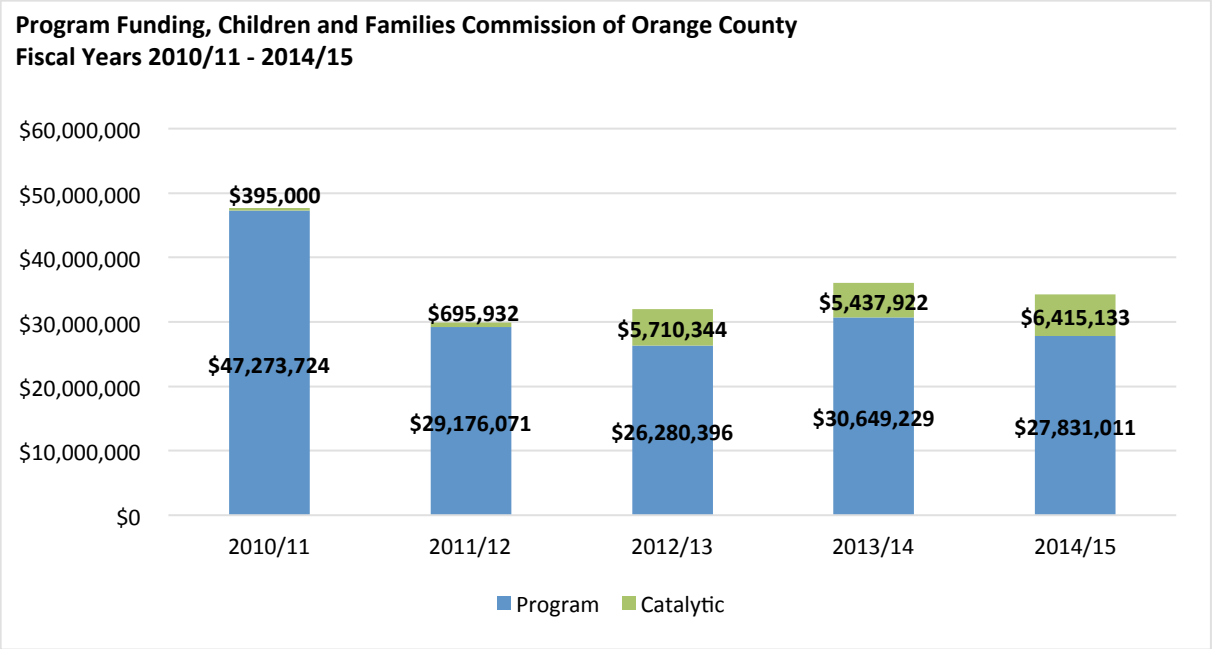
Revenue

While actual revenue declined only 1.7% in fiscal year 2014/15, Proposition 10 tobacco tax revenue is projected to decline annually at an average annual rate between 3.5% and 4%.

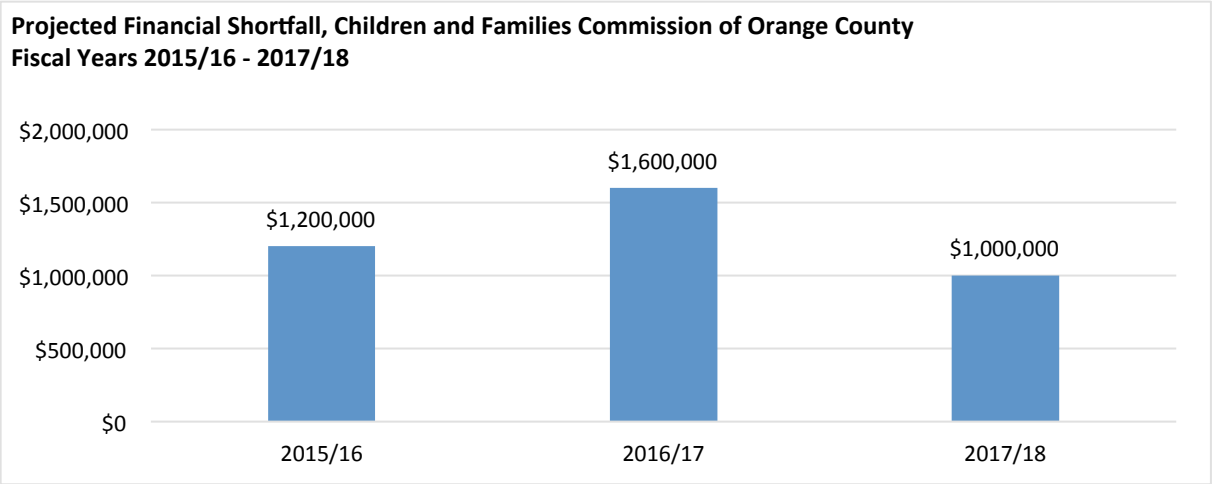


Program Funding

Fiscal year 2014/15 was the first of the three-year funding actions approved by the Commission in February 2014. The step-down approach embedded in the approved Long Term Financial Plan assumes a reduction of base budget program spending to align with declining tobacco tax revenue and provide sustainable program funding in future years. Beginning in fiscal year 2011/12, the Commission made a strategic change in its funding strategy, transitioning to one-time catalytic investments as an increasing share of its portfolio. Catalytic investments are intended to be one-time, system-level funding awards that improve the systems that serve young children and their families without requiring on-going funding support. Catalytic funding allows the Commission to make one-time investments that will impact children for many years, recognizing the steady decline in Commission revenue.



The chart below presents the planned financial shortfall in outlying years based on the 2014 Long-Term Financial Plan.



Commission policy dictates that administrative costs are no more than 10% of the annual budget. Commission staff have worked to implement numerous cost reduction strategies to reduce operating costs and this will continue to be a priority for Commission management to develop efficient administrative operations, while ensuring that program and collaborative planning, sustainability efforts and grantee oversight is not diminished or impacted. In fiscal year 2013/14, administrative costs were 6.1% of the Commission's final expenses. In fiscal year 2014/15, administrative costs were further reduced to only 5.8% of final expenses. Administrative cost savings have been achieved through multiple strategies, including reducing staff and consultant support, relocating offices to more cost-efficient space and developing a methodology for staff to account for their time spent on direct program services.

In terms of evaluation costs, the Commission spent 2.1% of its final expenses on evaluation-related activities in both fiscal years 2013/14 and 2014/15. One tool used to control evaluation costs has been the planning process with five Southern California Commissions to develop common data as a basis for a Request for Proposal for the development of a common data system to facilitate data collection and reporting across the region.

Sustainability Strategies

The Commission adopted a three-year business plan in fiscal year 2014/15 with an operational imperative *to markedly increase the resources to sustain the Commission-funded initiatives that measurably contribute to children's healthy development and school readiness by 2018*. The Commission continues to focus on addressing the sustainability challenge as tobacco tax revenue declines, and building the resources and partnerships to sustain, support and expand services for young children in Orange County.

The targeted outcomes include identifying $3 million to $5 million in sustainability strategies by 2018 through revenue and/or program efficiencies and strategically pursing at least two national, major foundation or federal grants annually. Examples of sustainability strategies include:

- Transitioning an increasing portion of the funding portfolio from sustaining to catalytic investments. Catalytic investments are one-time funding that are intended to improve the system of care for young child, as well as reduce or eliminate ongoing funding; sustain multi-year services; and/or support infrastructure development to attract external funding sources.
- Pursuing federal and state leveraging opportunities including Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM). Since the inception of the program, the Commission and its agency partners have generated close to $47 million in federal funding.
- Ensuring that the organizations that receive Commission grants are fiscally and administratively sound. Fund development, business planning, and sustainability efforts are supported through technical assistance offered to grantees.

Strategic Partnerships

The Commission continues to develop and nurture key community partnerships in order to build upon and not replicate existing systems of care. The Commission has developed several key partnerships:

Orange County Health Care System

Supporting children's healthy development is a priority for the Commission with efforts focused on ensuring that children have access to health coverage starting at birth; ensuring that young children have a health home and appropriately use the services; ensuring the availability of quality primary and specialty care services, including oral heath, vision care, and early intervention services; and improving the quality of health care services specifically focused on the birth to age five population. To support these priorities, the Commission has developed partnerships with hospitals, community clinics, public health, community organizations, medical professionals, and other health funders. For example:

- *Hospital and Community Based Organizations* – The Commission has partnered with birthing hospitals and community-based programs that provide parent support services as part of the Bridges Maternal Child Health Network program. This partnership allows the Commission to make initial contact with newborns and families in Orange County.
- *Leading Pediatric Hospitals* – Collaborative programs are designed to ensure that pediatric specialty care is available to address identified health and development needs. One joint project is The Center for Autism and Neurodevelopmental Disorders that provides an integrated approach to care and other early intervention services. The Center serves as a foundation for the Help Me Grow Orange County program that connects children, their families, and providers to early intervention services available in the community.
- *Community Clinics* – In addition to a partnership with the community clinics that provide access to pediatric care and preventive services, long term support for a children's dental initiative includes support for the flagship dental organization Healthy Smiles for Kids of Orange County along with additional community clinics.
- *Health Funders Partnership of Orange County* – Members collectively work to improve the health of Orange County residents, as well as to enhance the impact and efficiency of health philanthropy. The Commission will continue to work with the Health Funders Partnership on collaborative countywide strategies on prevention, early intervention, access to health services and other health promotion initiatives.

Orange County School Districts

A primary program initiative of the Commission is school readiness. This includes working with children prior to kindergarten entry, and working with schools to develop a successful transition path from early care programs into elementary school. School Readiness Nurses also assist in bridging communication between health and education service systems to ensure that young children are healthy and ready to learn.

Local and Regional Funders

The Commission participates as a member of several local and regional funding collaboratives when common missions and objectives create an opportunity for collective impact. The Commission is an active member of the Health Funders Partnership, the Orange County Funders Roundtable as well as other project-specific partnerships. These partnerships allow the Commission to strengthen its community impact, develop diverse funding bases for program sustainability, and strengthen community support for outcomes for children and families.

Local Government and Business Community

The Commission is on the forefront of working with local government and business leaders to promote the importance of school readiness for workforce development. The Commission maintains active involvement with local governments and the business community through participation in the Orange County Forum and working with business support groups, such as the Orange County Business Council and the Association of California Cities, Orange County.

Community-Based Organizations

Local health and human service organizations throughout Orange County administer and execute the programs funded by the Commission. Partnerships with these organizations are essential to reaching the diverse ethnic and geographic populations in Orange County.

Statewide Partnerships

Achievement of the goals and objectives set forth in the Commission's Strategic Plan requires statewide and regional partnerships with other county commissions or the state commission. The opportunity for multi-county plans and programs is specifically authorized in Proposition 10 and has been successfully utilized in Orange County. Authorized activities include multi-county programs, technical assistance activities, legislative and policy advocacy, and serving as fiscal sponsor for statewide programs such as AmeriCorps, which include activities that benefit Orange County.

Commission partnerships avoid duplication of effort and provide more efficient and targeted service delivery. Commission supported partnerships among health care providers, family resource centers, clinics, schools districts, and early childhood education providers form the foundation for service delivery to families with young children.

The Outcomes

The Commission implements a standardized set of indicators to address each of its targeted outcomes and objectives. The "Services Provided by…" tables (see Table 3 below) in this report detail the services provided for each subcategory and include four columns: the first two columns list the Strategic Plan outcomes and services used by Commission-funded programs and the third and fourth columns list the number of clients and services delivered, respectively.

In fiscal year 2014/15, there were 137,228 new Children ages 0-5; 116,269 new Family Member; and 12,552 new Service Providers served by Commission-funded programs. Children ages 0-5 received over 1.8 million services, while their Family Members received over 765,000 services. Over 21,000 services were provided to Service Providers during fiscal year 2014/15 (see Table 1 below).

Between fiscal years 2013/14 and 2014/15, there was a 20% decrease in the number of Children ages 0-5; a 26% decrease in the number of Family Members; and a 19% decrease in the number of Providers served. In terms of the number of services provided, between fiscal years 2013/14 and 2014/15, there was only a 10% decrease in the number of services provided to Children ages 0-5. There was 26% reduction in the services provided to Family Members and a 35% decrease in the number of Provider services.

The decrease in clients served during the past fiscal year has been identified to be attributed to a combination of the following factors: 1) a reduction in funding levels among some programs; 2) the declining birth rate in Orange County; 3) program model changes; an, 4) data collection compliance. It should be noted that while there have been reductions in funding related to reductions in numbers served, many of the programs have been able to sustain their delivery of services without Commission funding. For example, while the Commission no longer funds some clinics, they continue to provide developmental screenings and assessments to young children in Orange County. While fewer families have been served in the past year, there has been a 14% increase in families living at 200 percent or below the poverty line, indicating the need for more intensive services.

To strengthen the link between funding and provider performance, the Commission is working to increase compliance with the Commission's outcome systems and regular reporting of measureable outcomes for all programs and strategies.

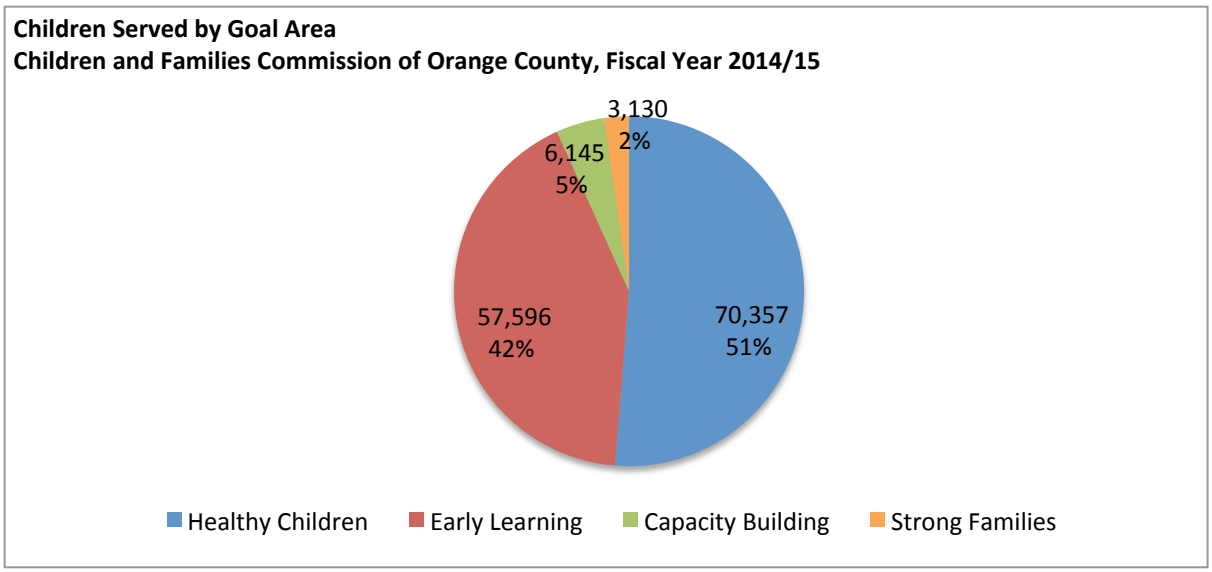
During fiscal year 2014/15, the Commission funded 126 organizations to implement 248 individual programs serving children, families, and providers. This report provides details on the numbers children, family members, and service providers served by Commission-funded programs and the services that were provided to them. For each funding subcategory, the following data are provided along with the data source(s):

Data	Data Source(s)
Number of children ages 0-5, family members, and service providers receiving services from Commission-funded programs	• Commission Data Collection and Reporting System
Number of services provided to children, family members, and service providers	
Number of children with client level data	• Commission Data Collection and Reporting System; Bridges Connect Data System for Children 0-5 (Client Level Data on children receiving intensive services and whose parents consent to data collection)
Age breakouts of children with client level data	
Ethnicity of children with client level data	
Primary Language of children with client level data	
Poverty level of children with client level data	
Numbers of different types of services provided to children, family members, and service providers	• Commission Data Collection and Reporting System
Key Service Outcomes	• Service Outcome Questionnaires (SOQs) in Commission Data Collection and Reporting System, Bridges Connect, and the Homeless Management Information System

This report provides the above information for the Commission as a whole. In addition, appendices are available, which provide the information by Commission goal areas and funding subcategories:

Commission Goal Area	Funding Subcategory
All	Commission-Wide Data
Healthy Children	Bridges Maternal Child Health Network Community Clinics Health Access and Education Children's Dental Pediatric Health Services School Readiness Nursing Nutrition and Fitness
Strong Families	Homeless Prevention Family Support Services
Early Learning	Early Learning Specialist Early Literacy CARES Plus and Child Signature Programs Other Early Learning Programs
Capacity Building	Capacity Building / AmeriCorps/VISTA Performance Outcomes Measurement System

In fiscal year 2014/15, a majority of the children (51%) were served through the Commission's Healthy Children goal area and another 42% were served through the Early Learning goal area. Only 5% of children were served through the Capacity Building goal area, and 2% through the Strong Families goal area.



Commission-Wide Data

Table 1. Aggregate Data for all Commission-Funded Programs

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	137,228	116,289	12,552
Number of services provided	1,820,320	765,211	21,356

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served[1] in FY 14/15 Based on Client Level Data

Variable Considered	Category Label	Count[2]	Percent
Total number of children with client-level data		7,841	100
Age at most recent interview	Under Three	4,067	51.9
	Three through Five	3,774	48.1
Ethnicity	Amer. Indian/Alaska Native	20	0.3
	Asian	278	3.7
	Black/African American	135	1.8
	Hispanic/Latino	5,639	74.2
	Pacific Islander	24	0.3
	White	727	9.6
	Vietnamese	118	1.6
	Multiracial	381	5.0
	Other	87	1.1

	Unknown	188	2.5
Primary Language	English	2,895	38.8
	Spanish	3,592	48.2
	Vietnamese	99	1.3
	Other	218	2.9
	Unknown	650	8.7
At or Below 200% Federal Poverty Level		5,957	90.8

[1]A child can be served by more than one provider. In that event, the child is counted each time he/she is served by a different provider.

[2]The counts for specific demographic variables may be less than the total number of children entered in the Commission's Data Collection and Reporting System and Bridges Connect. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by All Commission-Funded Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.1 Children are born healthy	Clinical prenatal visits	641	1,855
	Case management meetings/home visits to support prenatal care	706	2,516
	Classes to support healthy pregnancy	72	27
	Pregnant women receive support for healthy pregnancy and early childhood health	8,637	8,637
	Home visits/case management conducted with expectant mothers with a history of ATOD abuse	36	156
	Classes for at-risk for ATOD	342	63
	Home visits/case management meetings conducted with parents with a history of ATOD abuse	59	273
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as	Providers trained on how to screen, assess and/or identify child developmental milestones	226	248
	Providers educated on child development, recognizing key milestones, and the importance of screening and/or assessment	4,345	8,459
	Providers receive informational materials regarding developmental milestones and development	314	9,325
	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	15,593	20,666
	Parents receive education, resources, referrals, and support regarding their child's development	3,163	9,469
	Parents receive referrals regarding their child's health and developmental concerns	4,468	4,761

Table 3. Services Provided by All Commission-Funded Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
appropriate	Parents are linked to referred services for their child's health and developmental concerns	2,199	2,304
	Parents receive informational materials regarding developmental milestones and development	121	737
	Children receive vision screening	10,636	11,118
	Children receive hearing screening	9,668	10,386
	Children receive body composition and stature screening (height, weight, Body Mass Index)	9,539	9,855
	Children receive health status screening (e.g., asthma, allergies, etc.)	11,620	12,230
	Children receive behavior health screening using Commission-approved tool	1,221	1,223
	Children receive comprehensive screening (Includes: vision, hearing, height, weight, health, and developmental milestones using PEDS or ASQ)	9,712	9,668
	Children receive assessment (e.g., vision, hearing, speech/language, psychosocial issues, motor skills, health, special needs, and/or parent-child functioning)	977	9,451
HC.3 Children have and use a regular place for medical and dental care	Children are linked with health insurance enrollment	2,623	2,649
	Children are linked to a health care home	2,727	2,756
	Children receive primary care services/visits, including well child and sick visits	4,395	11,684
	Children are linked to a dental home	1,691	1,691
	Children receive a dental screening	16,925	17,066
	Children receive preventative dental treatment (e.g., cleaning, sealant)	10,863	16,605
	Children receive restorative dental treatment (e.g., carries)	439	2,651
	Children receive emergency dental treatment (e.g., abscess)	38	218
	Children with special needs receive dental care	583	1,508
	Parents receive training on oral health	11,849	14,221
	Children receive oral health education	16,873	18,208
	Providers receive oral health education	389	492
HC.4 Children grow up healthy	Mothers receive breastfeeding education, intervention and support	14,993	16,749
	Children enrolled in multi-disciplinary weight loss and/or physical activities program	217	529
	Children receive nutrition and physical activity education	917	917
	Children participate in YMCA Aquatic Center programs	845	10,002
	Parents participate in YMCA Aquatic Center programs	236	1,709

Table 3. Services Provided by All Commission-Funded Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
	Children participate in YMCA sports programs	240	3,092
	Children screened for up to date immunizations	13,601	17,168
	Children receive specialty care clinic visits	982	4,631
	Children receive specialty care follow-up clinic visits* *(all children are repeat/returning)	1,545	2,863
	Parents receive home visits focused on ongoing medical surveillance and linkage to appropriate referrals	67	489
	Parents receive specialty care education, resources, referrals, and support	4,116	10,438
	Providers receive specialty care education	387	387
SF.1 Families are stably housed	Children receive emergency or transitional shelter (bed nights)	493	40,180
	Family members emergency or transitional shelter (bed nights)	817	56,038
	Parents receive weekly case management services	350	6,981
SF.2 Children are safe and well cared for	Parents receive home safety checks	1,944	3,167
	Parents receive training about preventable injuries and deaths	31	235
	Home visitors and/or program staff will assess and provide service plans to improve parent knowledge of healthy child development using a Commission-approved tool	487	487
	Home visits to improve parent knowledge of healthy child development	2,765	19,771
	Office visits to improve parent knowledge of healthy child development	14,004	17,371
	Parents participate in parenting education classes/series on healthy child development	6,682	582
	Children receive health education classes	7,696	713
	Children receive group interventions to improve healthy child development	313	37
	Providers receive consultations to improve provider knowledge of healthy child development	814	1,087
SF.3 Caregivers have ready access to family support services and resources	Mothers are screened with the Bridges Screening Tool	11,457	11,457
	Parents receive referrals to services	22,382	46,196
	Parents receive referrals to MCHN programs	1,936	1,936
	Parents receive referrals to non-MCHN programs	11,326	42,548
	Providers receive referrals to services	599	853
	Parents receive follow up on referrals and services are accessed	7,389	15,632
	Parents receive Kit for New Parents	15,541	15,541
	Family support and child development teacher trainings	195	15

Table 3. Services Provided by All Commission-Funded Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Children receive behavioral health treatment services	44	250
	Providers are educated to increase awareness and identification of behavioral health issues	734	233
	Providers receive training on behavioral health treatment services for children 0-5	323	26
	Parents receive education, resources, referrals, and support regarding their child's behavioral health issues	475	2,486
	Parents receive behavioral health screening	876	4,234
	Staff participate in case management team meetings to support the needs of the families served	131	257
EL.1 Children have the developmental skills* to be proficient learners in school *Early literacy/ numeracy, self-regulation, social expression, and self-care and motor skills	Children read to at physicians' offices or clinics	12,663	1,102
	Parents participate in a program designed to increase the frequency of reading at home	12,509	397,674
	Children participate in a program designed to increase the frequency of reading at home	41,534	478,513
	Parents receive literacy information/assistance in waiting rooms or community events	17,415	9,434
	Provider will recruit and support pediatrician offices to participate in Reach Out Read National Program	78	108
	Books distributed to children	N/A	135,424
	New and used books collected for distribution	N/A	136,102
	Children participating in early literacy programs	435	514
	Children participate in early math programs	9,226	872,298
	Parents receive speech and language services (classes)	1,190	1,045
	Providers will conduct classroom assessments using an established tool such as ECERS or ELLCO	459	459
	Providers are given resources and early intervention strategies for appropriate early care	376	2,063
	Providers receive training for the implementation of the CARES Plus program	425	558
	Children receive center-based early care and education services other than preschool	543	9,050
	Children receive enhanced school readiness services through other preschool programs	278	2,357
	Parents participate in a drop-in, family-focused early learning program (i.e., Learning Link)	3,518	43,736
	Children participate in a drop-in, family-focused early learning program (i.e., Learning Link)	3,490	57,088
EL.2 Schools	Children visit Kindergarten classrooms prior to start of	7,392	7,392

Table 3. Services Provided by All Commission-Funded Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
are ready for children when they enter kindergarten	school year		
	School readiness and child development teacher trainings	1,145	45
	Provide coaching and in-class training for early educators	74	517
	Children's health and development records are transferred to their elementary school prior to entering kindergarten	4,858	4,858
EL.3 Parents have the supports that contribute to children's readiness for school success	Parents receive tools, resources, information and/or training needed to transition their child to school	20,775	56,524
CB.1 Increase sustainability	Dollar amount raised	N/A	$10,024,219
	Dollar amount received by leveraging Commission dollars	N/A	$5,128,660
	Dollar amount of in-kind contribution generated	N/A	$2,933,092
	CSP match dollars submitted	N/A	$3,888,215
	Number of volunteers recruited	2,059	N/A
	YMCA will make available space for use by Commission grantees (days)	N/A	116
CB.2 Increase access and efficiency, quality and effectiveness	Public information and outreach campaign to increase community awareness to promote access	N/A	189
	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	1,127
	Children with special needs served	3,259	3,259
	Technical assistance is provided, such as assistance with sustainability plans, evaluation activities, and providing quality services	119	1,126
	Providers receive trainings to build the capacity of the agency to increase quality services	3,068	594
	Provide transportation to parents to health or social services	25	143
	Provide transportation to children 0-5 to health or social services	18	109
	Provide specialized child care to children 0-5	5	130

Table 4. Service Outcomes for All Commission-funded Programs

Key Strategic Plan Objectives	SOQ Results
Healthy Children	
• Increase to at least 90% the proportion of all pregnant women who receive early prenatal care, and decrease racial/ ethnic disparities	• 88.0% of mothers received prenatal care in the first trimester
• Increase to 100% the proportion of children who have a health care home	• 99.2% of children had a dental health home at the end of services (compared to 64.3% at the beginning of services)
• Increase to 100% the number of children with health coverage	• 99.1% of children served had dental insurance at the end of services (compared to 94.6% at the beginning of services)
• Increase age appropriate immunization levels to at least 95%	• 94.2% of children received all age appropriate immunizations at the end of services (compared to 86.4% at the beginning of services)
• Reduce dental cavities so that the proportion of young children with one or more cavities is no more than 9%	• 83.2% of children had no cavities at the end of services (compared to 71.6% at the beginning of services)
• Increase to at least 90% the proportion of mothers who breastfeed their babies at early post-partum and to 50% those who continue to breastfeed at 6 months, any or exclusive	• 54.3% of mothers breastfed their babies until 6 months of age
Strong Families	
• Reduce the number of children who are homeless to zero	• 63.1% of children were unstably housed or at risk for homelessness at the end of services (compared to 97.4% at beginning of services)
• Reduce the number of children who are homeless to zero	• 56.2% of children 3 or older were attending school on a regular basis or most of the time at the end of services (compared to 35.8% at the beginning of services)
Early Learning	
• 75% of typically developing children are effective learners in literacy	• 25.2% of children knew none of the alphabet letters by name at the beginning of services compared to only 6.8% at the end of services
• 75% of typically developing children are effective learners in literacy	• 91.4% of children could identify his or her written name at the end of services, compared to only 62.1% at the beginning of services
• 75% of typically developing children are effective learners in literacy	• 97.9% of children had familiarity with books at the end of services, compared to 87.9% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 92.0% of children could count a group of three to five objects by touching each object at the

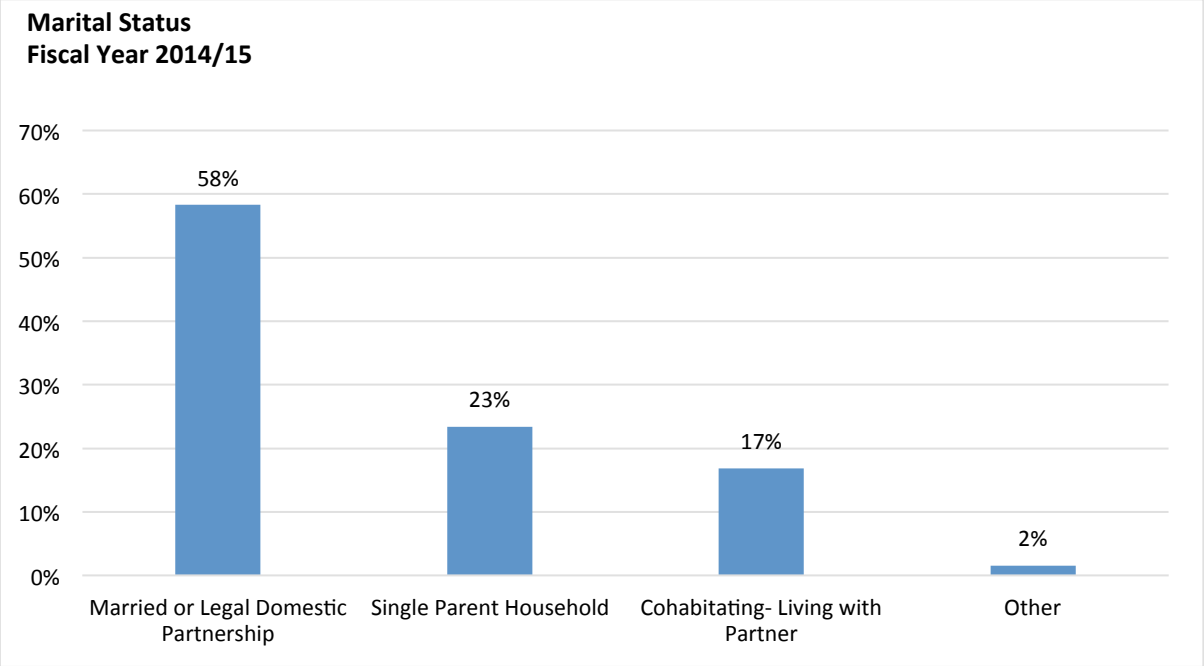
Key Strategic Plan Objectives	SOQ Results
	end of services, compared to 74.9% at the beginning of services.
• 80% of typically developing children are effective learners in numeracy	• 92.0% of children could correctly name at least two shapes at the end of services, compared to only 75.2% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 81.3% of children could recite at least five numbers in order at the end of services, compared to only 56.3% at the beginning of services
• 75% of typically developing children are socially competent	• 97.3% of children could follow simple two-step oral directions at the end of services, compared to 90.0% at the beginning of services
• 75% of typically developing children are socially competent	• 95.7% of children cooperated with the daily classroom routine most of the time at the end of services, compared to 90.5% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 75.8% of parents taught their children letters, numbers, or words at least three times in the prior week at the end of services, compared to 62.9% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 87.9% of parents played with toys or games indoors at least three times in the prior week at the end of services, compared to 81.7% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 69.7% of parents went on outings with their child at least three times in the prior week at the end of services, compared to 59.0% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 90.1% of parents talked with their child about daily activities at the end of services, compared to 81.9% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 73.6% of parents played, games, sports or exercised with their child at least three times in the prior week at the end of services, compared to 63.4% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 90.1% of parents felt they had sufficient information and support for their child to attend Kindergarten at the end of services, compared to 82.6% at the beginning of services

Commission-Funded Grantees' Intake and Exit Surveys

Commission-funded grantees collect client-level information on participating children and their families who consent to share information. This information is collected at the beginning of services and again at the end of services. In fiscal year 2014/15, there were 7,454 intake surveys completed and 8,094 exit surveys completed.[1]

Marital Status

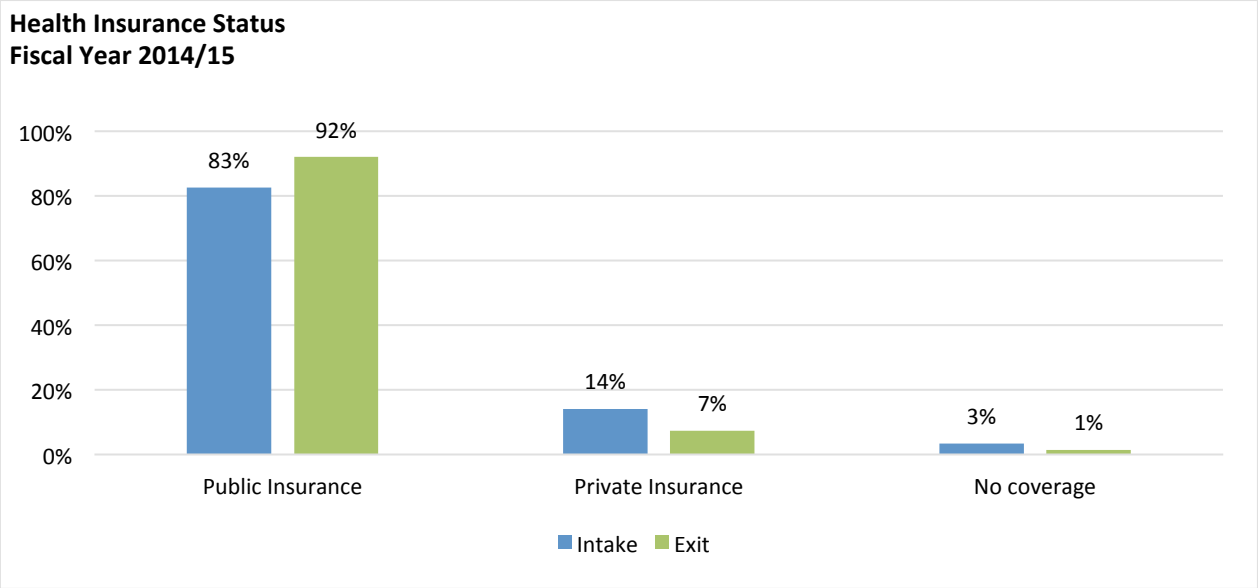
Fully 58% of the children whose families completed an intake survey lived in a household where the caregivers were married or in a legal domestic partnership. Less than one-quarter (23%) of the children were in a single parent household, and another 17% were in a household where caregivers were cohabitating but not married or in a domestic partnership. There were 2% living in a household where the marital status was "other".



[1] Intake and Exit surveys include those entered into the Commission's evaluation data system as well as into Bridges Connect.

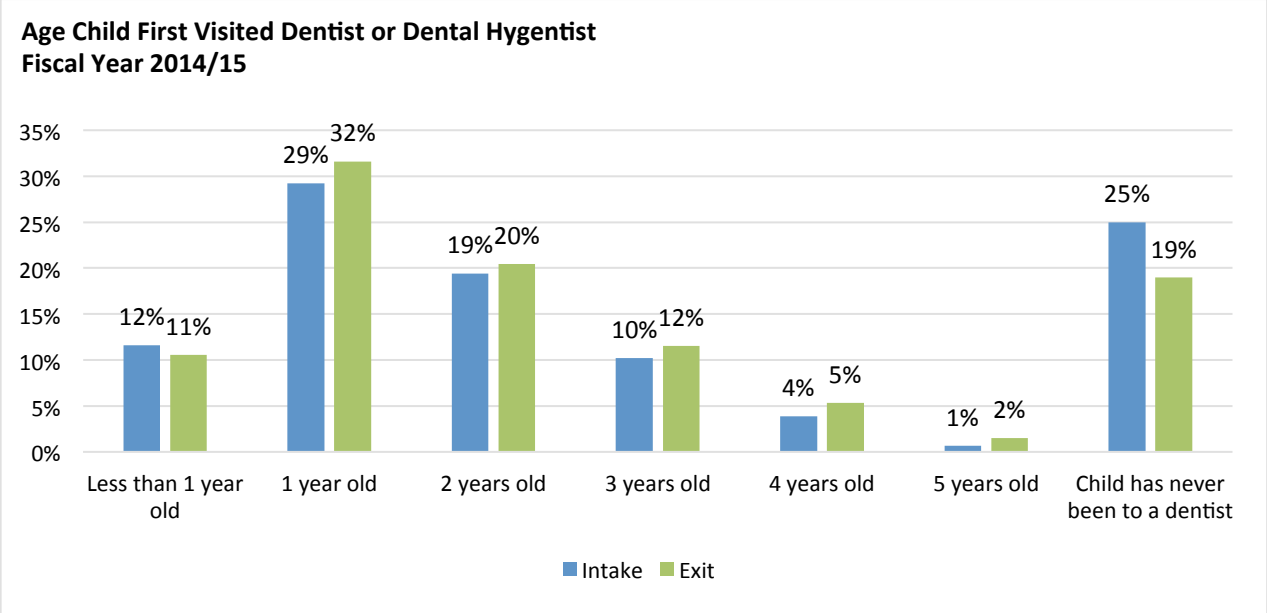
Health Insurance

There were fewer children who were uninsured at exit (1%) than at intake (3%). There were fewer children covered through private insurance at exit (7%) than at intake (14%); but more covered through public insurance at exit (92%) than at intake (83%).



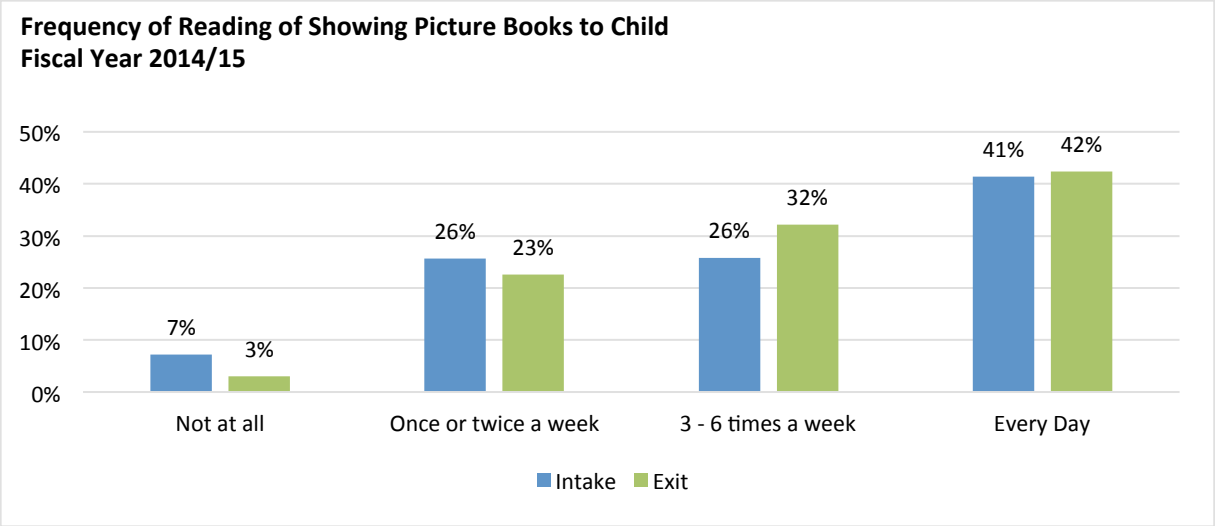
Dental Care

At completion of Commission-funded services, fewer children had never been to a dentist (19%) compared to at the beginning of receiving services (25%).



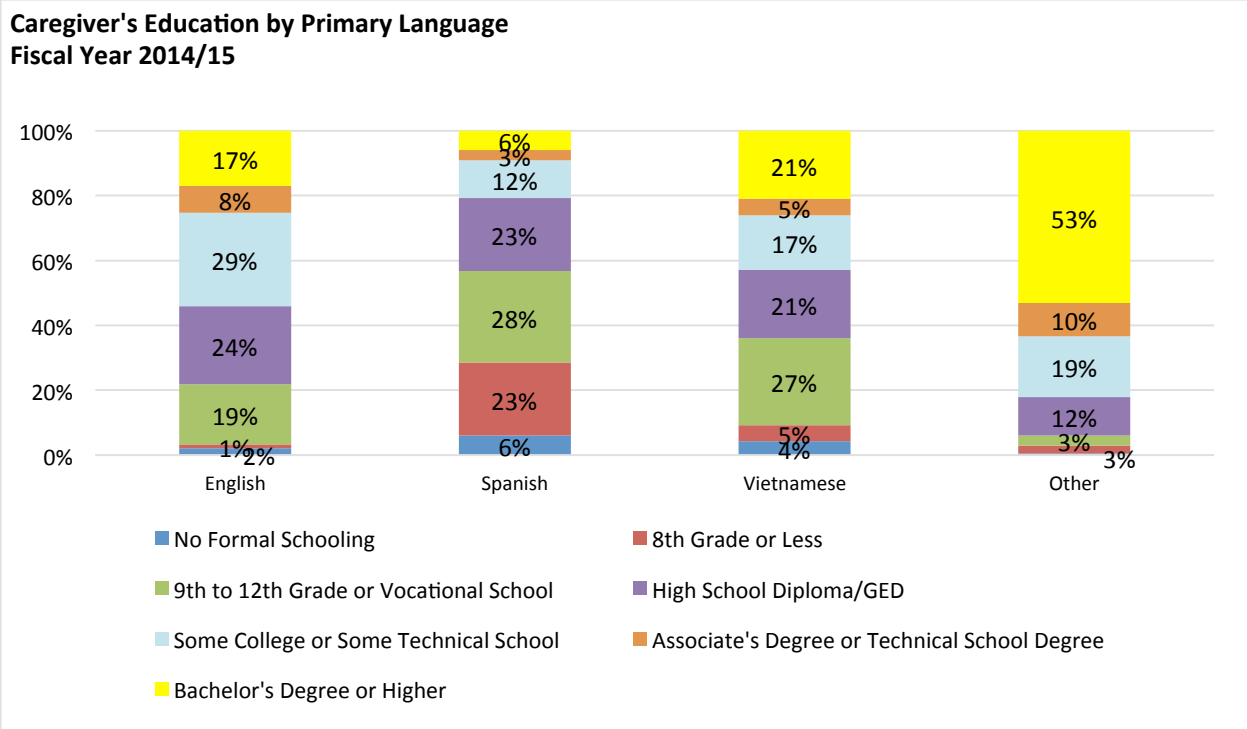
Frequency or Reading to Child

More families were reading to their children 3-6 times a week or daily at exit than at intake. In addition, at exit, only 3% of families indicated that they did not read to their child (compared with 7% at intake).



Education and Primary Language

Caregivers whose primary language was "Other" (e.g., Farsi, Korean, etc.) represented the highest percentage of college graduates, with those speaking Vietnamese having the second highest percentage with a college degree (21%). Only 6% of the caregivers who speak Spanish as a primary language had a Bachelor's degree of higher.



HEALTHY CHILDREN

The following appendices document progress made on the Commission goal area of Healthy Children. The Healthy Children goal area consists of seven funding subcategories:

- Bridges Maternal Child Health Network
- Community Clinics
- Health Access and Education
- Children's Dental
- Pediatric Health Services
- School Readiness Nursing
- Nutrition and Fitness

APPENDIX 1:

Bridges Maternal Child Health Network

FY 14/15

Children and Families Commission of Orange County Bridges Maternal Child Health Network Report

This program report describes the Commission's investments in the Bridges Maternal Child Health Network and the outcome of those investments. Bridges is a county-wide program aimed to ensure all prenatal women and their babies have: a medical home; health and other risk factors identified; access to information about healthy child development; and availability of home visiting/early intervention services as needed, based on an assessment of their risk. The program provides an array of services funded by the Commission devoted to supporting the health and development of children from prenatal through age five. This report also documents challenges and opportunities to ensuring a healthy start for all children and the Commission's actions, programs and recommendations to reduce barriers for all Orange County children.

Background

The Bridges Maternal Child Health Network (Bridges Network) is a county-wide program, which is implemented through a network of interdisciplinary providers that includes: 10 high birth hospitals, four community organizations, and County Public Health Nursing. The Bridges Network provides early outreach and referral services to identify families with specific needs and links the families with home visitation and health access services for additional support. Collectively, the Bridges Network helps to ensure that children are: born healthy; have and use a health home for comprehensive health services; access age appropriate immunizations; receive early behavioral screening and assessments so that conditions may be identified, assessed, and managed; and are raised in healthy and safe environments. Through this model of prevention and early intervention, the Commission is helping Orange County's children have the healthiest start possible and reducing the need for costlier, more complex intervention services.

Commission-funded Services in Orange County

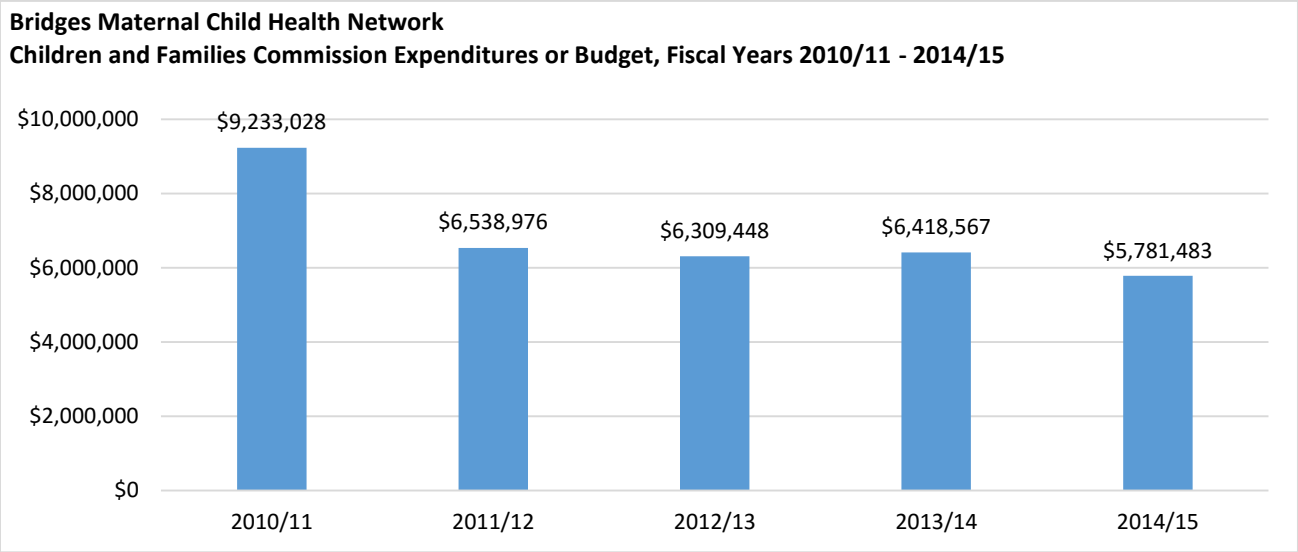
The Bridges Network members are a collective impact model to ensure children in Orange County have a healthy start. Annually the Bridges Network provides over 14,000 children and almost 23,000 parents or family members with over 200,000 services county-wide. Services include but are not limited to:

- Prenatal outreach and education
- Kit for New Parent(s)
- Bridges screening and referrals
- Breastfeeding support and education
- Home visits
- Home safety screening
- Behavioral health screening
- Child abuse prevention education
- Health insurance assistance
- Health home linkage
- Age appropriate immunizations

- Screenings (developmental, vision, hearing, dental, etc.)
- Health assessments
- Referrals and linkages to community resources
- Education on health related topics: in home and community-based including: oral health, immunizations, insurance, development, home safety, prenatal health, breastfeeding, safe sleep, nutrition, substance abuse, and secondhand smoke

Commission Investment

In fiscal year 2014/15, the Commission funded the Bridges Network at $5.8 million. The Bridges Network was one of the Commission's first funded programs and has received funding support of more than $34.2 million since fiscal year 2010/11.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in the Bridges Network produced the following services for children from birth through age five:

Table 1. Aggregate Data for Bridges Network

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	14,567	22,926	32
Number of services provided	77,915	133,606	971

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Bridges Network

Variable Considered	Category Label	Total[2] Count[1]	Total[2] Percent
Total number of children with client-level data		2,250	100
Age at most recent interview	Under age Three	1,814	81.2
	Three through Five	419	18.8
Ethnicity	Amer. Indian/Alaska Native	1	0.1
	Asian	18	0.9
	Black/African American	13	0.7
	Hispanic/Latino	1,706	87.0
	Pacific Islander	3	0.2
	White	88	4.5
	Vietnamese	31	1.6
	Multiracial	74	3.8
	Other	22	1.1
	Unknown	4	0.2
Primary Language	English	614	27.4
	Spanish	1,085	48.4
	Vietnamese	24	1.1
	Other	72	3.2
	Unknown	445	19.9
At or Below 200% Federal Poverty Level		1,711	95.3

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

[2]The majority of clients served by Bridges Providers were also served by Bridges Hospitals. The Total column includes the unduplicated number of clients served by both Bridges Hospitals and Providers.

Table 3. Services Provided by Bridges Network Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.1 Children are born healthy	Case management meetings/home visits to support prenatal care	706	2,516
	Classes to support healthy pregnancy	64	9
	Pregnant women receive support for healthy pregnancy and early childhood health	8,568	8,568
	Home visits/case management conducted with expectant mothers with a history of ATOD abuse	36	156
	Classes for at-risk ATOD	342	63
	Home visits/case management meetings conducted with parents with a history of ATOD abuse	59	273
HC.2 Children receive early screening and, when necessary, assessment for	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	1,780	3,106

Strategic Plan Outcome	Service	Clients Served	Number of Services
developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Children receive comprehensive screening (Includes: vision, hearing, height, weight, health, and developmental milestones using PEDS or ASQ)	271	271
	Children are linked with health insurance enrollment	227	227
HC.3 Children have and use a regular place for medical and dental care	Children are linked to a health care home	234	234
	Parents receive training on oral health	1,921	3,295
	Mothers receive breastfeeding education, intervention and support	14,993	16,749
HC.4 Children grow up healthy	Children screened for up to date immunizations	2,146	5,291
	Parents receive home visits focused on ongoing medical surveillance and linkage to appropriate referrals	67	489
SF.2 Children are safe and well cared for	Parents receive home safety checks	1,944	3,167
	Home visits to improve parent knowledge of healthy child development	2,765	19,771
SF.3 Caregivers have ready access to family support services and resources	Mothers are screened with the Bridges Screening Tool	11,457	11,457
	Parents receive referrals to MCHN programs	1,936	1,936
	Parents receive referrals to non-MCHN programs	11,326	42,548
	Parents receive follow up on referrals and services are accessed	1,536	4,313
	Parents receive Kit for New Parents	15,541	15,541
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Parents receive behavioral health screening	786	4,153
CB.1 Increase sustainability	Dollar amount raised	N/A	$150,900
	Dollar amount received by leveraging Commission dollars	N/A	$4,827,989
	Dollar amount of in-kind contribution generated	N/A	$2,885,023
CB.2 Increase access and efficiency, quality and effectiveness	Public information and outreach campaign to increase community awareness to promote access	N/A	1
	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	9
	Children with special needs served	333	333
	Technical assistance is provided, such as assistance with sustainability plans, evaluation activities, and providing quality services	19	964
	Providers receive trainings to build the capacity of the agency to increase quality services	13	5

*Children receive more than one screening over the course of the program.

Table 4. Service Outcomes (SOQs) for Bridges MCHN

Key Strategic Plan Objectives	SOQ Results
Healthy Children	
• Increase to at least 90% the proportion of all pregnant women who receive early prenatal care, and decrease racial/ ethnic disparities	• 86.3% of mothers received prenatal care in the first trimester
• Reduce the percentage of infants exposed to alcohol, tobacco, and other drugs (ATOD) to zero percent (0%)	• 10.8% of expectant mothers used ATOD prior to starting intervention
• Increase age appropriate immunization levels to at least 95%	• 93.0% of children received all age appropriate immunizations at the end of services (compared to 86.7% at the beginning of services)
• Increase to at least 90% the proportion of mothers who breastfeed their babies at early post-partum and to 50% those who continue to breastfeed at 6 months, any or exclusive	• 54.3% of mothers breastfed their babies until 6 months of age

Program Highlights and Outcomes

This section provides a summary of each of the major service components within the Bridges Network.

Prenatal Home Visitation

In April 2015, MOMS Orange County and the University of California-Irvine's manuscript, "A Community-Based Home Visitation Program's Impact on Birth Outcomes" was accepted for publication by the peer-reviewed American Journal of Maternal Child Nursing, with publication expected by the end of 2015. With the publication of this journal article, MOMS Orange County is one step closer to being recognized as an evidenced-based model, whereby becoming eligible for federal funding opportunities.

At MOMS Orange County, new positions were added to both the team of paraprofessionals and professionals who are solely funded by the Commission. The ability to add these positions is a direct result of investing Medicaid Targeted Case Management reimbursement dollars. Specific positions include:

- 0.5 full-time equivalent (FTE) Registered Nurse with a Master's degree and clinical experience from a partner hospital-St. Joseph Hospital; and
- 1 FTE Paraprofessional: Home Visitor with a Bachelor's degree.

In addition, MOMS Orange County is committed to ensuring that staff has high-level continuing education as part of their overall competency as paraprofessionals. Home visitors and health educators received education and/or training to enhance their knowledge base and skills.

Public Health Nursing Services

The **Public Health Nursing** team continues to work with high-risk prenatal and post-partum clients to ensure healthy beginnings.

The **Substance Exposed Infant Program** serves high-risk prenatal and postpartum women with illicit drug use, mental health conditions, and/or HIV positive status. For fiscal year 2014/15, the average birth weight for infants born into the program was seven pounds and three ounces; the average gestational age at time of delivery for infants was 39 weeks; and 98% of the infants born presented with negative urine toxicology results.

In fiscal year 2014/15, there were a total of 160 children who met the criteria and received Public Health Nursing services. In addition, the program increased its capacity to provide Health Access Promotion Services by two full-time Public Health Nurses. These two nurses completed orientation and became Certified Lactation Educators.

In fiscal year 2014/15, **Nurse-Family Partnership** hired an additional 5.0 full-time equivalent Public Health Nurses, which increased service capacity by 115-125 families (based on 23-25 caseloads per FTE). The program capacity is now 170-185 families, serving first time pregnant women under the age of 24. Three of the new Public Health Nurses completed their education to become Certificated Lactation Educator/Counselors, resulting in a total of eight program nurse home visitors who are Certified Lactation Educators and one Nurse Home Visitor who is an International Board Certified Lactation Consultant.

Infant and Toddler Home Visitation Programs

Among the **Infant Home Visitation** and **Toddler Home Visitation** partners (Children's Bureau and Child Abuse Prevention Center), evidence-based models continue to be employed (i.e., Keys to Interactive Parenting Scale – KIPS; Positive Parenting Program – Triple P) to ensure strong outcomes. Participants in the infant program continue to show marked improvement on the KIPS items with improved quality parent-child interactions. Access to and utilization of the home visitation services, continue to show positive changes for children and family in bonding and attachment.

Through a piloted field placement program, the **Child Abuse Prevention Center** worked with two Master of Social Work interns to distribute over $77,000 worth of in-kind goods to families. The goods, which were funded through campaigns and grants awards included gift cards, diapers, baby wipes, bus passes, and strollers, as well as other needed items.

The Toddler Home Visitation programs documented great improvements in toddler behavior. One assessment the program uses is the Eyberg Child Behavior Inventory, which is a parent rating scale that assesses child behavior problems. It includes an Intensity Scale, which measures the frequency of each problem behavior. Providers noted that children who scored above the cutoff in the clinical range on the Intensity Scale fell below the cutoff and into the average or low average range for behavioral problems at the end of services.

The **Children's Bureau** and **Child Abuse Prevention Center** also continued to implement the Positive Parenting Program (Triple P), an evidence-based parenting program backed up by more than 30 years of ongoing research. Parents utilizing Triple P techniques reported having better relationships with their children and more positive interactions. Participants reported positive

feelings towards parenting at high levels in both the pre and post assessment. Additionally, parents had reduced depression, anxiety, and stress as assessed using the Depression, Anxiety, and Stress Scale (DASS-21). In particular, parents felt more confident in their parenting skills as indicated on the pre and post Parenting Tasks Checklist assessment.

Both Toddler Home Visiting Program agencies continued to show strengthened parent-child interactions and an increase in positive parenting. The program has increased its outreach in the area working with local organizations, obstetricians and pediatricians, Family Resource Centers, the school district and Department of Education, and the local library. They also participate actively with the La Habra and Fullerton Collaboratives, groups working to share opportunities and maximize resources and effectiveness through communication for residents. The program was supplemented with $47,871 of in-kind donations providing basic needs and other items to families, helping to alleviate their financial stress.

Hospital Partners

The Bridges Maternal Child Health Network **Hospitals** reported a total of 27,278 births in fiscal year 2014/15, an increase of 2% compared to fiscal year 2013/14. There was a significant increase in just two hospitals, by 13% and 16%; however six hospitals reported a decrease in births by as much as 12%. The Bridges Hospitals exceeded their milestone target for prenatal outreach by 82%—reaching 8,568 pregnant women. They also exceeded their milestone targets for breastfeeding education and intervention by providing support to 13,661 mothers, and for client intake authorizations signed by 1,759 parents who support the Commission's programs and services. Collectively, the Bridges Hospitals referred 1,935 mothers to a Bridges Network home visitation agency, exceeding their milestone target for referrals by 48%. Despite an overall decrease in the total number of home visitation program referrals from hospitals, five of the 10 Bridges Hospitals increased their rate of referrals.

This year, Bridges Hospitals focused on capturing data for the mothers missed or ineligible for a Bridges screening at bedside; as well as identifying the reasons mothers who were screened were not referred to the Bridges Network. The Hospital Association of Southern California facilitated quarterly meetings with the hospitals and met with them individually to support their efforts in increasing Bridges Network services. These efforts include prenatal outreach to more physician offices and building relationships with community partners; best practice sharing for successfully obtaining parent authorization to share client (child) information and support Commission programs; and providing more breastfeeding support resources to parents as suggested in the hospitals' breastfeeding training with a lactation expert and neonatologist from the Children's Hospital of Orange County.

Other Support Project Highlights

Breastfeeding Consortium

In January 2015, the Community Perinatal Network formed the Hospital Breastfeeding Consortium as an open forum to assist hospital leadership in implementing the Ten Steps to Baby-Friendly USA. The goal of the consortium is to facilitate hospital efforts to adopt the "Ten Steps to Successful Breastfeeding" as outlined by Baby-Friendly USA in order to meet the requirements of Senate Bill 402 – Baby-Friendly Hospital Initiative. The Commission provided one-time support for the consortium in the amount of $135,000.

Of the 17 birthing hospitals in Orange County, six are designated as Baby-Friendly and key leadership at these hospitals serve as mentors to the others beginning their journey, one hospital is awaiting final survey, and two hospitals have submitted a letter of intent to Baby-Friendly USA.

A Baby-Friendly toolkit was developed to assist hospitals with evidence-based practice policies, professional organizations guidelines, literature, and examples for each of the Ten steps. The toolkit will be used to assist hospitals in moving along the continuum towards baby-friendly status. Each hospital was provided with a copy of the toolkit for reference throughout this process. Additional components will be added as progression continues. These components will also be made available on the Community Perinatal Network website. Hospitals were provided assistance with policy writing that supports the Ten Steps with example policies from designated hospitals. Some hospitals are still not providing rooming-in 24/7 (Step 7). Each hospital was provided with the breastfeeding support resource list to assist with discharge follow-up and successful breastfeeding within the first two weeks of the infant's life. Challenges identified include purchasing formula, physician support, and pacifier use.

Relationships have been developed with the Orange County Health Care Agency as well as the Orange County Perinatal Council to bridge the gap between outpatient, inpatient, and follow-up support. Project staff is working on the breastfeeding subcommittee of Orange County Perinatal Council to develop support activities in the outpatient setting including Women, Infants and Children (WIC), Comprehensive Perinatal Services Program, and physician support. A breastfeeding tip sheet is being developed to improve physician support of breastfeeding prenatally.

Safe Sleep Orange County

The Commission is a member of the Orange County Children's Partnership, a 22-member advisory body made up of public agencies and representative community agencies and individuals. This year, the Safe Sleep Orange County subcommittee was formed to look at the issues related to safe sleep and to increase awareness about the importance of safe sleep environments for infants. The Commission committed $7,500 to support implementation of the demonstration project through two agencies: the American Academy of Pediatrics, California Chapter IV and St Joseph Hospital of Orange, which is one of the busiest Bridges Network hospitals.

In addition to the American Academy of Pediatrics, St. Joseph Hospital of Orange and the Commission, Safe Sleep Orange County membership includes the leadership of the County of Orange Health Care Agency, Orange County Perinatal Council and the Community Perinatal Network. Recently, the subcommittee developed an educational campaign to bring awareness to preventable infant deaths due to unsafe sleep environments and practices. The campaign includes a one-hour training tool to provide up-to-date information on safe sleep practices. Health professionals who complete the online training may be eligible for one hour of continuing education units through the Community Perinatal Network. A tri-fold safe sleep educational brochure has also been developed in English, Spanish and Vietnamese for distribution to parents and families throughout the county. Additional efforts will evaluate the impact of assessing infant sleep plans in the hospital setting and providing portable cribs to families in need.

Sustainability Strategies

As the Commission seeks to sustain services for Orange County's families, Pay for Success (PFS) contracting has emerged as a promising opportunity. Pay for Success is an approach for assisting

local partnerships to work in new ways to fund health and social service strategies designed to improve outcomes, and ultimately reduce the costs for addressing these issues.

Over the past year, the Commission has made substantial positive progress in developing an understanding of the Pay for Success model, securing project funding, and creating a more robust knowledge of the impact of the Bridges Network on families in Orange County. Key project milestones include:

- Received $100,000 California Pay for Success Initiative technical assistance grant, launched by Nonprofit Finance Fund and the James Irvine Foundation. This support allowed the Commission and partners to explore how to transition the Bridges Network away from grant funding and into a reimbursable model grounded in the achievement of targeted health outcomes.
- Received additional $50,000 award from the Nonprofit Finance Fund and the James Irvine Foundation to support analysis of Bridges Network data matched with data to document how Bridges clients perform on Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Received additional $100,000 technical assistance award from Third Sector Capital Partners, Inc. supported by federal funding from the Corporation for National and Community Services (CNCS). The CNCS "Accelerating Assistance Award" provides support through June 2016 to assist in validating outcomes, quantifying the impact of the Bridges Network, and exploring potential payment structures.
- Received $140,000 California Pay for Success Phase II technical assistance award to complete the feasibility assessment for future transaction structuring.

In addition to helping the Commission explore innovative funding mechanisms, these awards have created significant value in strengthening the Bridges Network evaluation and program model.

Bridges Network Challenges

Early Prenatal Care

Accessing timely prenatal care in the first trimester is important in ensuring a healthy pregnancy. While access to care has improved with the Affordable Care Act and updates in Medi-Cal coverage, many mothers are still not receiving timely prenatal care. In Orange County 10.3% of the births in 2013 had no to late prenatal care.[1] Of the 123 zip codes throughout the county, 44 or 36% of zip codes had late or no prenatal care at a rate higher than the county rate of 10.3%. Furthermore, the percentage of women receiving early prenatal care in Orange County decreased almost 4% in 10 years, dropping from 91.7% in 2004 to 88.3% in 2013. This decrease was reflected among all racial and ethnic groups.[2] The Commission, in partnership with the Orange County Perinatal Council, is assessing this issue and trying to understand the issues and barriers to access to timely prenatal care. The goal is to improve these rates and ensure that all mothers access prenatal care as early as possible in their pregnancy.

[1] 2013 Orange County Birth Statistical Master File
[2] *Ibid.*

Perinatal and Postnatal Depression

Perinatal depression is the most common complication of childbirth, annually affecting over one million women in the United States. National prevalence rates of perinatal depression can be as high as 20%, while approximately 14.5% of women experience postpartum depression.[3] Orange County reports figures lower than the national average with an estimated 13.3% and 14.2% of women experiencing perinatal and postpartum depression, respectively. Untreated perinatal and postpartum depression can have devastating effects on families. Commission-supported prenatal and postnatal home visitation programs screen for depression, anxiety, and stress to help mothers and families cope and address these concerns and to develop strong bonding, attachment and parenting skills. In partnership with the Orange County Perinatal Council, the Commission and its partners, have helped to develop a Perinatal Mood and Anxiety Disorders Algorithm for assessment and referral for providers in Orange County, including a referral matrix for providers and community members.

Breastfeeding Rates

Breastfeeding provides lifelong health advantages for both mothers and infants; providing nourishment and a foundation for a healthy immune system. The American Academy of Pediatricians recommends exclusive breastfeeding for at least the first six months, and Orange County ranks 34th in the state for exclusive breastfeeding.. The percentage of mothers who reported exclusive breastfeeding while in the hospital has increased in recent years, up from 55.2% in 2010 to 63.7% in 2014. The Commission is addressing this relatively low rate of exclusive breastfeeding by funding the Breastfeeding Consortium to help bring all Bridges Network Hospitals to Baby Friendly status, to support and encourage breastfeeding in the hospital, and to provide the support resources to continue breastfeeding in the home.

[3] Thurgood S, Avery M & Williamson L. Postpartum Depression (PPD). American Journal of Clinical Medicine, 2009; 6(2): 17-22.

APPENDIX 2:

Community Clinics

FY 14/15

Children and Families Commission of Orange County Community Clinics Report

This program report describes the Commission's investments in community clinics that serve young children and the outcomes of those investments. It also documents barriers for young children and their families in receiving quality health-care, as well as the Commission's actions, programs and recommendations to increase the percentage of children prenatal through age five in Orange County who are healthy by ensuring the availability and use of a "health home" for physical, dental, and mental health services. The Community Clinics initiative increases health coverage and facilitates access to quality pediatric care and primary care with doctors and nurses trained to provide prenatal screenings, checkups, and immunizations. The services provided in the community clinics and health centers serve the needs of all Orange County children.

Background

Community clinics can increase families' access to health services and qualified pediatric care. Because access to health-care and appropriate utilization of services is a Commission strategic priority, the Commission has supported the clinics in several important ways to ensure that quality services are available to young children. Investments have included a focus on expanding access to not only primary and specialty care but also a catalytic funding focus on increasing long-term sustainability of Commission-funded clinics. Prior year catalytic investments included supporting clinics in implementing electronic medical records, participating an a National Committee Quality Assurance – Patient Centered Medical Home project, receiving technical assistance in practice management and seeking the Federally Qualified Health Center (FQHC) designation. These efforts have assisted the clinics in transitioning off of Commission funds to a more self-sustaining model.

Commission Investment

The Commission provides funding in support of the health centers' focus to meet the needs of children and families in the county. Clinics that that were funded to expand access to pediatric care for young children include:

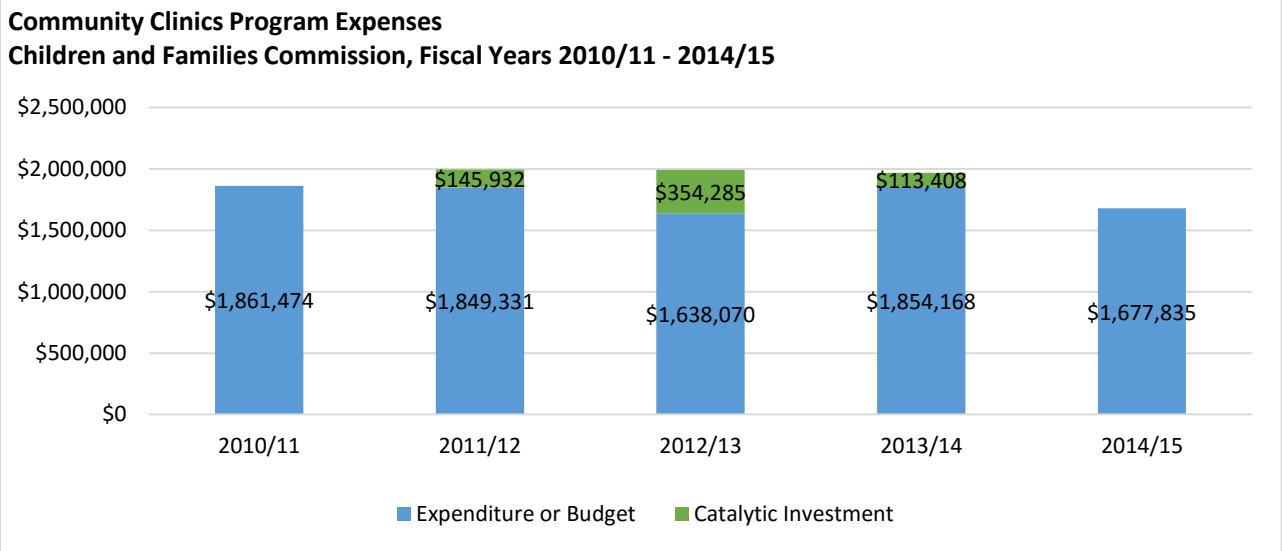
- Friends of Family Health Center (Pediatric Dental);
- Hurtt Family Health Center;
- Newport-Mesa Unified School District (HOPE Clinic);
- Sierra Health Center; and
- St. Jude Neighborhood Health Center.

Community-based health access programs that were funded through clinic-directed funding include:

- Boys and Girls Clubs of Garden Grove / ARCHES, which provides supportive and complementary services;
- Children's Health Initiative, which provides health access and outreach to link to health insurance and a healthcare home; and
- One OC / Fiscal Sponsor for Dr. Riba's Health Club, which provides community-based prevention and treatment services including nutrition, fitness education and a multi-disciplinary weight loss program.

For more than 40 years, the Coalition of Orange County Community Health Centers (Coalition) has served as a membership organization for freestanding, mobile community-based non-profit clinics offering a forum in which clinic leaders can share ideas. The Coalition is a consortium of safety net providers and key partners creating access to quality health-care for vulnerable, underserved communities. To leverage this expertise, the Commission funds the Coalition to provide direct support to community clinics, facilitate collaboration between community clinics, to provide support to clinics in their sustainability efforts, and encourage clinic participation in Reach Out and Read and other early literacy projects.

The Coalition also administers a Centralized Pediatrician and Pediatric Nurse Practitioner project to provide well-child and sick child visits at designated Orange County community clinics. Services include developmental screenings using American Academy of Pediatrics approved screening tools, and vision, hearing, nutrition and dental services. In fiscal year 2014/15, the Coalition targeted Commission funding to purchase additional screening devices in support of the health care needs of young children. The new technology and services included lead and vision screening.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in the community clinics produced the following services for children from birth through age five:

Table 1. Aggregate Data for Community Clinics

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	13,694	4,927	287
Number of services provided	31,272	13,911	622

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Community Clinics

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		1,078	100
Age at most recent interview	Under Three	587	54.5
	Three through Five	491	45.5
Ethnicity	Amer. Indian/Alaska Native	3	0.3
	Asian	51	4.6
	Black/African American	26	1.6
	Hispanic/Latino	687	63.3
	Pacific Islander	7	0.6
	White	149	13.7
	Vietnamese	19	1.7
	Multiracial	96	8.8
	Other	16	1.5
	Unknown	32	2.9
Primary Language	English	553	50.9
	Spanish	414	38.1
	Vietnamese	25	2.3
	Other	29	2.7
	Unknown	65	6.0
At or Below 200% Federal Poverty Level		757	94.2

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Community Clinic Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.1 Children are born healthy	Clinical prenatal visits	641	1,855
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	3,537	5,974
	Parents receive education, resources, referrals, and support regarding their child's development	1,900	2,063
	Children receive vision screening	260	275
HC.3 Children have and use a regular place for medical and dental care	Children are linked with health insurance enrollment	1,241	1,241
	Children are linked to a health care home	2,245	2,245
	Children receive primary care services (visit), including well child and sick visits	4,348	11,609
	Children are linked to a dental home	280	280
	Children receive a dental screening	78	150

Strategic Plan Outcome	Service	Clients Served	Number of Services
	Children receive preventative dental treatment (e.g., cleaning, sealant)	2,332	5,775
	Children receive restorative dental treatment (e.g., cavities)	117	1,443
HC.4 Children grow up healthy	Children screened for up to date immunizations	223	331
SF.2 Children are safe and well cared for	Office visits to improve parent knowledge of healthy child development	127	369
SF.3 Caregivers have ready access to family support services and resources	Parents receive referrals to services	5,200	5,664
	Providers receive referrals to services	145	363
	Parents receive follow up on referrals and services are accessed	2,908	4,116
EL.1 Children have the developmental skills to be proficient learners in school	Children read to at physicians' offices or clinics	1,070	239
	Books distributed to children	N/A	1,881
CB.1 Increase sustainability	Dollar amount raised	N/A	$985,027
CB.2 Increase access and efficiency, quality and effectiveness	Public information and outreach campaign to increase community awareness to promote access	N/A	71
	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	90
	Children with special needs served	330	330
	Providers receive trainings to build the capacity of the agency to increase quality services	24	60

Table 4. Service Outcomes (SOQs) for Community Clinics

Key Strategic Plan Objectives	SOQ Results
Healthy Children	
• Increase to at least 90% the proportion of all pregnant women who receive early prenatal care, and decrease racial/ ethnic disparities	• 91.5% of mothers received prenatal care in the first trimester
• Reduce the percentage of infants exposed to alcohol, tobacco, and other drugs (ATOD) to zero percent (0%)	• 6.5% of expectant mothers used ATOD prior to starting intervention
• Increase to 100% the proportion of children who have a health care home	• 99.3% of children had a dental health home at the end of services (compared to 58.1% at the beginning of services)
• Increase to 100% the number of children with health coverage	• 99.3% of children served had dental insurance at the end of services (compared to 63.8% at the beginning of services)

• Increase age appropriate immunization levels to at least 95%	• 100% of children received all age appropriate immunizations at the end of services (compared to 64.7% at the beginning of services)
Strong Families	
• Reduce the number of children who are homeless to zero	• 40.0% of children had a regular childcare arrangement at the end of services (compared to 31.4% at the beginning of services)

Community Clinics Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in children's health outcomes as evidenced by the number of children and families served annually in Orange County. Still, several challenges remain, from funding concerns for future needs to dental and mental health coverage for the pediatric patients.

Through the Commission's investments over the past 10 years, the quality and capacity of community clinics to provide pediatric primary care services has grown. In addition, during the last several years, the majority of clinics that receive Commission funding have applied for, and received, Federally Qualified Health Center (FQHC) designation. However, the transition to this funding model has proven to be challenging. The Federally Qualified Health Center designation allows clinics to receive reimbursement from the federal government, which has the potential to provide an ongoing and stable funding stream, but it requires a robust business and financial management system. While the community clinics are making progress to meet these needs, this transition continues to be a challenge.

APPENDIX 3:

Health Access and Education

FY 14/15

Children and Families Commission of Orange County Health Access and Education Report

This program report describes the Commission's investments in Health Access and Education and the outcome of those investments. The Commission provides funding to support parents' and providers' ability to access information that can increase access, quality and utilization of pediatric services.

Background

A child's health is heavily influenced by his or her access to health care. Access is improved through the direct provision of health care and utilization of health access and coverage programs, and providing health education, in-home support services, parenting classes, and other services for pregnant women and families with young children. While health access is emphasized in all programs related to the Commission's Healthy Children goal area, is the primary focus of the Commission investments with both 2-1-1 Orange County and the California Chapter 4 American Academy of Pediatrics.

2-1-1 Orange County

2-1-1 Orange County has its roots in a prior organization known as InfoLink Orange County. In 2005, the California Public Utilities Commission designated Info Link Orange County as the 2-1-1 service provider for the county, and in 2006 the organization formally changed its name to 2-1-1 Orange County. 2-1-1 Orange County maintains an up-to-date database with information on thousands of programs. 2-1-1 refers callers to organizations qualified to address their specific need for health and human services, including food, shelter, transportation, prenatal care, substance abuse, child development and elder care. Since 2-1-1's designation as the County's Information and Referral entity, the Commission has recognized the need to support and ensure the accuracy and timeliness of the referrals made by 2-1-1 to Orange County's families with young children seeking services.

California Chapter 4 American Academy of Pediatrics Reach Out and Read

Fewer than four in ten children ages five years and younger in Orange County are read to daily.[1] Further, minority and low-income children are less likely to be read to every day than their non-minority and higher income peers.[2] By age three, children from lower-income families have heard roughly 30 million fewer words than their more affluent peers.[3] Proficiency in reading by the end of third grade is a crucial marker in a child's educational development; yet only one-third (32%) of fourth graders in Orange County's public schools met reading standards in 2015.[4]

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[1] UCLA Center for Health Policy Research. California Health Interview Survey. 2014

[2] Russ S, Perez V, Garro N, Klass P, Kuo AA, Gershun M, Halfon N, Zuckerman, B. Reading Across the Nation: A Chartbook (2007): Reach Out and Read National Center, Boston, MA.

[3] Hart, B. Risley, T. Meaningful Differences in the Everyday Experiences of Young American Children (1995), Paul H. Brookes Publishing Co.

[4] California Department of Education, DataQuest. Smarter Balance Test Scores for Fourth Graders—Reading: Demonstrating understanding of literary and non-fictional texts.

Commission-funded Services in Orange County

The Commission's Healthy Children goal area includes a focus on increasing the number of children that have access and consistently use a medical home, access developmental screenings and are linked to services, when needed. One strategy to achieve these outcomes is to support the work of both 2-1-1 Orange County and the Orange County Chapter of the American Academy of Pediatrics.

2-1-1 Orange County

2-1-1 Orange County is the designated, countywide 24 hours, seven days a week information and referral provider. The Commission supports 2-1-1 Orange County to develop and maintain relationships with community agencies reaching the zero to five population and their families, and ensuring that contact and service information is accurate. 2-1-1 Orange County also trains Information and Referral specialist to provide ongoing coaching on call handling, how to use the database and how to link callers to needed community resources. 2-1-1 Orange County tracks phone calls and needs specific to the young children and develops a trend analysis for the Commission that assists in identifying needs and gaps in services.

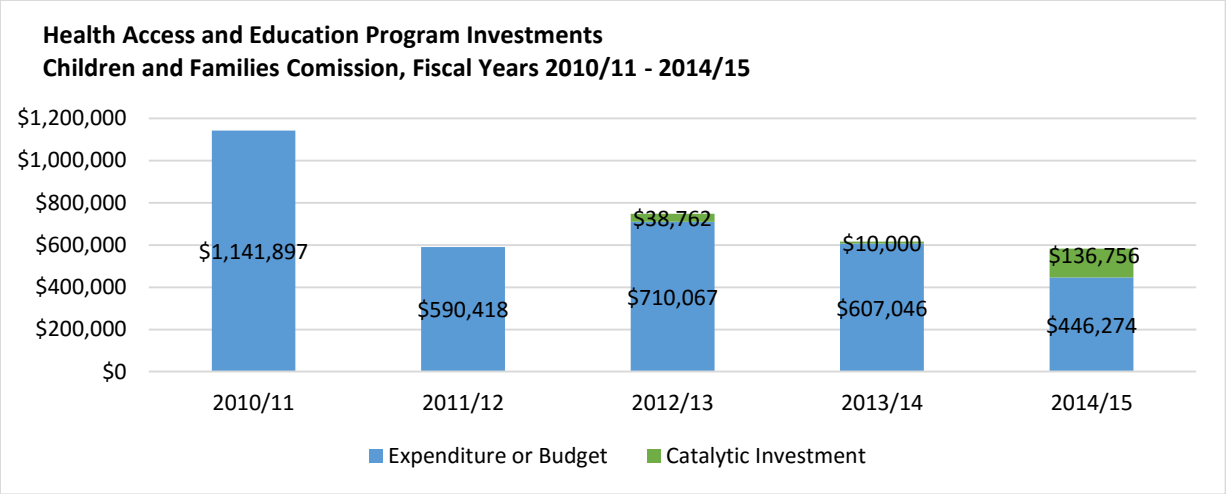
California Chapter 4 American Academy of Pediatrics

The Commission funds the Orange County division of the American Academy of Pediatrics to implement a Reach Out and Read program in pediatric health offices. Reach Out and Read is a national program that prepares young children to succeed in school by partnering with doctors to prescribe books and encourage families to read together. This early-literacy program focuses on children six months to five years old, trains and supports medical providers who give books to children at well-child exams, and provides advice to parents about the importance of reading aloud. Reach Out and Read builds on the unique relationship between parents and medical providers to develop essential early literacy skills in young children via the existing healthcare infrastructure.

During regular pediatric check-ups, pediatricians, family physicians and nurse practitioners give new, developmentally-appropriate books to children and advise parents about the importance of reading aloud every day with their children. As a result of this evidence-based intervention, parents learn new ways to stimulate their child's literacy development, have more books in their home, and read to their children more often. Parents are supported as their child's first, and most important, teachers.

Commission Investment

Since fiscal year 2010/11, the Commission has allocated more than $3.6 million to support the services provided for young children through the Health Access and Education program. The Commission has reduced program funding by 61% over the last five years. The major reductions include reduction in the support for children health insurance enrollment, child passenger safety, and reduction in scope to target critical programs and support.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in health access and education programs produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Health Access and Education Grantees

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	N/A	15,864	655
Number of services provided	N/A	35,359	219

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Services Provided by Health Access Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Providers trained on how to screen, assess and/or identify child developmental milestones	60	82
	Providers educated on child development, recognizing key milestones, and the importance of developmental screenings	142	10
	Providers receive informational materials regarding developmental milestones and development	314	9,325
SF.3 Caregivers have ready access to family support services and resources	Parents receive referrals to services	15,684	35,359

Strategic Plan Outcome	Service	Clients Served	Number of Services
EL.1 Children have the developmental skills to be proficient learners in school	Provider will recruit and support pediatrician offices to participate in Reach Out Read National Program	78	108
CB.1 Increase sustainability	Dollar amount raised	N/A	$58,916
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	98
	Technical assistance is provided, such as assistance with sustainability plans, evaluation activities, and providing quality services	77	119

Program Highlights and Outcomes

Despite reductions in funding, the Health Access and Education program area is making an impact within both families with children ages five years and younger as well as supporting the provider community. This is evidenced by an increase in information and referral contacts at 2-1-1 to provide trainings and outreach on developmental screenings and Reach Out Read for the American Academy of Pediatrics.

2-1-1 Orange County

Growing in their capacity to serve the Orange County community, 2-1-1 Orange County saw an increase in usage during fiscal year 2014/15, measured by a 39% increase in the number of unique calls as well as a 19% increase in the number of views to its website. 2-1-1 Orange County also provided 24 trainings regarding their online information portal with over 390 people participating throughout the year.

In fiscal year 2014/15, 2-1-1 Orange County participated in regional collaborative meetings and attended over 65 meetings with organizations that work with populations that have children ages five years and younger. To further increase strategic thinking and community planning to align resources to the needs in the Orange County community, 2-1-1 Orange County began to share a *Trends Report* at meetings, one-on-one and via email, thereby educating over 15 agencies (more than 30 staff) on trends in needs, gaps and duplication of services.

American Academy of Pediatrics, California Chapter 4

In fiscal year 2014/15, the American Academy of Pediatrics, California Chapter 4 (AAP) continued their efforts with the Reach Out and Read and developmental screening programs in Orange County. Currently, 54 active pediatric offices/clinics are implementing the program and successfully maintained 100% reporting compliance through June 2015.

Orange County's Reach Out and Read sites collectively serve over 85,000 children per year, giving out over 19,500 new books annually. To date, the Reach Out and Read program has distributed over 606,000 books to children six months through age five years.

APPENDIX 4:
Children's Dental
FY 14/15

Children and Families Commission of Orange County Children's Dental Report

This report describes the Commission's investments in the oral health of young children in Orange County, and the outcome of those investments. It also documents barriers to young children receiving dental care and Commission actions and policy recommendations to improving oral health outcomes for all Orange County children.

Background

In 2000, the Surgeon General reported that tooth decay was the most common chronic childhood disease, resulting in more than 51 million lost school hours each year. This prompted the Commission to prioritize and improve oral health outcomes for young children. Fifteen years later, the Commission is continuing to invest in multiple strategies, including increased education and prevention, expanded access to screening, and building a network of providers to provide basic and restorative care for young children. Significant progress has been made as Orange County has the highest percentage of low-income children in the state who have received a preventative visit annually,[8] further collaborative efforts are needed to ensure that no child enters kindergarten with untreated tooth decay or misses school because of dental disease. Good dental health is important for children's healthy growth and development, yet a survey conducted by the Dental Health Foundation found that one in three children in Orange County had untreated tooth decay, a rate higher than the statewide average.[9] Furthermore, 10% of Orange County children (ages one through 18) reported never having visited a dentist, and when only young children (ages one through five) are considered, the proportion of children who have never visited a dentist increases to 20%.[10]

Commission-funded Services in Orange County

The Commission responded to children's oral health needs with an initial $1 million investment in fiscal year 2002/03 to support the creation of a child-friendly oral health center and launch a new nonprofit exclusively focused on providing dental care and prevention services to children. The Healthy Smiles for Kids of Orange County (Healthy Smiles) children's dental clinic opened in 2005.

Today, Healthy Smiles works in partnership with a collaborative of countywide community clinics to provide education and treatment services annually to more than 19,000 young children and more than 8,000 family members to prevent and treat tooth decay, including the following:

- Dental screenings;
- Sealants and fluoride treatments;
- Restorative treatment, including for children requiring sedation;
- Parent and caregiver oral health education; and
- A pediatric dental residency program.

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[8] *"Pediatric Denti-Cal Dentists by CA Counties."* Children Now. 2014 Web. 22 January 2015.

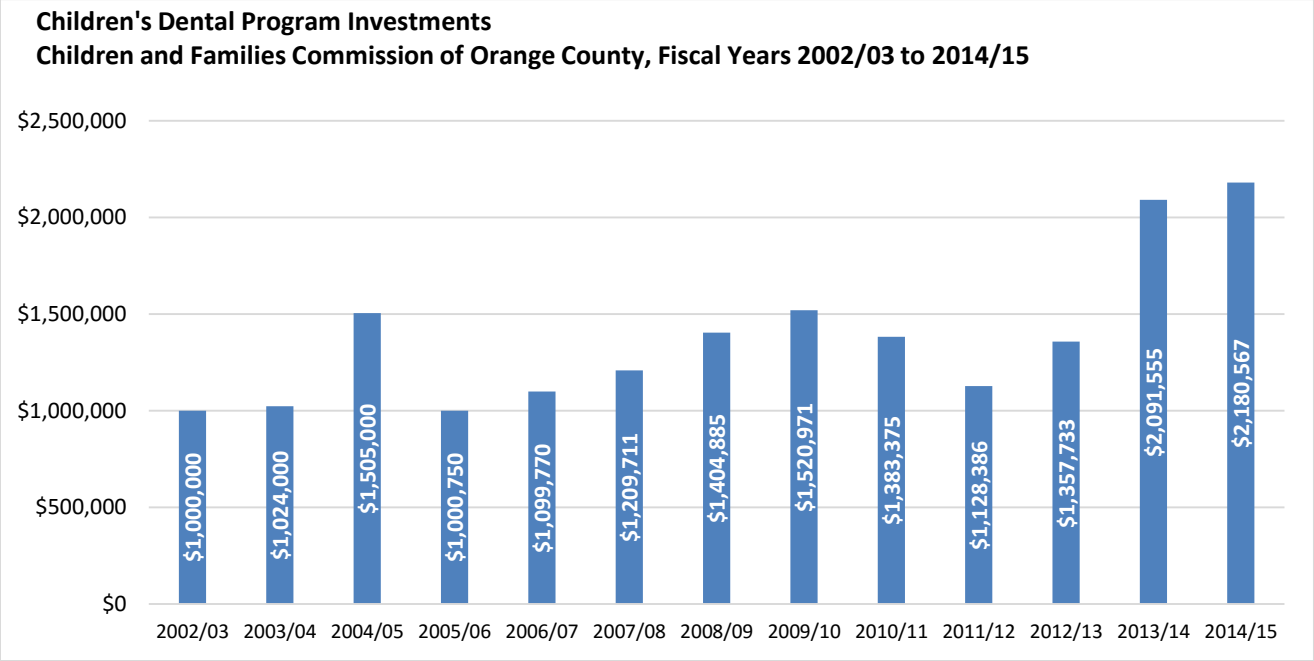
[9] Dental Health Foundation. An oral health assessment of Orange County's kindergarten and 3rd grade children. Orange County Smile Survey. 2005.

[10] UCLA Center for Health Policy Research. California Health Interview Survey. 2011-2012.

Services are provided through seven fixed clinic sites, two mobile dental vans, and a partnership with the Children's Hospital of Orange County (CHOC Children's). The pediatric dental residency program partners include CHOC Children's and the University of Southern California's Advanced Pediatric Dentistry Program. The Commission also funds School Readiness Nurses who conduct almost 10,000 dental screenings each year, provide parent and caregiver oral health education, and refer children for dental services as needed. More than 90% of children treated at Healthy Smiles live in households with incomes at or below 200% of the Federal Poverty Level.

Commission Investment

Since the initial investment in fiscal year 2002/03, the Commission has allocated almost $18 million to support children's dental programs in Orange County. In fiscal year 2012/13, the Commission made an additional $20 million catalytic investment to sustain children's dental health over a 10-year period (fiscal years 2012/13 to 2021/22), including the continued pediatric dental residency program, expanded access to services in south Orange County, and promotion of the importance of early screening and prevention. In addition to the residency program, the Commission supports a retention program that makes student loan payments on behalf of pediatric dentists who are willing to continue their work with Healthy Smiles once they have graduated.



Fiscal Years 12/13 and 13/14 include expenditures from the $20 million catalytic allocation.

The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in children's dental programs produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Children's Dental

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	19,808	9,916	389
Number of services provided	40,653	17,131	492

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Children's Dental

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		1,521	100
Age at most recent interview	Under Three	678	44.6
	Three through Five	843	55.4
Ethnicity	Amer. Indian/Alaska Native	9	0.6
	Asian	50	3.3
	Black/African American	17	1.1
	Hispanic/Latino	1,230	80.5
	Pacific Islander	9	0.6
	White	128	8.4
	Vietnamese	16	1.0
	Multiracial	38	2.5
	Other	10	0.7
	Unknown	21	1.4
Primary Language	English	686	44.9
	Spanish	803	52.6
	Vietnamese	9	0.6
	Other	19	1.2
	Unknown	11	0.7
At or Below 200% Federal Poverty Level		1,234	94.1

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Children's Dental

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.3 Children have and use a regular place for medical and dental care	Children are linked with health insurance enrollment	37	37
	Children are linked to a dental home	1,284	1,284
	Children receive a dental screening	7,456	7,456
	Children receive preventative dental treatment (e.g., cleaning, sealant)	8,531	10,830
	Children receive restorative dental treatment	322	1,208
	Children receive emergency dental treatment	38	218
	Children with special needs receive dental care	583	1,508

Strategic Plan Outcome	Service	Clients Served	Number of Services
	Parents receive training on oral health	9,928	10,926
	Children receive oral health education	16,873	18,208
	Providers receive oral health education	389	492
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	379	668
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	8

Table 4. Service Outcomes (SOQs) for Children's Dental Grantees

Key Strategic Plan Objectives	SOQ Results
Healthy Children	
• Increase to 100% the proportion of children who have a health care home	• 99.7% of children had a dental health home at the end of services (compared to 56.8% at the beginning of services)
• Increase to 100% the number of children with health coverage	• 99.7% of children served had dental insurance at the end of services (compared to 97.9% at the beginning of services)
• Reduce dental cavities so that the proportion of young children with one or more cavities is no more than 9%	• 83.2% of children had no cavities at the end of services (compared to 71.6% at the beginning of services)

Program Highlights and Outcomes

The investment in children's oral health is having an impact. More young children are visiting the dentist and doing so at an earlier age; a local pediatric dental workforce is being developed; and more families are taking action in response to education about the importance of preventive care.

More Local Pediatric Dentists

Since program inception in 2005, Healthy Smiles has trained 63 pediatric dental residents serving Orange and Los Angeles counties. Eight residents are continuing to practice in Orange County; seven of those are in practices accepting Denti-Cal. Further, community pediatric dental providers have been engaged to serve as adjunct faculty to the residency program, which has contributed to increasing access to dental care and improved comprehensive quality care to the most vulnerable children in Orange County.

More Preventive Care

Orange County has a high percentage of children with Denti-Cal who access preventive care. At 49%, Orange County has the highest percentage among California counties of children ages birth through five enrolled in Denti-Cal who received at least one preventive visit within the past year,[11] suggesting that the county's dental health programs and outreach have been effective in promoting preventive oral health care.

[11] *"Pediatric Denti-Cal Dentists by CA Counties."* Children Now. 2014 Web. 22 January 2015.

Children's Dental Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in children's oral health in Orange County. Still, several challenges remain, from a workforce shortage, to low reimbursement rates for service, to family barriers to accessing care.

Shortage of Dentists to Treat Young Children

In October 2013, Healthy Smiles conducted a survey of dentists available to serve children enrolled in Denti-Cal in Orange County. At that time, there were 546 active general and pediatric dentists on the Orange County Denti-Cal roster. Of those, 59% (321) were general dentists. If a general dentist indicated they would see children, a follow up question was asked whether the dentist offered nitrous or other sedation services for children under five. Of those contacted, only four general dentists offered sedation. The rest of the general dentists saw the child for an initial exam and then referred out to a specialist for treatment.

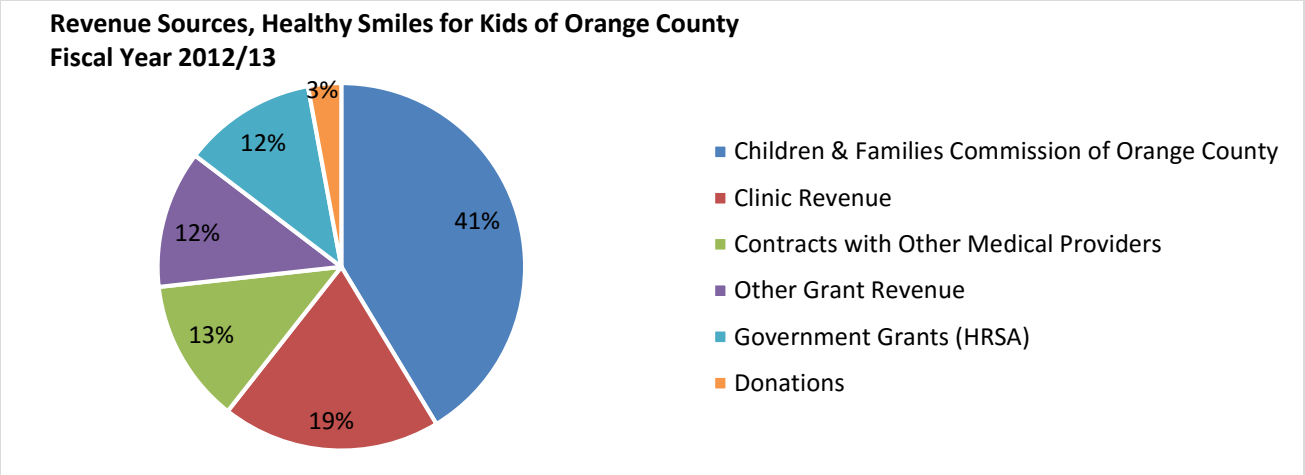
Shortage of Pediatric Dentists Who Take Denti-Cal

In 2013, Children Now reported there were 67,075 children birth through age five were enrolled in Denti-Cal in Orange County. They found 54 Orange County pediatric dentists accepting Denti-Cal, resulting in a ratio of one pediatric dentist per 1,242 children under five years old – among the best ratios of all California counties. However, when Healthy Smiles conducted their October 2013 survey, they found many dentists had closed to Denti-Cal patients. The majority of practices closed their panels effective September 1, 2013, which was when the reimbursement reduction went into effect.

Specifically among pediatric dentists, the Healthy Smiles' survey found only seven accepting Denti-Cal. Extrapolating from Healthy Smiles' survey sample, it is estimated that there were approximately 20 Denti-Cal dentists available to treat the growing number of Orange County children from birth to age five who are enrolled under Medi-Cal (then at approximately 98,000). As a result, the level of access to treatment for the very young child is actually much lower – closer to one pediatric dentist to 4,900 children with Denti-Cal.

Low Reimbursement Rates & Other Barriers

Several factors contribute to the phenomenon of few Denti-Cal dentists to serve a large and growing population of Denti-Cal children. Perhaps the most salient factor is that Denti-Cal reimbursement covers only a fraction of the cost to provide services. California has one of the lowest reimbursement rates in the nation compared to other state Medicaid dental programs. According to a recent audit by the California Department of Health Care Services, California's reimbursements are approximately 35% of the national average for comparable Medicaid reimbursements. Further, California has not raised its dental reimbursement rates since fiscal year 2000/01 and in September 2013, implemented a 10% state-mandated payment reduction for most dental service providers. When comparing Denti-Cal to private insurance, Denti-Cal reimbursement is one-third of private insurance reimbursement, thus, there is little financial incentive for pediatric dentists to provide services to Denti-Cal patients.



The Children & Families Commission portion includes expended revenue from the $20 million catalytic allocation.

Long Wait Times

The average wait time for a child needing general anesthesia is approximately four months at Healthy Smiles' clinic, and eight months at CHOC Children's. Children requiring treatment in a hospital setting are referred to CHOC Children's. Despite increased access to treatment under sedation at both the Healthy Smile's clinic and CHOC Children's, annually several children must be referred to other sources of care.

Currently, at any given time, the average number of children on Healthy Smile's waiting list for treatment under general anesthesia is 80. In fiscal year 2013/14, more than 150 children were referred out from Healthy Smiles because of the long wait time to access treatment. Wait times for treatment vary from a few days to nine months at Healthy Smiles, and from one to 14 months at CHOC Children's. Treatment is scheduled based on the urgency of a child's condition, the availability of a sedation day appropriate to their health status, and the acuity of the child's medical condition. At CHOC Children's, treatments may need to be rescheduled if the child is sick and unable to undergo treatment, contributing to delays.

Family Barriers to Accessing Oral Health Care

There are many reasons families do not access oral health care for their young children. Health care providers are still fighting the myth that baby teeth do not matter since they are going to fall out eventually. When parents do seek care for their child, if sedation is necessary, they may be afraid of having their child put under sedation and delay getting care. When moderate or deep sedation is required, there is a waiting list for sedation services and treatment.

Many families are confused about what Medi-Cal covers and do not know they have access to Denti-Cal. Assuming they will have to pay for dental services, lower income families may delay care. If they do try to access service, they may be overwhelmed by the difficulty of navigating the system. Lack of housing stability proves to be a barrier for providers' ability to track and treat children in families that are transient.

Finally, transportation is a major barrier. It can be difficult and time consuming to use the bus system to get a child to and from a dental clinic, especially if the child needs sedation. This is particularly true if a family lives in southern Orange County where bus service is limited and the destination is central or north Orange County where the Healthy Smiles clinic or the Santa Ana Surgery Center are located.

APPENDIX 5:

Pediatric Health Services

FY 14/15

Children and Families Commission of Orange County Pediatric Health Services Report

This program report describes the Commission's investments in the Pediatric Health Services Programs and the outcome of those investments. The Commission supports investments to improve the availability and quality of primary and specialty pediatric health care for young children by leveraging resources, expertise, and presence of the two largest providers of pediatric care in Orange County. This report also documents the Commission's actions, programs and recommendations to optimize children's health development through prevention, early identification, and referral to early intervention and treatment for all Orange County children.

Background

Since November 2000, the Commission has worked to develop a structure to provide for ongoing collaborative pediatric primary and specialty programs with the Children's Hospital of Orange County (CHOC Children's) and the University of California-Irvine. In May 2003, the Commission approved the formation of the Pediatric Health Services Committee. The Committee's responsibilities include: Identifying priority pediatric health needs based on assessment of local conditions and issues, including input from educational and other communities; developing recommended programmatic areas for funding for improvements in children's health related to school readiness; overseeing and evaluating the Commission's investments in pediatric health services; and serving as the Commission's Technical Advisory Committee.

Commission-funded Services in Orange County

One of the main investments the Commission and the Pediatric Health Services Committee have made has been towards supporting young children's development. There are four programs housed within Early Developmental Services.

- **The Center for Autism and Neurodevelopmental Disorders** (The Center) (formerly For OC Kids Neurodevelopmental Center) provides comprehensive evaluations, diagnosis, treatment, and management of children of all ages who are suspected of having developmental, behavioral or learning problems. The Center also provides family support, education, and advocacy.
- **Child Behavior Pathways** (formerly CUIDAR) provides a preventive and "intervention before diagnosis" approach for behavioral disorders through the use of nine-week Community Parent Education (COPE) classes, nine-week COPEing with Toddler Behavior classes, social skills lessons for children, and teacher training services. Child Behavior Pathways helps parents and teachers effectively manage challenging behaviors, improve family/classroom functioning, and encourage healthy relationships with infants, toddlers, and preschool age children.
- **Early Developmental Assessment Center** provides comprehensive, multidisciplinary developmental and nutritional assessments, education, intervention strategies, care coordination and advocacy for high-risk infants and toddlers who have been referred from neonatal intensive care units and the community.

- **Help Me Grow Orange County** is a national model for connection to a variety of developmental and behavioral services. Help Me Grow also works with primary health care providers to promote and offer trainings in developmental surveillance and screening.

In 2012, the Commission joined with the William and Nancy Thompson Family Foundation to make a catalytic funding award that is leading to an expansion of services and stronger connections among the four programs. In addition, the Commission funds specialty services, such as the pediatric subspecialty loan repayment program, community support services, vision services, and asthma.

Pediatric Subspecialty Loan Repayment. The loan repayment program was created by the Commission in 2009 to address the shortage of pediatric subspecialists and the difficulties in recruiting such specialists to Orange County. Providers receive up to $125,000 for expenses incurred for undergraduate education and graduate medical education. In exchange, the physicians agree to serve children through age five and to affiliate with an Orange County hospital, clinic or physician practice with a patient base of at least 51% Medi-Cal beneficiaries for a three-year period.

Community Support. In May 2012, the Pediatric Health Services Committee recommended a catalytic funding set-aside of $250,000 in support of strategies to address the problem of child abuse, neglect and trauma in Orange County. The catalytic funding was focused on supporting the development of the Orange County Social Services Agency Chief Medical Officer position. A candidate was recruited into the position in fiscal year 2014/15. The Chief Medical Officer serves as an advisor and expert in the development and application of comprehensive integrated health programs and services, including prevention efforts for current Social Services Agency clients and those at-risk of requiring services.

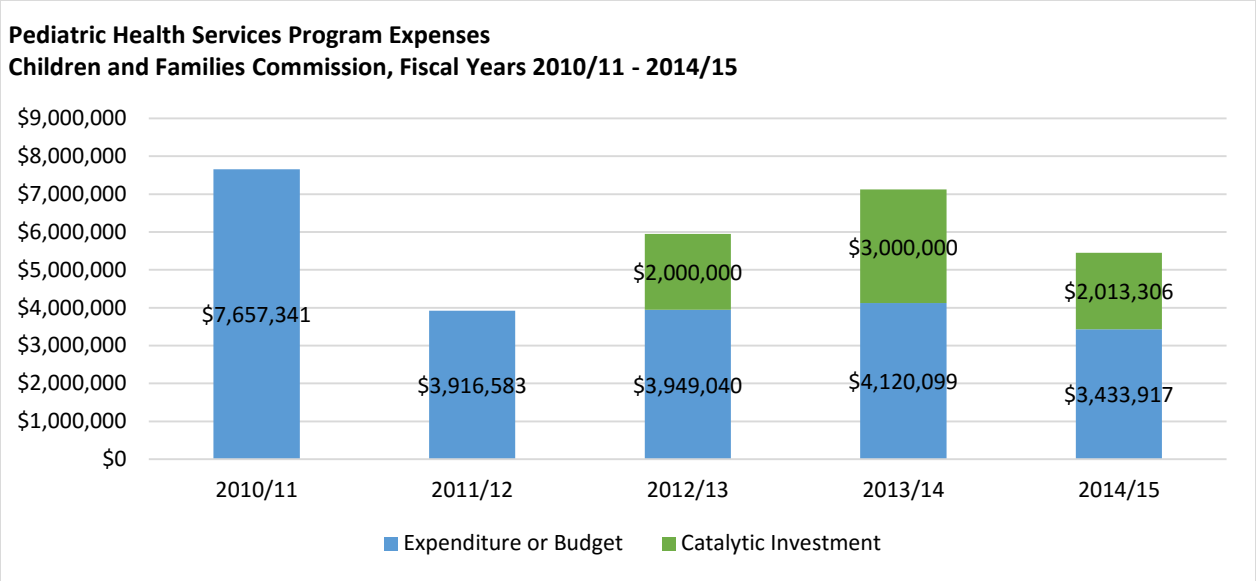
Pediatric Vision Services. In May 2013, the Commission allocated $1.5 million in catalytic funding for Orange County pediatric vision services. The project is implemented through a contract with University of California-Irvine's The Gavin Herbert Eye Institute as well as CHOC Children's hospital. The goals of the pediatric vision services included:

- Identify and implement standards of care for Orange County pediatric vision services;
- Expand ages to ensure screening of three and four year olds;
- Ensure connection to the medical home, health coverage;
- Implement an information technology system for the management of vision related health information; and
- Develop educational component for child's family and community providers.

Asthma Program. The Asthma program was initially funded in 2001 and aimed to optimize the health of young children with asthma and chronic lung disease through parent and patient education, asthma screening, treatment, referrals and case management services. The Asthma program collaborates with the Breathmobile, a fully equipped mobile medical clinic, to provide comprehensive asthma care services to underserved young children in Orange County. Fiscal year 2014/15 was the last year of the Asthma program funding from the Commission.

Commission Investment

Since fiscal year 2011/11, the Commission has allocated more than $23 million to support the health services provided for young children through the Pediatric Health Services Initiative.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in pediatric health services programs produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Pediatric Health Services

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	3,706	7,017	4,622
Number of services provided	24,475	28,686	10,356

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Pediatric Health Services

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		130	100
Age at most recent interview	Under Three	29	22.8
	Three through Five	101	77.7
Ethnicity	Amer. Indian/Alaska Native	0	0.0
	Asian	2	1.5
	Black/African American	2	1.5
	Hispanic/Latino	77	57.5
	Pacific Islander	0	0.0
	White	33	24.6
	Vietnamese	1	10.4
	Multiracial	14	6.7
	Other	2	1.5
	Unknown	3	2.2

Primary Language	English	74	55.2
	Spanish	53	39.6
	Vietnamese	0	0.0
	Other	3	2.2
	Unknown	4	3.0
At or Below 200% Federal Poverty Level		113	63.4

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Pediatric Health Services

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Providers trained on how to screen, assess and/or identify child developmental milestones	166	166
	Providers educated on child development, recognizing key milestones, and the importance of screening and/or assessment	4,203	8,449
	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)*	223	281
	Parents receive education, resources, referrals, and support regarding their child's development	713	920
	Children receive behavior health screening using Commission-approved tool	278	278
	Children receive assessment (e.g., vision, hearing, speech/language, psychosocial issues, motor skills, health, special needs, and/or parent-child functioning)	977	9,451
HC.4 Children grow up healthy	Children enrolled in multi-disciplinary weight loss and/or physical activities program	36	72
	Children receive specialty care clinic visits	982	4,631
	Children receive specialty care follow-up clinic visits* *(all children are repeat/returning)	1,545	2,863
	Parents receive specialty care education, resources, referrals, and support	4,116	10,438
SF.2 Children are safe and well cared for	Parents participate in parenting education classes/series on healthy child development	393	15
	Children receive group interventions to improve healthy child development	45	21
SF.3 Caregivers have ready access to family support services and resources	Parents receive referrals to services	1,498	5,173
	Providers receive referrals to services	454	490
	Parents receive follow up on referrals and services are accessed	746	1,237

Table 3. Services Provided by Pediatric Health Services

Strategic Plan Outcome	Service	Clients Served	Number of Services
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Providers receive training on behavioral health treatment services for children 0-5	121	4
CB.1 Increase sustainability	Dollar amount raised	N/A	$30,000
	CSP match dollars submitted	N/A	$481,880
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	390
	Children with special needs served	437	437

Program Highlights and Outcomes

In 2014, the **Early Developmental Assessment Center** (EDAC) reviewed data of all the children served through California Children's Services who were born in 2011 and should have completed three visits with the program. The percentage of children with a normal neurologic exam rose to 87% at Visit 3, up from 66% at Visit 1. Between Visit 1 and Visit 3, the percentage of children who were hospitalized, had surgery, or were on medication declined. There was a steady increase in the percentage of children who were receiving five or more special services (such as physical, occupational, or speech/language therapy) across the three visits. By Visit 2, 34% of the children were receiving Early Start services from the Regional Center and another 18% were referred for Early Start services. By Visit 3, 15% of children were receiving five or more services (up from 2% at Visit 1). At Visit 3, 51% of the children were screened for autism using the M-CHAT (a validated screening tool for autism) and 10% were referred for further assessment. By Visit 2, 34% of the children were receiving Early Start services from the Regional Center of Orange County and another 18% were referred for Early Start services. These rates were about the same at Visit 3.

In June 2014, EDAC was awarded with CPQCC "Surprise Data Award" for referring 100% of discharged to home eligible Very Low Birth Weight infants to a High Risk Infant Follow-up program for three continuous years (2010-2012).

In a recent review of its data, **Help Me Grow Orange County** found that for families who utilized Help Me Grow, children were connected or were in the process of connecting to at least one referral in a referral category 77% of the time, similar to the rates of the previous two years. The top two reasons children were not connected to any referrals in a referral category were lack of follow-through by the parents (55% of the time), and the child was connected to an alternate service in another referral category (11%).

In fiscal year 2014/15, **Specialty Services** program received an additional $15,000 from the Lon V. Smith Foundation to provide free glasses to disadvantaged children, which will enhance the existing vision services that are supported by the Commission.

Pediatric Health Services Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in children's health in Orange County through the support of Pediatric Health Services. Still, several challenges remain, from accessibility to lack of consistent data to ensuring care coordination for special populations.

Accessibility

With implementation of the Affordable Care Act, the rate of uninsured in Orange County has declined significantly—from 18.0% who lacked health insurance in 2010 to 11.2% in 2014. For young children ages five and under, the percentage who did not have health insurance improved even more drastically—from 7.6% uninsured in 2010 down to 3.2% in 2014.[1] Commission staff works with the First 5 Association of California to review challenges and opportunities to impact children's primary and specialty services, including promoting early identification and intervention to optimize children's healthy development. Key focus areas have included Healthcare Effectiveness Data and Information Set (HEDIS) measures and an emphasis on prevention in managed care and inclusion of Applied Behavioral Analysis as a Medi-Cal covered service. Commission staff, as advocacy chair of the First 5 Association, will continue to dialogue with State Medicaid officials about options and opportunities.

Lack of Consistent, Child Level Data

A core strategy of the Commission is to impact early identification and intervention to optimize children's healthy development. Several public services systems that provide these services (e.g., Medi-Cal and private medical providers, public clinics, school district services, community-based organizations) collect child-level data but there is little county level data available related to core prevention and early intervention services. Consequently, there are little data available to measure, manage, and monitor the impact of changes in the health care system on children. Improved shared data technology would assist in ensuring coordination of care and integration of services across these diverse sectors. In addition, investments in data integration strategies such as a registry have the potential to provide aggregate data as a tool to monitor success in achieving local results for children.

Care Coordination for Special Populations

Care coordination is critical for special populations. Special populations include, but are not limited to, children with special health care needs, those in the foster care system, children who are homeless, and children born to teen mothers. Special populations also include children and families at risk due to poverty. It is important to keep a careful watch on these special populations to ensure needed services are still covered. It is recommended that local and regional planning continue to focus on care coordination to deploy current and new resources more effectively. Models such as Help Me Grow Orange County, and progress on the Lucille Packard Foundation Care Coordination for Kids project, along with the progress of the Developmental Screening Network and its development of a developmental screening registry have potential to addressing this barrier in efficiently and effectively linking children to early intervention services.

[1] American Community Survey, 1-Year Estimates, 2014

APPENDIX 6:
School Readiness Nursing
FY 14/15

Children and Families Commission of Orange County School Readiness Nursing Report

This program report describes the Commission's investments in the School Readiness Nursing Initiative and the outcome of those investments. It also documents the barriers for young children, the gaps associated with the identification and referral for children and their families, and the Commission's actions, programs and recommendations to address these barriers for all Orange County children.

Background

The Commission established the School Readiness Nursing initiative in 2004 in an effort to foster the health and development of the young child before he/she starts school. Furthermore, in order to ensure an adequate workforce in Orange County, the Commission funded the "Professional School Nurse Education Project" in 2005 to establish an accessible school nurse credential program at California State University, Fullerton. The American Academy of Pediatrics, California Chapter 4, has been instrumental in supporting the development of the School Readiness Nursing standards and practices.

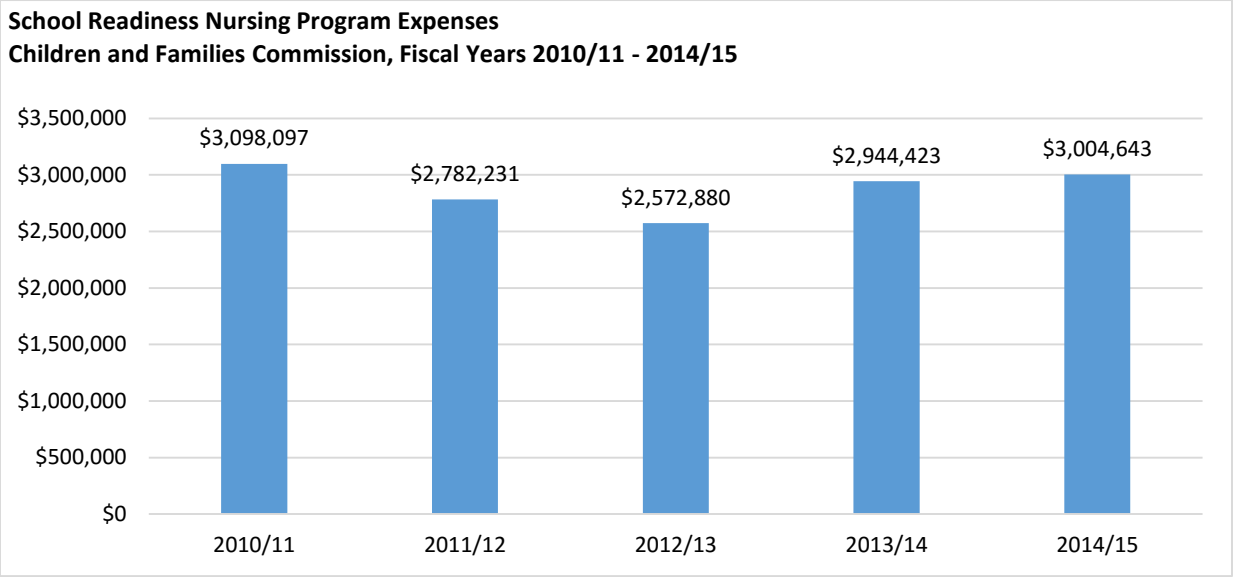
Commission-funded Services in Orange County

In fiscal year 2014/15, the Commission funded 29 full-time equivalent (FTE) School Readiness Nurses, deploying them in all 25 school districts in Orange County with a kindergarten population, to provide health-care related services. Services provided by the School Readiness Nurses include screenings for young children from the birth to age five for hearing, immunization, oral health, vision, and development / behavior, and linking to any needed services to optimize healthy child development. A Medical Director position with the Orange County Department of Education was created and funded in partnership with the Orange County Health Care Agency, Mental Health Services Act and Hoag Memorial Presbyterian Hospital. This position provides expertise and consultation to the School Readiness Nurses in support of integrated child health and wellness programs. Based on the documented outcomes and successes of this program, the Commission continues to fund the role of the School Readiness Nurse in each school district.

Commission Investment

Since fiscal year 2010/11, the Commission has allocated more than $14.4 million to support the health services provided for young children through the School Readiness Nursing Initiative. The importance of early screening and identification of health concerns as well as referrals to community resources has been an important goal for this program. In 2013, the Commission identified that a large percentage of preschool children were unable to access early vision services in Orange County and determined that vision services must be provided for these children as a necessary part of health care. In fiscal year 2014/15, the Commission funded the purchase of the PlusOptix Vision Screener for the School Readiness Nurses as an important screening technology for the nurses to use in identifying children with vision needs. In 2013, the Commission funded a $1.5 million catalytic grant to develop a vision screening program to provide access to vision services for all children in the County. Beginning September 2015, the School Readiness Nurses will be working with the Gavin

Herbert Eye Institute to identify children with vision concerns (amblyopia) at a young age (three and four years) and to refer them for corrective lenses.



The Outcomes

The investment in the School Readiness Nursing initiative serves to promote lifelong health practices in children from birth through age five and their families to prevent/decrease health problems, diseases and disorders and to facilitate early identification and treatment of health problems. The services provided by the School Readiness Nurses promote a healthier quality of life and continue to prepare children for a successful educational experience. Early identification of health related concerns and referral to community resources have proven to address the health care needs of young children at an early age and improve long-term outcomes with early identification.

Services Provided

In fiscal year 2014/15, the Commission's investment in the School Readiness Nursing initiative produced the following services for children birth through age five:

Table 1. Aggregate Data for School Readiness Nursing

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	17,758	11,842	753
Number of services provided	127,530	28,605	1,290

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by School Readiness Nursing

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		529	100
Age at most recent interview	Under Three	77	14.6
	Three through Five	452	85.4
Ethnicity	Amer. Indian/Alaska Native	0	0.0
	Asian	41	7.7
	Black/African American	3	0.6
	Hispanic/Latino	313	59.1
	Pacific Islander	1	0.2
	White	57	10.8
	Vietnamese	13	2.5
	Multiracial	22	4.2
	Other	13	2.5
	Unknown	67	12.6
Primary Language	English	192	36.2
	Spanish	229	42.2
	Vietnamese	13	2.5
	Other	32	6.0
	Unknown	64	12.1
At or Below 200% Federal Poverty Level		372	83.5

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by School Readiness Nursing Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	9,627	10,486
	Parents receive referrals regarding their child's health and developmental concerns	4,468	4,761
	Parents are linked to referred services for their child's health and developmental concerns	2,199	2,304
	Children receive vision screening	10,376	10,843
	Children receive hearing screening	9,668	10,386
	Children receive body composition and stature screening (height, weight, BMI)	9,539	9,855
	Children receive health status screening (e.g., asthma, allergies, etc.)	11,620	12,230
	Children receive comprehensive screening (Includes: vision, hearing, height, weight, health, and developmental milestones using PEDS or ASQ)	8,245	8,245
HC.3 Children have and use a regular place	Children are linked with health insurance enrollment	107	107
	Children are linked to a health care home	89	89

Strategic Plan Outcome	Service	Clients Served	Number of Services
for medical and dental care	Children receive primary care services (visit), including well child and sick visits	47	75
	Children receive a dental screening	9,404	9,473
HC.4 Children grow up healthy	Children screened for up to date immunizations	11,201	11,341
SF.2 Children are safe and well cared for	Office visits to improve parent knowledge of healthy child development	13,775	16,351
	Parents participate in parenting education classes/series on healthy child development	6,181	479
	Children receive health education classes	7,696	713
	Providers receive consultations to improve provider knowledge of healthy child development	814	1,087
CB.2 Increase access and efficiency, quality and effectiveness	Children with special needs served	1,269	1,269

Table 4. Service Outcomes (SOQs) for School Readiness Nursing Grantees

Key Strategic Plan Objectives	SOQ Results
Healthy Children	
• Increase to 100% the number of children with health coverage	• 98.5% of children served had dental insurance at the end of services (compared to 96.4% at the beginning of services)
• Increase to 100% the proportion of children who have a health care home	• 97.5% of children had a dental health home at the end of services (compared to 98.4% at the beginning of services)
• Increase age appropriate immunization levels to at least 95%	• 96.3% of children received all age appropriate immunizations at the end of services (compared to 95.3% at the beginning of services)

Program Highlights and Outcomes

During fiscal year 2014/15, the School Readiness Nurses met quarterly to support their on-going educational needs in order to maintain the expert focus they provide. Community resource information related to the services provided was presented at each meeting and integrated with the work of the School Readiness Nurses. The quarterly meetings focused on specific topics of interest, identified by the nurses to provide educational updates in support of the role that the nurses have as they provide guidance for the families they serve.

In order to provide expert care for the children and families that the School Readiness Nurses work with, the Best Practice Committee was created to provide current clinical updates that will support the services that the nurses provide. The Best Practice Committee meets quarterly to review the standards of care and the practices that exist in the school districts. In fiscal year 2014/15, the focus was on obesity and working with children in the school districts who have with a Body Mass Index greater than 95% and less than 5%. Follow-up and supportive care is provided for these children through education by Registered Dieticians who provide dietary recommendations for the family to utilize. One additional clinical focus has been vision screening for the preschool child with the advent of the PlusOptix Vision Screener that will provide technical support in the evaluation of children with vision concerns. With the support of Dr. Robert Lingua at the Gavin Herbert Eye Institute, the screening and referral criteria for the preschool-aged child have been reviewed. Based

on the use of new technology, the referral criteria are being revised to address the needs of the preschool child at an earlier age.

The role of the School Readiness Nurse continues to expand and provide important support for the children and families they serve and with clinical updates being provided by the community resources and with the clinical expertise of these resources, the needs of the children and families that the School Readiness Nurses serve are being met effectively.

School Readiness Nursing Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in children's health in Orange County through the support of the School Readiness Nursing. Still, several challenges remain, including gaps in the existing services available in the county, access to care for all children, the importance of immunization for all children in the county, and sustainability for the School Readiness Nursing initiative.

Gaps in Existing System

Gaps in services exist, such as mental health and developmental access to care for the preschool-aged child. Diagnosis at an early age is often not attained, which can delay and prevent access to services. The School Readiness Nurses continue to work with local pediatricians to support their role in the diagnosis of children at an earlier age so children can be eligible for and access services.

Immunization Rates

Immunization rates for children in the south part of Orange County are significantly lower than in other areas. The importance of vaccination compliance is a health concern as evidenced by the recent increase in the pertussis rates and concerns over other health care issues such as measles and polio, which continue to rise, creating significant concerns for the health of all children when immunization rates are lower in particular areas of the county. The California State Legislature recently passed Assembly Bill 2107, which removes the right of parents to refuse immunizations for their children based on personal beliefs. Children will not be allowed to attend public school if not fully immunized, which will protect the rights of other children who comply with the immunization requirements when entering school. The barrier to the immunization rates will continue to be a challenge for the nurses who work with parents that are impacted by this new requirement. Collaboration within the health care community will be essential in addressing this concern in the future.

Program Sustainability

The School Readiness Nurses continue to expand the services they provide annually in each school district, serving more children and families annually than initially anticipated through the funded positions. The expectations for the School Readiness Nurses have also expanded through new initiatives such as the expanded vision screening and providing the School Readiness Nurses as a resource to the Child Signature Program. As the scope of work has expanded, School Readiness Nurses continue to reprioritize to meet the needs of the children and families in the school districts. The importance of sustainability is a significant challenge that will need to be addressed through innovative funding resources and efforts to support this role in the future.

APPENDIX 7:

Nutrition and Fitness

FY 14/15

Children and Families Commission of Orange County Nutrition and Fitness Report

This program report describes the Commission's investments in children's nutrition and fitness, which includes two programs: Serving Kids Hope (formerly known as Dr. Riba's Health Club) and the Santa Ana Family YMCA. It documents the outcome of those investments, as well as barriers to providing young children with needed nutrition and fitness services.

Background

Nationwide, the increase in childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years. In line with national trends, one-third (32.8%) of Orange County children are overweight or obese.[1] Of the 32.8% of Orange County students with an unhealthy body composition in 2014, 15.6% were considered to be obese, while 17.2% were considered overweight.

Children who are overweight are more likely to become overweight or obese adults. A sedentary lifestyle and being overweight are among the primary risk factors for many chronic diseases and premature death. Research confirms that fitness, healthy eating and maintaining a healthy body weight can have positive impacts on both physical and mental health.

The Commission is committed to addressing the growing rate of obesity among very young children, particularly those in lower socio-economic communities. The 2012 *Healthy People, Healthy Places* Report cited research that has shown that access to parks and places for physical activity significantly increases the level of exercise[2].

Commission-funded Services in Orange County

The Serving Kids Hope program uses a multidisciplinary team that reaches underserved children from birth through age five to diagnose children who are obese. Serving Kids Hope provides medical care for obese children, helping to: stop the increase of excessive weight gain, normalize the velocity of growth and Body Mass Index (BMI) percentile, improve family feeding dynamics, increase physical fitness levels, and learn about proper nutrition and health issues.

The Santa Ana Family YMCA helps families build a commitment to fitness and maintain a healthy body weight by providing access to fitness and prevention through their Santa Ana facility, which includes modular units for services and programs, a soccer arena, a splash pool, community pool and the Olympic-sized joint use pool with Santa Ana Unified School District (contingent on a 30-year joint use agreement). The facility allows the agency to provide health, nutrition, physical fitness, pool safety, and community services to Santa Ana and residents of adjacent communities.

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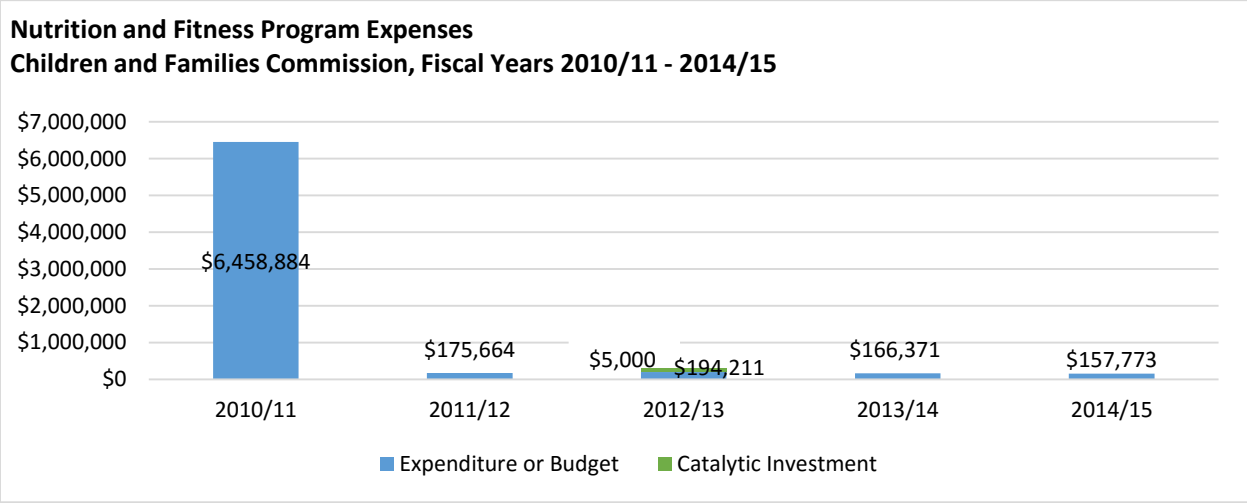
[1] Data are the combined results of 5th, 7th and 9th grade students taking the California Department of Education Fitnessgram.

[2] Research finds that youth without access to opportunities for physical activity during non-school hours are less likely to be as physically active as their peers, and at least one study shows that by increasing access to places for physical activity, youth not only have higher levels of activity but are less likely to be overweight or obese. Childhood Obesity, October 2012 Volume 8, Number 5, *The Role of Parks in Obesity Prevention and Improving the Public's Health.*

Additionally, the Commission promotes preventive nutrition and fitness throughout its programs. For example, by promoting breastfeeding as part of the Bridges Maternal Child Health Network services, and by ensuring that nutrition and fitness are included as key subject matter in educational resources provided by various Commission-funded programs to parents and providers of children's services.

Commission Investment

The Commission's investment in Nutrition and Fitness Services has been relatively consistent over the last five years, except for fiscal year 2010/11, which included an allocation of more than $6 million in catalytic expenditures to support the development of the Santa Ana Family YMCA. The Commission provided this up front catalytic funding to support the development of a new facility in Santa Ana that would continue to provide services for a minimum of 10 years without addition Commission financial support.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in nutrition and fitness programs produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Nutrition and Fitness

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	2,157	249	280
Number of services provided	14,370	1,722	288

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Nutrition and Fitness

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		177	100
Age at most recent interview	Under Three	30	16.9
	Three through Five	147	83.1
Ethnicity	Amer. Indian/Alaska Native	0	0.0
	Asian	5	2.8
	Black/African American	1	0.6
	Hispanic/Latino	152	84.4
	Pacific Islander	0	0.0
	White	10	5.6
	Vietnamese	0	0.0
	Multiracial	3	1.7
	Other	1	0.6
	Unknown	8	4.4
Primary Language	English	52	28.9
	Spanish	120	66.7
	Vietnamese	1	0.6
	Other	0	0.0
	Unknown	7	3.9
At or Below 200% Federal Poverty Level		130	84.8

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Nutrition and Fitness

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.4 Children grow up healthy	Children enrolled in multi-disciplinary weight loss and/or physical activities program	181	457
	Children receive nutrition and physical activity education	917	917
	Children participate in YMCA Aquatic Center programs	845	10,002
	Parents participate in YMCA Aquatic Center programs	236	1,709
	Children participate in YMCA sports programs	240	3,092
	Providers receive specialty care education	387	387
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	14	14
CB.1 Increase sustainability	YMCA will make available space for use by Commission grantees (days)	N/A	116
CB.2 Increase access and	Public information and outreach campaign to increase community awareness to promote access	N/A	1

Table 3. Services Provided by Nutrition and Fitness

Strategic Plan Outcome	Service	Clients Served	Number of Services
efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	8
	Technical assistance is provided, such as assistance with sustainability plans, evaluation activities, and providing quality services	7	15

Program Highlights and Outcomes

Children become overweight and obese for a variety of reasons. The most common causes are genetic factors, lack of physical activity, unhealthy eating patterns, or a combination of these factors. A child's total diet and activity level play an important role in determining a child's weight. The Commission's investments to promote fitness and nutrition have focused on prevention and treatment services for children that have a medical diagnosis of obese or at risk of being obese through Serving Kids Hope and promoting active play through our partnership with the Santa Ana Family YMCA.

Serving Kids Hope

Serving Kids Hope utilizes a multidisciplinary team that reaches 4,000 underserved children (from birth through age 18) annually, through a variety of services including but not limited to: education and outreach to preschools and other community providers that have a high degree of involvement with families who have children ages birth through age five; provider training on specific nutrition and fitness information; and direct treatment of children that are obese or at risk of obesity.

In fiscal year 2014/15, Serving Kids Hope provided clinic care to a total of 181 children from birth through age five with approximately 84% of those children decreasing or maintaining their Body Mass Index (BMI) whereby they were able to normalize their velocity of growth, lose weight, maintain weight, or normalize their weight. Other related outcomes include: improving family feeding dynamics, increase physical fitness levels, and learning about proper nutrition and health issues. Serving Kids Hope focuses on educating the whole family and using a multi-disciplinary approach so long term success is measured by registered dietitians, fitness trainers, and case managers who ensure that families are well-versed in the psychology of feeding, nutritional principles, and age appropriate activity levels. The team observes the families in action to ensure that they have put these principles into action before "graduating" a family from the program.

Santa Ana Family YMCA

In May 2008, the Commission approved $8.5 million in catalytic funding for an agreement with the YMCA to create and sustain physical fitness and obesity prevention/treatment services in Santa Ana. The site includes an aquatics center, an outdoor soccer arena and provides a home for Serving Kids Hope. The Santa Ana Family YMCA provided 9,810 services to 759 new children and 1,469 services to 214 parents/guardians including the following services:

- 543 new children participated in YMCA Aquatic Center programs including swim instruction and programming, representing 7,226 swim services (as calculated by number of children enrolled multiplied by frequency of classes)
- 214 new parents participated in YMCA Aquatic Center programs including swim instruction and programming, representing 1,469 services

- 216 new children participated in YMCA sports programs, representing 2,920 services (as calculated by number of children enrolled multiplied by number of activities by frequency of activities)

Nutrition and Fitness Program Challenges

No One Solution

No single action alone will reverse childhood obesity. Although there is no question that improving eating habits and increase physical activity are two critical strategies. Childhood Obesity requires comprehensive, multi-sectored approaches to address the many behavioral risk factors. These risk factors include the access to safe places to play (parks and playgrounds), affordability and access to healthy foods, eating and physical activity habits of family and friends.

STRONG FAMILIES

The following appendices document progress made on the Commission goal area of Strong Families. This includes two funding subcategories:

- Homeless Prevention
- Family Support Services

APPENDIX 8:

Homeless Prevention

FY 14/15

Children and Families Commission of Orange County Homeless Prevention Report

This program report describes the Commission's investments in the Homeless Prevention program and the outcome of those investments. It also documents the current state of homelessness and the Commission's actions, programs and recommendations to maintain a priority focus on this targeted and vulnerable population given the negative consequences for young children, if left unaddressed.

Background

According to the 2015 Point-in-Time count in Orange County, 31% of homeless adults reported having children under the age of 18.[1] The Orange County Department of Education identifies homeless children, and in the 2013/14 school year, there were 1,730 children living in an established shelter, 1,239 living in motels, and 241 living in their parent's vehicles or in parks or campgrounds.[2] In fiscal year 2014/15, there were 461 unduplicated households (including 1,523 unduplicated clients) with at least one child younger than age six served by emergency shelters, transitional housing, street outreach, or services and documented in the County's Homeless Management Information System. Although there are many paths to homelessness and not all homeless families fit the stereotype, the typical homeless family consists of a young single mother in her late twenties and two children, one or both usually younger than age six.[3] Lack of affordable housing, poverty and unemployment are the leading causes of homelessness for families with children.[4]

To improve outcomes for young children in the aforementioned areas and protect the health and safety of young children and their families, the Commission made it a priority to invest in shelter opportunities for families with very young children.

Commission-funded Services in Orange County

The Commission has identified homeless children as a strategic priority and has developed a close partnership with the County's homeless shelter providers and HomeAid Orange County.[5] To this end, the Commission has invested in capital (catalytic) and ongoing (operational) programs to provide direct services to homeless families with young children. Services include an emphasis on provision of basic needs such as food, shelter and clothing. In addition, the Commission places a special emphasis on providing services for high-risk pregnant women to achieve successful independent living and break the cycle of homelessness.

Shelter providers that receive Commission funding are required to provide mental health, supportive and other services, which are critical for successful outcomes. Many of the services are leveraged through Commission partners and in some cases are funded by other government resources (such as CalWorks, Social Services, Health Care Agency, and Department of Housing

[1] 2015 Orange County Point in Time Count
[2] Orange County Department of Education
[3] National Center on Family Homelessness. *The Characteristics and Needs of Families Experiencing Homelessness*. December 2011.
[4] The United States Conference of Mayors. *Hunger and Homelessness Survey*. December 2014. http://www.familyhomelessness.org/resources.php?p=sm
[5] HomeAid Orange County is a 501 (c) 3 charitable non-profit organization that builds and renovates shelters.

and Urban Development). These leveraging partnerships ensure maximization of Commission investments. Within the capital and ongoing funding models, the Commission is addressing a spectrum of services as follows:

- **Emergency Shelter**: length of stay is no longer than 90 days, with case management and support services to meet basic needs including but not limited to, clothing, food, and personal care items. This also includes augmented emergency services in conjunction with the County-funded Cold Weather Armory program to transition families into more stable housing. Currently one program is funded through an operational grant and four are catalytic (one of which is currently finishing construction).

- **Transitional Housing**: length of stay is up to 24 months with case management and support services to meet basic needs including but not limited to, clothing, food, and personal care items. Some providers are operating programs offering rapid re-housing, a strategy to provide financial assistance and services to prevent individuals and families from becoming homeless and help those who are experiencing homelessness to be quickly re-housed and stabilized.[6] Currently five programs are funded through operational grants and two are catalytic.

- **Case Management/Auxiliary Support Services:** one program, funded through an operational grant, provides case management and support services including linkages to help families identify and use a medical and dental home, and to connect them with the school district and/or appropriate childcare services.

Commission Investment

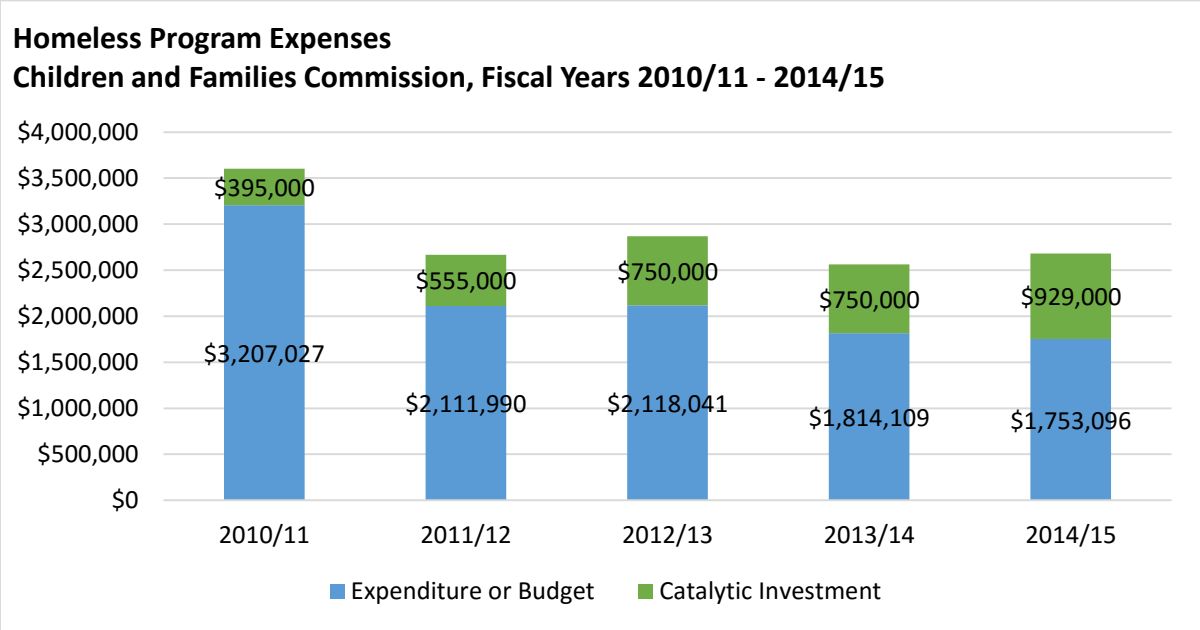
Since fiscal year 2010/11, the Commission has expended more than $11 million to support homeless prevention services in Orange County. An additional investment of $7 million in catalytic funding was approved in February 2012. Commission funding of homeless prevention services for families with children from birth through age five occurs through two primary strategies: operational and catalytic investments. Operational agreements provide ongoing support to improve the quality of supportive services to families. Catalytic investments are one-time funding projects designed to increase the capacity and infrastructure of the shelter system, which include the construction and/or operation of Emergency Shelter and Transitional Housing facilities throughout Orange County. Projects are identified in partnership with HomeAid Orange County and have been strong investments creating more than 400 transitional shelter beds for pregnant women and families with children ages five years and younger.

Following is a list of agencies currently funded through Commission investments in fiscal year 2014/15 (C* denotes catalytic funding):

- Casa Teresa- emergency shelter (C*) and transitional housing programs;
- Colette's Children's Home, Inc.- emergency shelter (C*) and transitional housing programs;
- Families Forward- transitional housing;
- Illumination Foundation- transitional housing;
- Laura's House- emergency shelter (C*);
- Mercy House Living Centers- emergency shelter;

[6] HUD.Gov/recovery

- Orange County Rescue Mission- transitional shelter (C*);
- Pathways of Hope- emergency shelter (C*) and transitional housing (C*);
- Precious Life Shelter- transitional shelter; and
- Visiting Nurses Association- case management/auxiliary support services.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in homeless prevention produced the following services for children ages birth through five years:

Table 1. Aggregate Data for Homeless Prevention

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	568	864	34
Number of services provided	40,782	72,716	175

*Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Homeless Prevention

Variable Considered	Category Label	Count	Percent
Total number of children with client-level data		450	100
Age at most recent interview	Under Three	249	55.3
	Three through Five	201	44.7
Ethnicity	Amer. Indian/Alaska Native	1	0.2
	Asian	4	0.9

	Black/African American	45	10.0
	Hispanic/Latino	277	68.0
	Pacific Islander	1	0.2
	White	116	25.8
	Vietnamese	0	0.0
	Multiracial	41	9.1
	Other	4	0.9
	Unknown	11	2.4
Primary Language	English	112	83.6
	Spanish	17	12.7
	Vietnamese	0	0.0
	Other	5	3.7
	Unknown	0	0.0
At or Below 200% Federal Poverty Level		449	93.1

Table 3. Services Provided by Homeless Prevention Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Parents receive informational materials regarding developmental milestones and development	121	737
HC.3 Children have and use a regular place for medical and dental care	Children are linked with health insurance enrollment	32	58
	Children are linked to a health care home	49	78
SF.1 Families are stably housed	Children receive emergency or transitional shelter (bed nights)	493	40,180
	Family members emergency or transitional shelter (bed nights)	817	56,038
	Parents receive weekly case management services	350	6,981
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	187	2,142
EL.1 Children have the developmental skills to be proficient learners in school	Parents participate in a program designed to increase the frequency of reading at home	92	853
	Children participate in a program designed to increase the frequency of reading at home	5	178
	Dollar amount raised	N/A	$385

Table 3. Services Provided by Homeless Prevention Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
CB.1 Increase sustainability	Dollar amount received by leveraging Commission dollars	N/A	$10,105
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	20

Table 4. Service Outcomes (SOQs) for Homeless Prevention Grantees

Key Strategic Plan Objectives	SOQ Results
Strong Families	
• Reduce the number of children who are homeless to zero	• 63.1% of children were unstably housed or at risk for homelessness at the end of services (compared to 97.4% at beginning of services)
• Reduce the number of children who are homeless to zero	• 56.2% of children 3 or older were attending school on a regular basis or most of the time at the end of services (compared to 35.8% at the beginning of services)

Program Highlights and Outcomes

The investment in Homeless Prevention is having an impact in several areas including increased capacity of the county's homeless system of care through additional beds and access to services to meet the needs of families with young children. While these successes are significant, legislation known as the HEARTH Act[7], and a subsequent plan[8] outline the federal strategy to prevent and end homelessness.

In Orange County, a 17-member advisory group makes up the Orange County's Commission to End Homelessness (previously Ending Homelessness 2020). The group's purpose is to provide strategic leadership to promote best practices, monitor outcomes, and report results on the success of the county's Ten-Year Plan to End Homelessness.[9] Commission staff has taken an active role in the local planning efforts through participation in the Commission to End Homelessness. This participation provides an opportunity to give a voice to the needs of the Commission's target population. In addition it provides access to the most current data and federal requirements to inform funding priorities to better align with federal standards.

[7] Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, passed in 2009, mandating strategies to end homelessness for federally funded entities providing homeless prevention services.

[8] United States Interagency Council on Homelessness. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.* 2010, Amended 2015.

[9] County of Orange, California. Ten Year Plan to End Homelessness. 2012. http://www.ocpartnership.net/images/website/1064/files/final_ten-year_plan_2012_445.pdf

Homeless Prevention Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in meeting children's basic needs including additional access to quality shelter programs preparing families to succeed in independent living. Still, several challenges remain, from assessing the issue of homelessness among children and families to access to affordable housing.

High Cost Of Living

The high cost of living, including affordable housing options, continues to be a significant barrier for Orange County families. The 2013 Family Financial Stability Index indicates that 41% of Orange County neighborhoods have a high concentration of families that are financially unstable, based on income, employment, and housing expenses.[10] When looking specifically at the numbers impacting the Commission's target population, 33% of children ages five and younger were identified as living in poverty.[11] Similarly, the county has been described as "job rich" and "housing poor" in reference to the decline in unemployment to pre-recession rates in contrast to the "dearth of affordable housing" as many families are being priced out of the market.[12] As a result many families are either seeking shelter services or getting "missed" in the count due to "doubling" or "tripling" up with other friends or family members.

Unique Needs of Pregnant/Parenting Women

Most definitions of "homeless children" are grounded in one of two primary Federal definitions: the Department of Housing and Urban Development (HUD) definition[13] and the Department of Education's definition[14] that is mandated by the McKinney-Vento Homeless Assistance Act, Title X, Part C. There are some limitations to these definitions, which do not fully represent the needs and unique challenges of pregnant and parenting women. Research using data culled from over 11,000 families applying for shelter found that certain characteristics put families at a higher risk of having to enter a shelter including but not limited to the following: female-headed household, pregnancy, child under two years old, history of public assistance, eviction threat, among other factors.[15] With the additional stressors faced by parents of young children, this population may require additional support systems or increased lengths of stay. This is an area where Commission staff and funded programs can contribute to the discussion and decision making efforts impacting program design.

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[10] County of Orange. OC Indicators Report. 2015. http://ocgov.com/civicax/filebank/blobdload.aspx?BlobID=45210
[11] Public Policy Institute of California. www.pppic.org
[12] *Ibid.*
[13] Definition mandated by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.
[14] See footnote 2.
[15] Shinn, M., & Greer, A. (2012). Targeting Homelessness Prevention Services More Effectively: Introducing a Screener for Home Base.

APPENDIX 9:

Family Support Services

FY 14/15

Children and Families Commission of Orange County Family Support Services Report

This program report describes the Commission's investments in family support services, which include Family Support Network, the Early Childhood System of Care, the Child Guidance Center, and Fullerton Joint Union High School District. It documents the outcome of those investments, as well as barriers to young children receiving developmental screenings and early intervention as needed.

Background

The primary focus of family support services is providing children with developmental screenings and early intervention through linkages to needed services identified through those screenings. Early intervention is a strategy for prevention as well as for maximizing a child's developmental trajectory. With intervention at birth or soon after the diagnosis of a disability or high risk factors, the developmental gains are greater and the likelihood of developing problems is reduced.[1] Further, early identification of developmental concerns and intervention promotes school readiness and healthy development.

Commission-funded Services in Orange County

Programs funded by the Commission that provide developmental screenings and linkage to services including the Family Support Network and the Early Childhood System of Care.

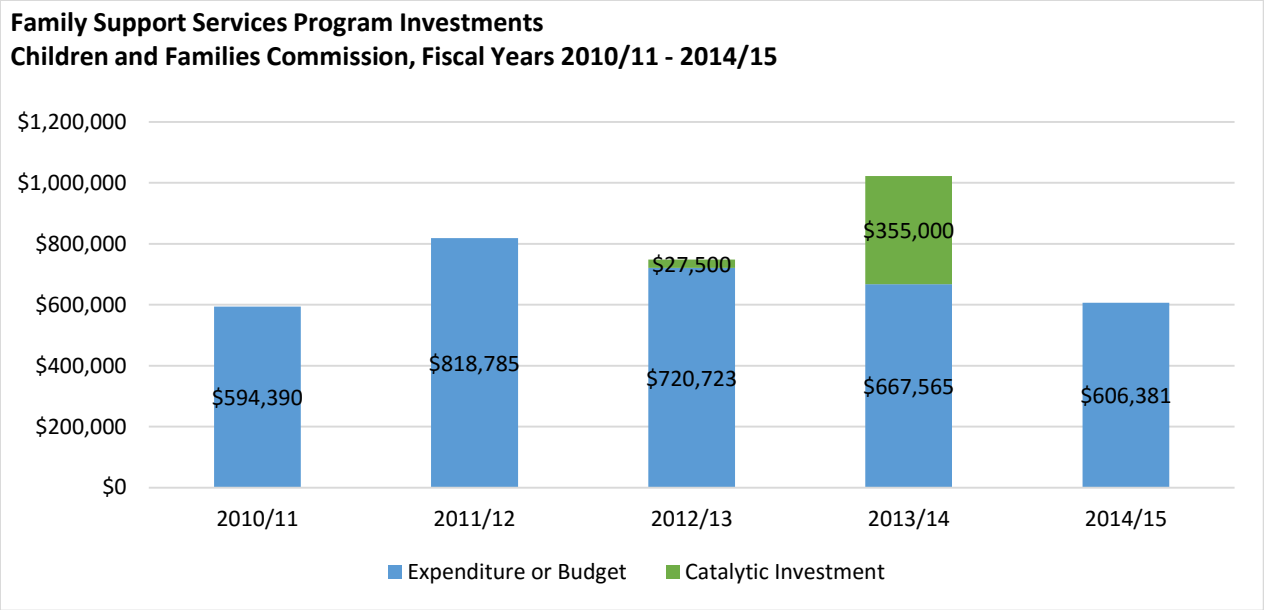
The Family Support Network provides comprehensive developmental and behavioral screening for children birth through age five at various Orange County sites in order to identify children with symptoms of developmental, cognitive or speech delays, and/or lack of healthcare coverage. Based on the screening results, Family Support Network refers children for further evaluation, intervention, and linkage to care.

The Early Childhood System of Care program is jointly funded by the Commission and the Orange County Social Services Agency to address the health and development needs of the children birth through age five entering the child welfare system. Public Health Nurses provide intensive case management to ensure that children receive developmental screenings and have access to primary care providers, primary dental services, and linkages to other community resources to maximize their potential.

[1] Cooper, J. H. (1981). "An Early Childhood Special Education Primer". Chapel Hill, NC: Technical Assistance Development System (TADS); Garland, C., N. W. Stone, J. Swanson, and G. Woodruff, eds. (1981). "Early Intervention for Children with Special Needs and their Families: Findings and Recommendations". Westar Series Paper No. 11. Seattle, WA: University of Washington. ED 207-278; Maisto, A. A., and M. L. German. (1979). "Variables Related to Progress in a Parent-Infant Training Program for High-Risk Infants." Journal of Pediatric Psychology 4: 409-419; Strain, P. S., C. C. Young, and J. Horowitz. (1981). "Generalized Behavior Change During Oppositional Child Training: An Examination of Child and Family Demographic Variables." Behavior Modification 1: 15-26.

Commission Investment

The Commission's investment in Family Support Services has been relatively consistent over the last five years with a high in fiscal year 2011/12 of $818,785 to a low in fiscal year 2010/11. The Commission allocated $5,500,000 in one time catalytic funding in 2012 to continue to support community-based developmental/behavioral screening and linkage to services. It is anticipated that the majority of that funding will be expended in the next two fiscal years and will result in continued services for a minimum of five years after.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in family support services programs produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Family Support Services Program Grants

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	2,562	2,706	7
Number of services provided	8,092	12,429	146

*Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Family Support Services

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		603	100
Age at most recent interview	Under Three	292	48.4
	Three through Five	311	51.6

Ethnicity	Amer. Indian/Alaska Native	1	0.2
	Asian	46	7.6
	Black/African American	10	1.7
	Hispanic/Latino	412	68.0
	Pacific Islander	0	0.0
	White	46	11.2
	Vietnamese	7	1.2
	Multiracial	50	8.3
	Other	6	1.0
	Unknown	28	4.6
Primary Language	English	280	46.2
	Spanish	254	41.9
	Vietnamese	6	1.0
	Other	25	4.1
	Unknown	41	6.8
At or Below 200% Federal Poverty Level		436	81.0

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Family Support Services

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.1 Children are born healthy	Classes to support healthy pregnancy	8	186
	Pregnant women receive support for healthy pregnancy and early childhood health	69	69
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	496	529
	Parents receive education, resources, referrals, and support regarding their child's development	550	6,486
	Children receive behavior health screening using Commission-approved tool	943	945
	Children receive comprehensive screening (Includes: vision, hearing, height, weight, health, and developmental milestones using PEDS or ASQ)	1,152	1,152
	Children are linked to a health care home	106	106
HC.3 Children have and use a regular place for medical and dental care	Children are linked to a dental home	127	127
	Children screened for up to date immunizations	40	205
SF.2 Children are safe and well cared for	Parents receive training about preventable injuries and deaths	31	235
	Office visits to improve parent knowledge of healthy child development	102	659

Strategic Plan Outcome	Service	Clients Served	Number of Services
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	1,080	1,802
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Children receive behavioral health treatment services	44	250
	Providers receive training on behavioral health treatment services for children 0-5	7	7
	Parents receive education, resources, referrals, and support regarding their child's behavioral health issues	217	1,091
	Parents receive behavioral health screening	90	90
CB.1 Increase sustainability	Dollar amount raised	N/A	$933,500
	Dollar amount received by leveraging Commission dollars	N/A	$251,816
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	3
	Children with special needs served	890	890
	Provide transportation to parents to health or social services	25	143
	Provide transportation to children 0-5 to health or social services	18	109
	Provide specialized child care to children 0-5	5	130

Program Highlights and Outcomes

A key outcome sought by the Commission is that children receive early screening, and when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkages to services as appropriate. In support of this outcome, the Commission data collection and reporting system tracks key data from all Commission-funded programs, including data on the number of children receiving developmental screening using an American Academy of Pediatrics recommended tools, provider trainings on screenings, assessment and identification of child developmental milestones, provider education, parent support, and referrals/linkages to services.

In fiscal year 2014/15, Family Support Network provided a total of 945 behavioral health screenings using an approved tool and 1,045 children received a comprehensive screening (including vision, hearing, height, weight, health dental, and developmental). Family Support Network provided 581 families over 1,000 referrals for additional services and followed up with parent to ensure they connected with community resources and services and provided 165 parents with education and resources regarding their child's behavioral health issues.

The Early Childhood System of Care services provided are followed by nursing services utilizing a case management model. The outcomes for fiscal year 2014/15 indicate that more children and families were served:

- 468 children were screened for developmental concerns, a 13% increase from the previous year;
- 547 parents were referred for developmental assessment of their children to the Early Developmental Assessment Center, Regional Center of Orange County, Help Me Grow,

Child Guidance Services, the school districts, and Head Start. This is an increase of 7% over the previous fiscal year;

- 106 children were referred for medical home coverage, which was similar to the previous fiscal year; and
- 127 children were referred for dental home coverage to community resources such as CalOptima & DentiCal services, which is a 22% increase in referrals from the previous fiscal year.

Also, in fiscal year 2014/15, staffing was increased to provide additional follow-up with parents receiving Early Childhood System of Care services. Missed appointments were decreased and 89%-92% of all appointments were completed with the additional staffing provided.

Family Support Services Challenges

Proposition 10 funding, allocated by the Commission, is working to provide developmental screenings and linkages to services for children in Orange County. Still, challenges remain from ensuring developmental and behavioral screenings and linkages occur, to lack of a uniform database to the need for more medical providers conducting screenings.

Implementing Developmental and Behavioral Screenings and Linkage to Services for Special Populations

California still lags in providing developmental and behavioral screenings for the more than three million children from birth through age five. This is particularly the case with at-risk populations, including children in the foster care system, infants participating in neonatal follow-up programs, infants and toddlers with special health care needs, and children in need of special education support.

No Uniform Database or Required Reporting

Developmental screenings are not required reporting by health or school systems, and there is no common or uniform database for reporting. Thus it is challenging to know what percentage of the children received a developmental screen or what percentage connected with services comprehensively. This makes it difficult to understand the return on investment and impact of early interventions to children's long-term outcomes.

Need to Increase Screenings by Medical Providers

A significant challenge identified is the need to increase the number of physicians conducting screenings using a validated tool.

EARLY LEARNING

The following appendices document progress made on the Commission goal area of Early Learning. This includes four funding subcategories:

- Early Learning Specialist
- Early Literacy
- CARES Plus and Child Signature Programs Other Early Learning Programs
- Other Early Learning Programs

APPENDIX 10:
Early Learning Specialists
FY 14/15

Children and Families Commission of Orange County Early Learning Specialists Program Report

This program report describes the Commission's investments in the Early Learning Specialists program and the outcome of those investments. It also documents barriers to young children receiving quality early care and education opportunities and Commission's actions, programs and recommendations to maximize the child's potential for success in school for all Orange County children.

Background

Since 2000, the Commission has partnered with the 24 school districts in Orange County that provide kindergarten to fund and hire Early Learning Specialists. School districts receive funding based on their kindergarten population to support up to two Early Learning Specialist positions that provide early care and education opportunities to meet early childhood development needs in their school district and connect families with community resources.

The Early Learning Specialists also develop strategies for program sustainability, including multi-faceted approaches such as internal cost reductions and program efficiencies, implementation of fee-for-service models, and active exploration of federal and state revenue sources, such as the new Local Control Funding Formula and including early learning in their school district's Local Control Accountability Plan.

Participating school districts:

1. Anaheim City
2. Brea Olinda
3. Buena Park
4. Capistrano
5. Centralia
6. Cypress
7. Fountain Valley
8. Fullerton
9. Garden Grove
10. Huntington Beach City
11. Irvine
12. Laguna Beach
13. La Habra/Lowell Joint
14. Los Alamitos
15. Magnolia
16. Newport Mesa
17. Ocean View
18. Orange
19. Placentia-Yorba Linda
20. Saddleback Valley
21. Santa Ana
22. Savanna
23. Tustin
24. Westminster

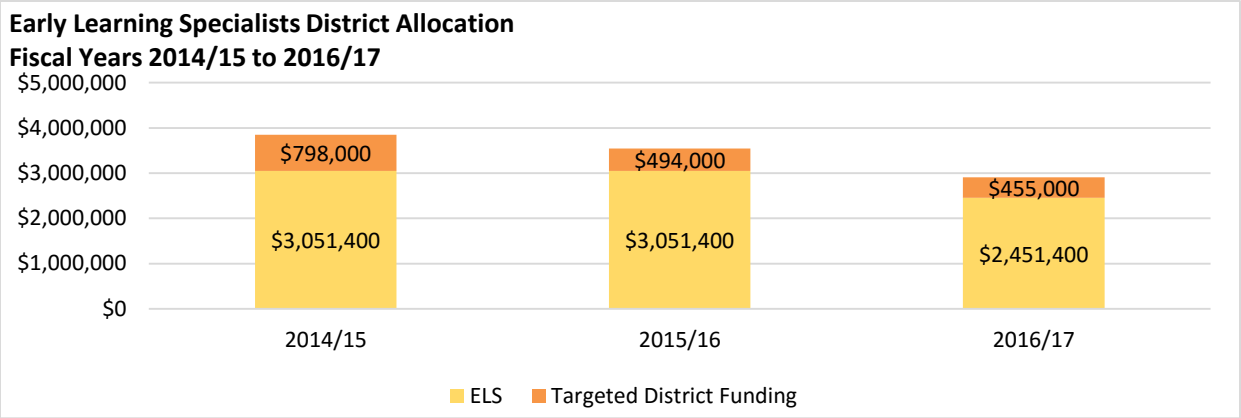
Commission-funded Services in Orange County

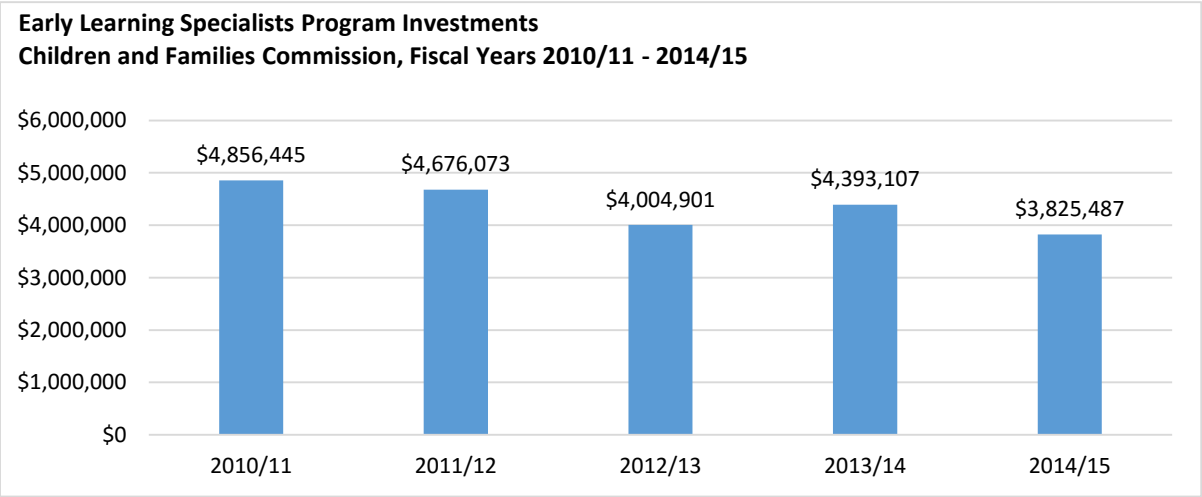
School district based early learning programs have received Commission funding since fiscal year 2000/01 with over $86 million invested in school readiness programs through the Early Learning Specialists, Capacity Building Programs, and competitive funding cycles.

Commission Investment

In February 2014, the Commission approved a three-year agreement to fund school districts with a kindergarten population through June 2017. The 24 eligible school districts received funding for a part-time, full-time or two full-time Early Learning Specialist positions, based on their district's kindergarten enrollment. A full-time equivalent position is funded at $87,500 annually. In addition, eight school districts that are performing below the county average in math and/or reading based on

second-grade proficiency scores received an additional one-time allocation of $150,000 to meet unique district needs for early learning expansion.





The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in Early Learning Specialists produced the following services and outcomes for children ages birth through five:

Table 1. Aggregate Data for Early Learning Specialist

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	14,084	15,223	1,628
Number of services provided	1,276,106	356,962	2,379

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Early Learning Specialist Programs

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		556	100
Age at most recent interview	Under Three	95	17.1
	Three through Five	461	82.9
Ethnicity	Amer. Indian/Alaska Native	1	0.2
	Asian	33	5.9
	Black/African American	3	0.5
	Hispanic/Latino	410	73.1
	Pacific Islander	1	0.2
	White	58	10.3
	Vietnamese	15	2.7
	Multiracial	21	3.7
	Other	9	1.6
	Unknown	10	1.8
Primary Language	English	166	29.6
	Spanish	349	62.2
	Vietnamese	15	2.7
	Other	22	3.9
	Unknown	9	1.6
At or Below 200% Federal Poverty Level		391	83.3

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Early Learning Specialist Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Providers are educated to increase awareness and identification of behavioral health issues	734	233
EL.1 Children have the developmental skills to be proficient learners in school	Parents participate in a program designed to increase the frequency of reading at home	10,096	356,110
	Children participate in a program designed to increase the frequency of reading at home	10,746	410,445
	Books distributed to children	N/A	42,672
	New and used books collected for distribution	N/A	45,943
	Children participate in early math programs	9,226	872,298
	Parents receive speech and language services (classes)	1,190	1,045
	Providers will conduct classroom assessments using an established tool such as ECERS or ELLCO	418	418
	Providers are given resources and early intervention strategies for appropriate early care	611	1,747

Strategic Plan Outcome	Service	Clients Served	Number of Services
	Parents participate in a drop-in, family-focused early learning program (i.e., Learning Link)	3,442	52,332
	Children participate in a drop-in, family-focused early learning program (i.e., Learning Link)	3,406	55,469
EL.2 Schools are ready for children when they enter kindergarten	Children visit Kindergarten classrooms prior to start of school year	7,392	7,392
	Children's health and development records are transferred to their elementary school prior to entering kindergarten	4,858	4,858
EL.3 Parents have the supports that contribute to children's readiness for school success	Parents receive tools, resources, information and/or training needed to transition their child to school	19,911	54,098
CB.1 Increase sustainability	Dollar amount raised	N/A	$7,829,829
	CSP match dollars submitted	N/A	$847,808
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	434
	Providers receive trainings to build the capacity of the agency to increase quality services	1,386	406

Table 4. Service Outcomes (SOQs) for Early Learning Specialists

Key Strategic Plan Objectives	SOQ Results
Early Learning	
• 75% of typically developing children are effective learners in literacy	• 26.2% of children knew none of the alphabet letters by name at the beginning of services compared to only 6.2% at the end of services
• 75% of typically developing children are effective learners in literacy	• 94.7% of children could identify his or her written name at the end of services, compared to only 65.5% at the beginning of services
• 75% of typically developing children are effective learners in literacy	• 99.4% of children had familiarity with books at the end of services, compared to 86.3% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 90.8% of children could count a group of three to five objects by touching each object at the end of services, compared to 72.5% at the beginning of services.
• 80% of typically developing children are effective learners in numeracy	• 95.0% of children could correctly name at least two shapes at the end of services, compared to only 77.4% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 84.6% of children could recite at least five numbers in order at the end of services, compared to only 54.0% at the beginning of services

Key Strategic Plan Objectives	SOQ Results
• 75% of typically developing children are socially competent	• 97.3% of children could follow simple two-step oral directions at the end of services, compared to 90.0% at the beginning of services
• 75% of typically developing children are socially competent	• 95.9% of children cooperated with the daily classroom routine most of the time at the end of services, compared to 90.1% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 71.5% of parents taught their children letters, numbers, or words at least three times in the prior week at the end of services, compared to 65.3% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 87.8% of parents played with toys or games indoors at least three times in the prior week at the end of services, compared to 80.4% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 71.4% of parents went on outings with their child at least three times in the prior week at the end of services, compared to 57.1% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 91.1% of parents talked with their child about daily activities at the end of services, compared to 83.2% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 73.6% of parents played, games, sports or exercised with their child at least three times in the prior week at the end of services, compared to 60.3% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 93.2% of parents felt they had sufficient information and support for their child to attend Kindergarten at the end of services, compared to 89.0% at the beginning of services

Program Highlights and Outcomes

The investment in the Early Learning Specialists program supports the strategic plan outcomes to:

- Increase availability and access to quality early care and education;
- Increase school readiness for children with special needs;
- Increase caregiver (parent and provider) knowledge and skills to promote children's readiness for school; and
- Improve transitions of children from preschool to kindergarten.

Increased Early Care and Education Availability

The long-term partnership with school districts to fund Early Learning Specialists continues to build the capacity of organizations that help disadvantaged parents to become first teachers for their children. In an effort to sustain program efforts as well as increase capacity, in fiscal year 2014/15, Orange County was awarded over $3.5 million in ongoing state preschool funding to serve approximately 500 children in all-inclusive full-day and part-day programs. This funding was secured mostly though the work of the Early Learning Specialists and will provide additional program options to children with special needs.

Increased Early Care and Education Provider Training

Through the work of the Early Learning Specialists, the quality of district-operated programs has increased. Individualized coaching sessions are provided to instructional staff, such as preschool and teachers' aides, and coordinated by the Early Learning Specialists. Feedback from the coaching sessions assists in planning more intentional instruction. In fiscal year 2014/15, 1,368 early care providers received specialized training to increase their adult-child interactions as well as early intervention strategies.

Increased Parent and Caregiver Knowledge and Skills

The Early Learning Specialists provided parents with resources through one-on one-parent meetings, group workshops, and family nights to assist parents in their understanding of the important part they play in their child's education. In fiscal year 2014/15, 19,911 parents received tools, resources, information and/or training needed to transition their child to school. In addition, 1,190 parents received specialized speech and language classes to gain more in-depth knowledge and understanding of the importance of language and literacy.

Increased Transition of Children from Preschool to Kindergarten

Eight school districts performing below the Orange County average in reading and math received an additional allocation supporting the goal to invest in select geographies in partnership with other funders and community organizations to demonstrate the power of holistic supports for disadvantaged children and families on the early learning outcomes of children. The Early Learning Specialists in these eight districts have been able to provide services that are more specialized to young children and parents in an effort to provide a smoother transition to kindergarten.

More School Districts are Implementing Learning Link Programs

The Early Learning Specialist at the Capistrano Unified School District began the first Learning Link Program in 2002, which has been replicated in 15 school districts throughout Orange County. The goal of Learning Link is to provide an accessible and creative learning environment to help young children become better prepared for kindergarten and guides parents in their role as their children's first teachers. Learning Link is an interactive place for parents to bond with their children and to support their growth across a range of disciplines, including early education, language development, health and wellness, and family support.

Learning Link programs offer various, hands-on academic learning opportunities and educational activities for children, which align with the latest research on early care and education and the California Preschool Learning Foundations. The Learning Link sites provide an engaging environment where teachers and specialists model skills and promote parent-child interaction and bonding. At these sites children are screened, suspected developmental delays are identified, and referrals are made to appropriate agencies for further evaluation and intervention, as necessary. Parents and children visit Learning Link sites together and interact with professional staff, including early education resource teachers and nurses, case managers, speech pathologists, and community liaisons. More than 3,400 parents and 3,400 children were served by the Learning Link program in fiscal year 2014/15 with over 55,000 services provided.

Vignette: Excerpt of Letter from a Learning Link Parent

"I have taken my boys (ages 1.5 and 4.5) to Learning Link about 4 or 5 times this spring and each time we have enjoyed it thoroughly. [The Early Learning Specialist (ELS)] has created a fantastic learning space. As a homeschooling parent, I was greatly inspired by how to set up stations and create spaces for children to have hands-on experiences to improve their knowledge and stretch

their imaginations…The atmosphere was peaceful yet fun (even with as many as 10 kids and their parents in there at once!) due to [the ELS's] efforts in setting it up appropriately ahead of time, and her efforts to keep things clean as the morning progressed. At any time of the morning, you'll find [the ELS] engaging with the children, showing them how to use the toys and resources, or talking with parents about how they can help their children at home. We made a 25-minute drive to be there, but it was worth it each time."

Early Learning Specialist Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in children's lives in Orange County. Still, several challenges remain, from the lack of availability and access to quality early care and education programs to low reimbursement rates for services to the increasing need for program design options that include services to children with special needs.

Lack of Availability and Access to Quality Child Care and Education Programs

Although there has been an increase from 13 to 18 school districts that provide state-funded preschool, many districts do not have the space to provide more services to families. With the addition of transitional kindergarten within the kindergarten through 12th grade instruction system, Early Learning Specialists are challenged to find space to house early learning programs within school district facilities.

Furthermore, the current maximum income requirements for families to qualify for state-funded programs are a barrier for families that make slightly more than the state guidelines. With parents working to meet the high cost of living in Orange County, the state's guidelines eliminate many families from qualifying for subsidized programs.

Lack of Services to Special Need Children

Access to preschool services for children with special needs has become an increasing barrier for school districts. District operated special education preschool programs are being redesigned to provide a more inclusive, universal approach for children rather than an exclusive special day class. Learning is not a single strategy that will accommodate everyone; rather, it refers to providing multiple approaches to learning in order to meet the needs of diverse learners. Funding to incorporate these methods and services is limited or non-existent.

APPENDIX 11:
Early Literacy
FY 14/15

Children and Families Commission of Orange County Early Literacy Programs Report

This program report describes the Commission's investments in early literacy programs for young children, as well as the impact of those investments. It also documents policy recommendations for improving early literacy outcomes for all Orange County children.

Background

Early literacy and math skills lay the foundation for children's success in school. An analysis of six longitudinal studies showed the strongest predictors of later achievement in school are school-entry math, reading, and attention skills.[1] Yet there are many children in Orange County who start kindergarten behind. This gap in early learning skills is exacerbated by poverty. By the time children from low-income families enter kindergarten, they are typically 12-14 months below national norms in language and pre-reading skills.[2] Children who are not proficient readers by the end of third grade are four times more likely to leave school without a diploma than proficient readers.[3] These high school dropouts earn approximately $10,000 a year less than graduates,[4] and cost society an estimated $292,000 over their lifetime.[5]

To help Orange County's children enter kindergarten ready to learn and start them on the best possible trajectory for success in school and in life, the Commission invests in early literacy and math programs to develop young children's learning skills. To address achievement gap that exists in Orange County, programs are focused on reaching children and families in high need communities.

Commission-funded Services in Orange County

The Commission funds two programs to promote early literacy and math that supports children's early learning and school readiness. The Early Literacy and Math Program provides direct services to children, parent engagement and education, and provider training. Key program elements include:

- A center-based early literacy and math program where children and their parents attend twice a week for 15 weeks, and uses evidence based curriculum (High Scope);
- Raising a Reader book bags;
- Waiting room readers/gently used books to support Reach Out and Read;
- Read for the Record and other community events;
- Book Bank (gently used book collection and distribution); and
- Early Childhood STEM conference for early educators' professional development.

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[1] Duncan GJ, Dowsett CJ, Claessens A, Magnuson K, Huston AC, Klebanov P, Pagani LS, Feinstein L, Engel M, Brooks-Gunn J, Sexton H, Duckworth K, Japel C. (2007). "School readiness and later achievement." Developmental Psychology 43.06: 1428-46. Web. 6 Sept. 2015.

[2] The Council of Chief State School Officers. (2009). "A Quiet Crisis: The Urgent Need to Build Early Childhood Systems and Quality Programs for Children Birth to Age Five." Web. 6 Sept. 2015.

[3] Hernandez DJ. (2012). "Double Jeopardy: How Third-Grade reading skills and Poverty Influence High School Graduation." The Annie E. Casey Foundation. Web. 6 Sept. 2015.

[4] http://www.census.gov/compendia/statab/2012/tables/12s0232.pdf

[5] Sum A, KhatiwadaI, McLaughlin J. (2009). "The Consequences of Dropping Out of High School." Northeastern University.

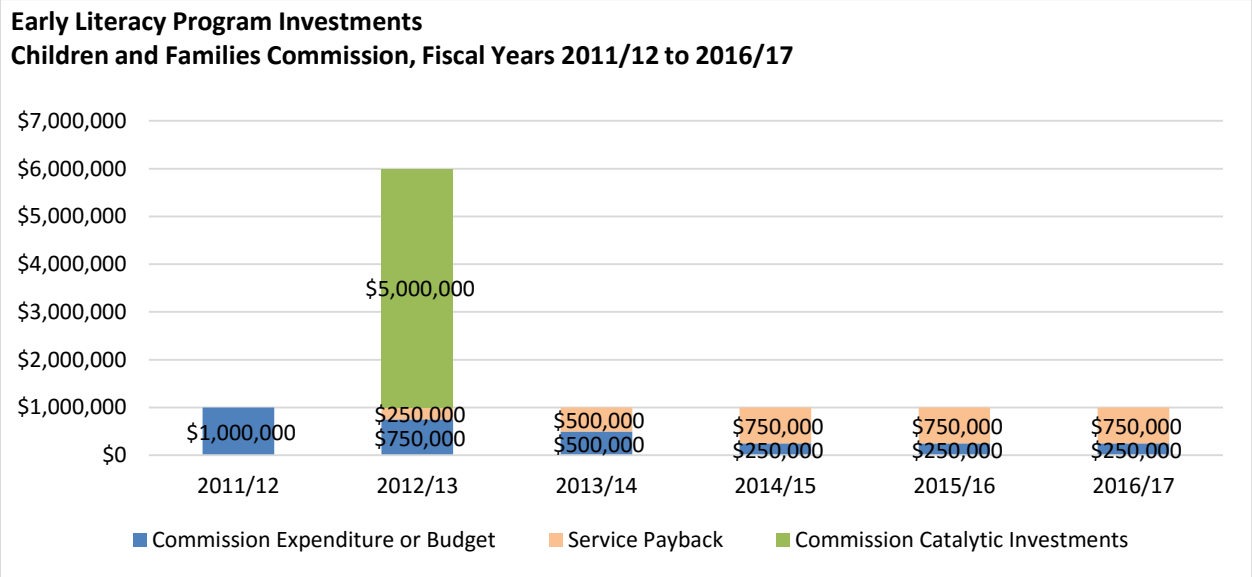
Additionally, the Commission, along with the United Way of Orange County, spearheads a collaborative effort called Champions for Children's Literacy. This collaborative's vision is to ensure Orange County's children are reading proficiently at grade level by third grade. Their goals include raising awareness of the importance of early literacy and raising funds to sustain implementation of early literacy programs.

Commission Investment

The Early Literacy and Math Program is funded at $1 million annually. In fiscal year 2011/12, THINK Together began managing the Early Literacy Program, and the Commission awarded $1 million in operating funds to THINK Together for this purpose. Prior to this, the Commission supported these programs in-house and with consultant support.

In fiscal year 2012/13, the program was expanded to include mathematics in addition to literacy. Also in fiscal year 2012/13, THINK Together received a $5 million catalytic grant from the Commission. Their service payback on that catalytic award began in fiscal year 2012/13, with Commission direct operating funds decreasing each year until fiscal year 2014/15, when the Commission's contribution rested at $250,000 (total program budget remains at $1 million). The service payback goes through 2022, with the Commission's operational support of $250,000/year dependent on renewal of agreements over that time frame. The current agreement goes through 2016/17.

In fiscal year 2014/15, the Commission set aside funds to match Orange County United Way dollars in order to hire a consultant to manage the Champions for Children's Literacy collaborative.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in early literacy programs produced the following services for children ages birth through five:

Table 1. Aggregate Data for Early Literacy

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	42,899	19,153	35
Number of services provided	166,798	48,292	60

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Early Literacy Programs

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		142	100
Age at most recent interview	Under Three	16	11.3
	Three through Five	126	87.7
Ethnicity	Amer. Indian/Alaska Native	1	0.7
	Asian	18	12.7
	Black/African American	1	0.7
	Hispanic/Latino	89	62.7
	Pacific Islander	1	0.7
	White	14	9.9
	Vietnamese	6	4.2
	Multiracial	7	4.9
	Other	4	2.8
	Unknown	1	0.7
Primary Language	English	64	45.1
	Spanish	63	44.4
	Vietnamese	3	2.1
	Other	11	7.7
	Unknown	1	0.7
At or Below 200% Federal Poverty Level		107	69.6

[1] The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Early Literacy Grantees

Strategic Plan Outcome	Service	Clients Served	Number of Services
EL.1 Children have the developmental skills to be proficient learners in school	Children read to at physicians' offices or clinics	11,563	863
	Parents participate in a program designed to increase the frequency of reading at home	2,177	39,304
	Children participate in a program designed to increase the frequency of reading at home	30,783	67,910
	Parents receive literacy information/assistance in waiting rooms or community events	17,415	9,434
	Books distributed to children	N/A	90,871
	New and used books collected for distribution	N/A	90,159

Strategic Plan Outcome	Service	Clients Served	Number of Services
	Providers are given resources and early intervention strategies for appropriate early care	25	29
	Children receive center-based early care and education services other than preschool	543	9,050
EL.3 Parents have the supports that contribute to children's readiness for school success	Parents receive tools, resources, information and/or training needed to transition their child to school	508	941
CB.1 Increase sustainability	Number of volunteers recruited	1,571	N/A
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	28
	Provider trainings to build the capacity of the agency to increase quality services	22	27

Table 4. Service Outcomes (SOQs) for Early Literacy Programs

Key Strategic Plan Objectives	SOQ Results
Early Learning	
• 75% of typically developing children are effective learners in literacy	• 13.3% of children knew none of the alphabet letters by name at the beginning of services compared to only 2.2% at the end of services
• 75% of typically developing children are effective learners in literacy	• 97.7% of children could identify his or her written name at the end of services, compared to only 68.1% at the beginning of services
• 75% of typically developing children are effective learners in literacy	• 96.3% of children had familiarity with books at the end of services, compared to 89.0% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 99.2% of children could count a group of three to five objects by touching each object at the end of services, compared to 86.8% at the beginning of services.
• 80% of typically developing children are effective learners in numeracy	• 98.5% of children could correctly name at least two shapes at the end of services, compared to only 80.2% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 86.6% of children could recite more than five numbers in order at the end of services, compared to only 66.7% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 82.6% of parents taught their children letters, numbers, or words at least three times in the prior week at the end of services, compared to 54.1% at the beginning of services

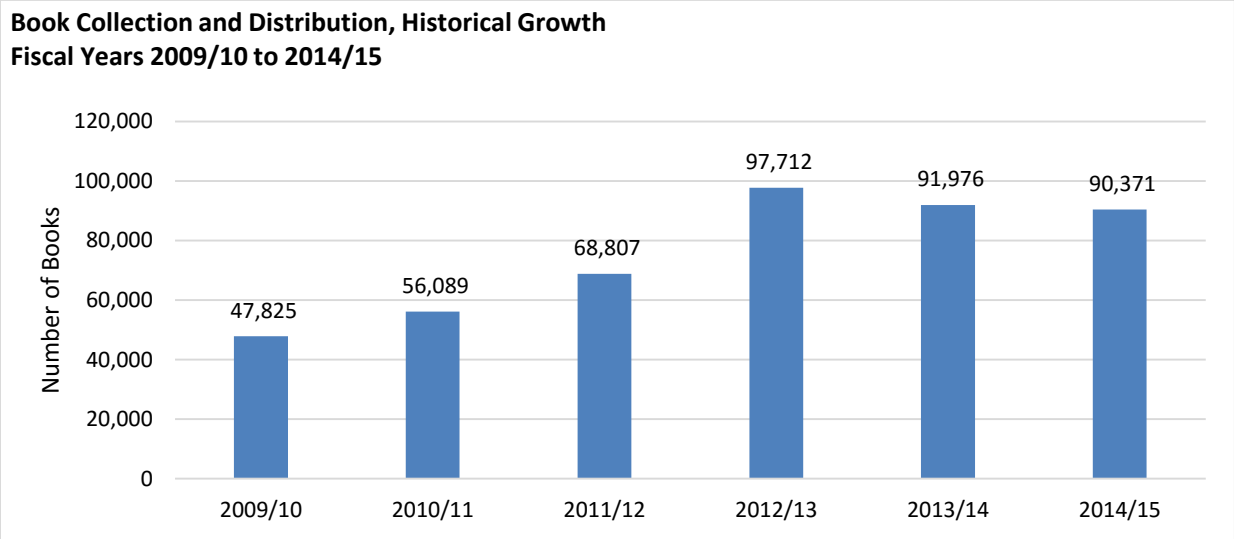
Key Strategic Plan Objectives	SOQ Results
• Increase parents' knowledge and involvement in preparing children for school	• 93.3% of parents talked with their child about daily activities at the end of services, compared to 77.6% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 96.7% of parents felt they had sufficient information and support for their child to attend Kindergarten at the end of services, compared to 80.0% at the beginning of services

The investment in developing children's early literacy and math skills is having an impact. More young children have books in their homes and in early learning settings as a result of the book bank and Raising a Reader programs. More children and caregivers in high need communities participated in evidence-based early learning programs, with children gaining early learning skills needed to start kindergarten. Children were read to and reading aloud was modeled to parents in waiting rooms and at community events like Read for the Record. And early educators received training on how to incorporate early math activities and education into their early learning programs.

Program Highlights and Outcomes

Book Bank

In fiscal year 2014/15, 90,371 children's books were redistributed to multiple communities across Orange County. The *We Care Wednesday* event at the Orange County Fair garnered over 55,000 books and THINK Together strengthened relationships with existing partners, and cultivated many new partners. The number of books collected through the Book Bank increased between 2009 and 2013, and then dropped the following two years (while remaining above 90,000 collected each year). The drop in books in recent years is due to a shift in calculations, where only age-appropriate books in good condition are counted.



Raising a Reader

Raising a Reader is an early literacy and family engagement program designed to help families develop book sharing routines with their child(ren). To practice the habit of sharing books, families are provided with a different book bag each week that contains award-winning books that they can

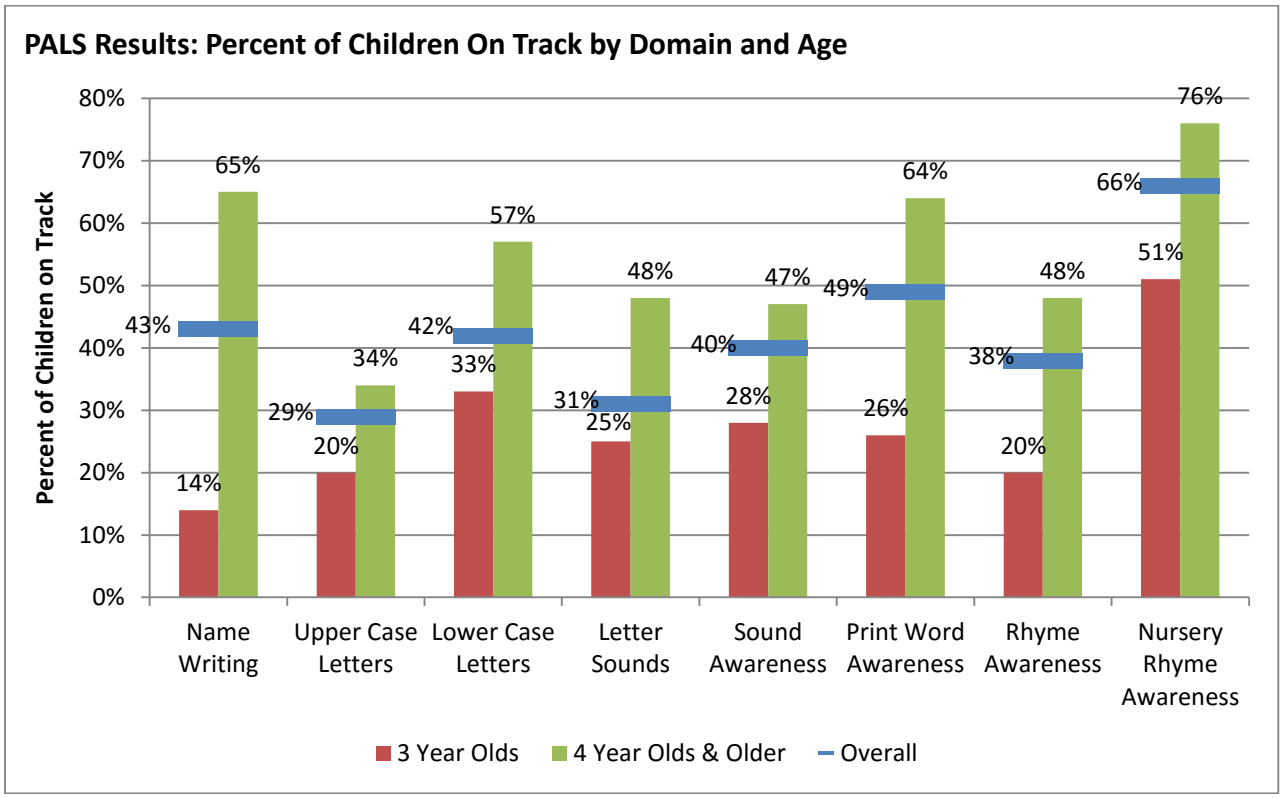
read with their children. With constant access to new books, caregivers are able to engage their children in regular reading to develop their child's literacy. This year, the program continued as an integrated component at THINK Together's Center-Based sites. The program was also expanded to new external partner sites.

In total, 2,025 bags are in rotation in Orange County at sites that THINK Together manages. THINK Together has leveraged Commission funding with support from the Free masons organization. With Free masons' funding, THINK expanded programming from five sites to seven, with five sites in Santa Ana and two sites in Buena Park. Raising a Reader has also expanded their book selections. In addition to each bag including a financial literacy book, as done in the past, the bags also now include a book focusing on Science, Technology, Engineering and Math (STEM).

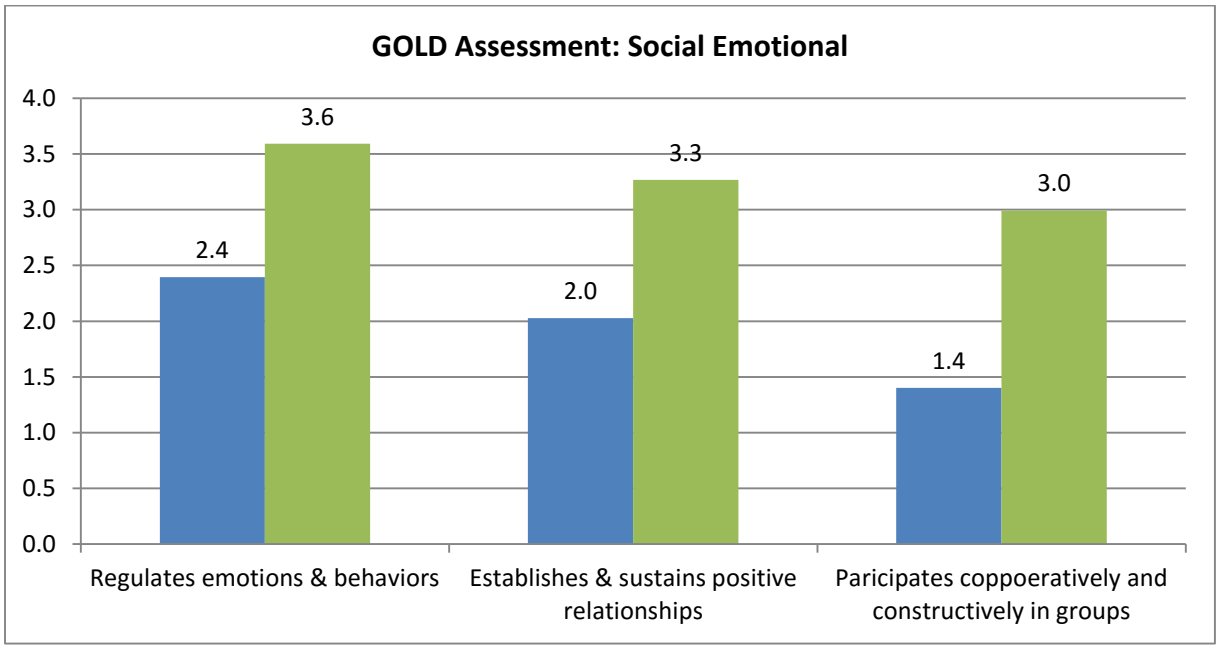
Center-Based Programs

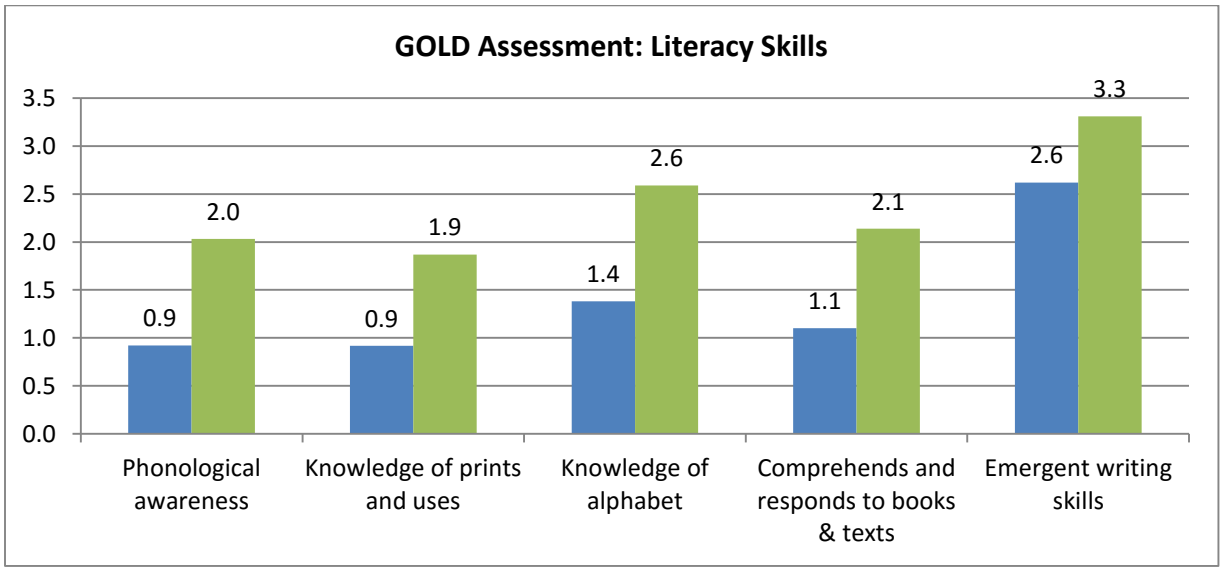
The Center-Based programs served 543 children and 485 adult participants/guardians in one of the two 15 week sessions and/or a summer session of early literacy and math preparedness at six different school sites located in four different cities in Orange County. The demographic makeup of the communities served at the different sites varied widely, but the data confirm that the Early Literacy Program successfully targeted communities of high-need. More than 47% of current families served identified themselves as low-income (household incomes of $25,000 a year or less), 80% self-identified as Hispanic/Latino, and reported having an average household size of five. According to the 2015 Federal Poverty Guidelines, a household size of five with a household income of $28,410 or less is below the official "Poverty Line."

The Phonological Awareness Literacy Screening (PALS) was administered to each student at the end of the first and second session of program. The results of the assessment indicate that four-year olds had higher rates of being "on-track" on certain domains, when compared to three-year olds.



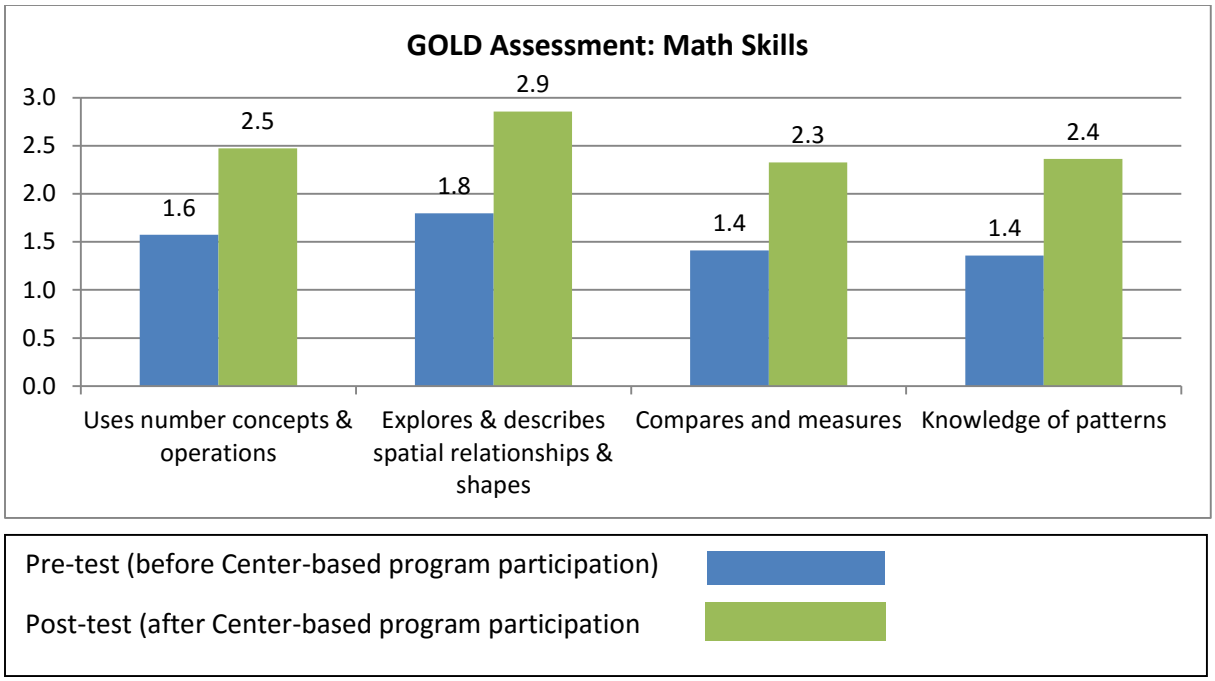
In fiscal year 2014/15, children also were assessed on Social Emotional Learning, Literacy Skills and Math Skills through the GOLD Assessment. Over 400 students were assessed through pre- and post-testing in all of these areas. As the charts below demonstrate, the average scores of students increased after participation in the Center-Based early learning program for every area of the assessment, with the greatest growth shown in Social Emotional Learning.





Pre-test (before Center-based program participation)

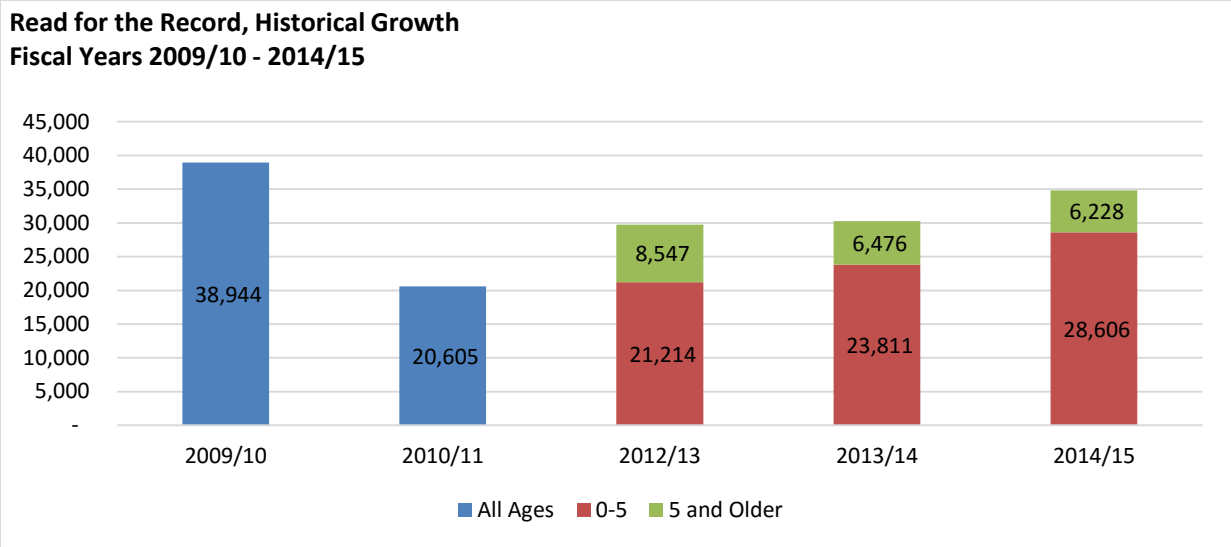
Post-test (after Center-based program participation



Read for the Record

Read for the Record is an annual reading event that promotes literacy by mobilizing adult participants/guardians and children to set a record for the largest reading experience. Every year, a highly reputable children's book is chosen by Jumpstart to be read at various types of venues across the country, thus creating a large unified movement that raises awareness of the importance of early literacy. The 2015 event again broke the previous record for number of children read to within a single week, totaling 34,834 children in Orange County. In total, THINK Together distributed more than 2,200 books to 120 sites. Each site was able to keep the books, while also giving out many of this year's designated book "*Bunny Cakes"* and other gently used books to children who were read to.

Historically, the number of children read to has risen steadily since the intentional targeting and tracking of children ages five years and younger began (see chart below). In 2009/10, a larger number of children were read to because it was not specified to partners to attempt to only read to children ages five and younger. In 2010/11, intentional efforts were made to read to children ages five and younger but it was learned that there were still many children being read to who were not ages five and younger. In 2012/13, children age five and younger continued to be targeted, but the sites also began tracking all children who were read to. Fiscal year 2014/15 surpassed the prior year for the target demographic of children ages five and younger.



Note: 2011/12 data not available.

Reach Out and Read

The Reach Out and Read program provided one-time modeling of side-by-side reading to more than 11,500 children who were with their parents in 57 clinic waiting rooms in 19 different cities throughout Orange County. About 29 of those clinics have been identified by the Orange County chapter of the American Academy of Pediatrics as eligible for support by the Reach Out and Read program, due to the fact that 60% or more of the population served have been identified as low socio-economic status.

A total of 11,563 children were read to throughout the year, falling short of the 12,500 goal established at the outset of the fiscal year. This is reflective of the year-to-year intentional downsizing of the program including fewer readers at clinics with early literacy rich environments. Since 2010, the program's growth has declined as a result of reallocation of limited resources to more high impact programs

Early Learning STEM Conference

In an effort to address the gap in early learning math, the Commission, THINK Together and the Children's Center at Caltech partnered to host the second statewide Early Learning STEM conference for early childhood educators. Attendance exceeded initial projections, with 580 early childhood educators attending the conference from all over California and presenters participating from all parts of the world. Also, as part of the conference follow up, the new Early Childhood STEM Mentorship (ECSM) program was created, which will launch in February 2016. The objective of ECSM is to further the professional development of current early learning teachers in the field by providing mentorship opportunities.

Champions for Children's Literacy

The Initial work of the Champions for Children's Literacy was completed in 2013/14 and defined the group's vision and strategic goals, as well as limited support for public awareness campaigns and exploration of successful literacy programs in Orange County. In order to increase the efficacy and countywide traction of this collaborative, a search was made for a consultant to staff this collaborative. In June 2015, a consultant was hired with a July 1, 2015 start date.

Vignette

Mrs. Garcia lives in Santa Ana with her three children.[6] She heard from a neighbor about the Early Literacy Program at Sepulveda Elementary, and how helpful it had been for her son in preparing him for kindergarten. Mrs. Garcia went to the school to find out more. She spoke to the lead teacher, who welcomed her into the classroom, and enrolled her child, Ruby, in the program. Ruby started the Early Literacy program in February. Knowing it was important to attend with Ruby, Mrs. Garcia spoke to her supervisor who allowed her to switch her schedule so she could participate. She says, "It was the best opportunity to be able to attend this program. Ruby came out of her shell. She felt comfortable with the teachers. Her brother and grandmother attended the days I could not." Mrs. Garcia also spoke highly of the Raising A Reader program. "We are not fortunate to have books or go to the library because of our schedules – we are always working," she said. "With Raising a Reader book bags, our family could read with Ruby. She now loves to read!"

Early Literacy Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in Orange County children's early literacy and math skills. Still, challenges remain.

Reevaluating and Redefining the Target Audience

Until this year, THINK Together's Center-Based programs have been targeted primarily to older preschool aged children (four and five years old). However, state funding has recently been allocated to several Orange County school districts that are implementing new preschool programs in their district. At times, these programs compete for space with THINK Together programs, and the school-based preschool program is given priority for the facility. Also, the same children are targeted (four to five year olds). Rather than be in competition with the school districts, the early literacy and math program needs to reevaluate its locations and targeted age groups so that Commission-funded programming is complementary to school district programming. THINK Together is already shifting some programming to target younger preschoolers, and even infants and toddlers. Overall, the Commission's investment and THINK's programming will need to review locations, facilities and ages served to best meet the community needs and maximize resources between the Commission funds and school district programming of state funds for preschool.

[6] Names have been changed to protect identities.

APPENDIX 12:

Child Signature Program (CSP) and CARES Plus

FY 14/15

Children and Families Commission of Orange County Child Signature Programs (CSP) and Comprehensive Approaches to Raising Education Standards (CARES) Plus Report

This program report describes the Commission's investments in the Child Signature Program (CSP) and Comprehensive Approaches to Raising Education Standards (CARES) program and the outcome of those investments. It also documents barriers to children entering kindergarten ready to learn and the Commission's actions, programs and recommendations to improve the quality of early learning programs for all Orange County children.

Background

The Child Signature Program (CSP) and Comprehensive Approaches to Raising Education Standards (CARES) Plus are First 5 California matching fund programs. The Orange County CARES Plus partnership was developed in 2011 to provide training and professional development for early educators working with high need, at-risk children and, to-date, has served close to 1,000 educators. The Orange County Child Signature Program partnership began in 2012 and invited eligible, subsidized early childhood programs to participate in a quality assessment and improvement process. Child Signature Program was expanded in 2013 to provide direct services to children and families attending the Child Signature Program programs. To-date, the program has served over 1,500 families. The aim of the CSP and CARES Plus programs is to invest in high quality preschool programs that enhance the quality of care and education that children receive.

Commission-funded Services in Orange County

The CARES Plus and Child Signature Program programs are matching fund partnerships with First 5 California. Some elements of the programs are prescribed by First 5 California and aligned statewide, however both programs allow for local design to meet the individual needs of Orange County. The Commission chose to subcontract with expert organizations to implement these program elements:

Early developmental screening, referral, and linkage to needed services

The Commission partnered with Help Me Grow Orange County to provide Family Support Specialists to make home visits, conduct needs assessments, and support the referral process with families participating in Child Signature Program. In addition, Help Me Grow staff trained all CARES Plus participants on the importance of early developmental screening and the Help Me Grow care coordination system.

Early Mental Health Services

The Commission partnered with Child Behavior Pathways to provide mental health specialists to observe children, work directly with parents and teachers, provide parenting education, and implement social skills classes for children.

Early Health Screening and Services

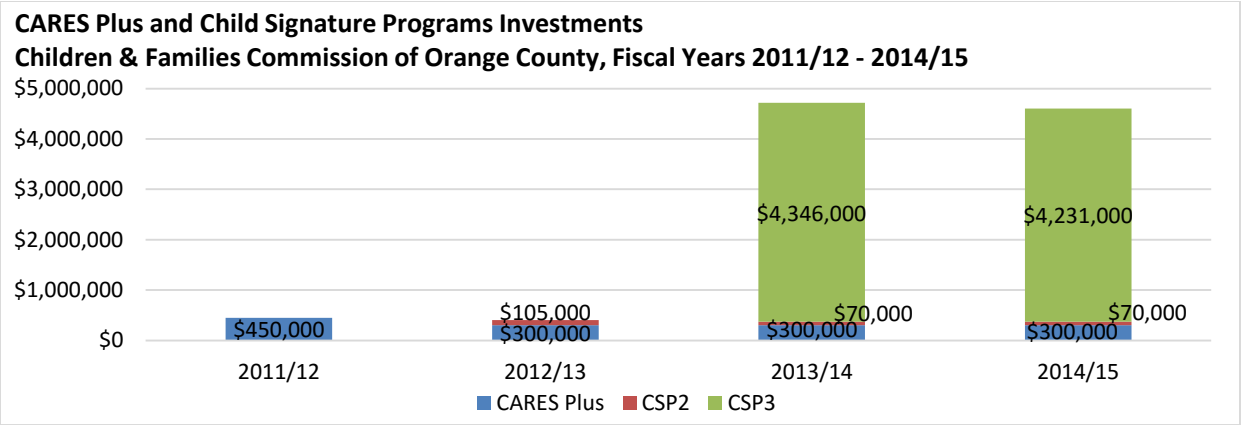
All children participating in Child Signature Program receive developmental screening through a School Readiness Nurse. The School Readiness Nurses are critical to the Child Signature Program case management process. In addition, Child Signature Program contracted with a physical activity and nutrition consultant and a dietician to provide individualized family support for children with a 98% or higher Body Mass Index (BMI).

High Quality Training and Coaching for Early Educators

The Commission contracted with both Children's Home Society and the Orange County Department of Education to implement the CARES Plus and Child Signature Program training and coaching components. Both organizations have strong connections to early educators in Orange County and were able to create the trusting relationships needed for an effective training and coaching process.

Commission Investment

Since the Orange County CARES Plus program began in 2011, the Commission has received and matched over $10 million from First 5 California. Both CARES Plus and the Child Signature Program required a local match. The CARES Plus match is 3:1 and the Child Signature Program match is 1:1.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in CARES Plus and Child Signature Program produced the following services for children ages birth through five:

Table 1. Aggregate Data for CARES Plus and CSP Programs

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	667	764	3,726
Number of services provided	2,132	8,128	4,236

* Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by CARES Plus and CSP Programs

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		36	100
Age at most recent interview	Under Three	2	5.6
	Three through Five	34	94.4
Ethnicity	Amer. Indian/Alaska Native	0	0.0
	Asian	0	0.0
	Black/African American	0	0.0
	Hispanic/Latino	34	94.4
	Pacific Islander	0	0.0
	White	1	2.8
	Vietnamese	0	0.0
	Multiracial	0	0.0
	Other	0	0.0
	Unknown	1	2.8
Primary Language	English	13	36.1
	Spanish	23	63.9
	Vietnamese	0	0.0
	Other	0	0.0
	Unknown	0	0.0
At or Below 200% Federal Poverty Level		29	98.7

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by CARES Plus and CSP Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
SF.2 Children are safe and well cared for	Home visitors and/or program staff will assess and provide service plans to improve parent knowledge of healthy child development using a Commission-approved tool	487	487
	Parents participate in parenting education classes/series on healthy child development	262	18
	Children receive group interventions to improve healthy child development	268	16
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	451	1,152
	Family support and child development teacher trainings	195	15
SF.4 Families have resources to support the management and treatment their child's behavioral health needs	Providers receive training on behavioral health treatment services for children 0-5	195	15
	Parents receive education, resources, referrals, and support regarding their child's behavioral health issues	258	1,395
	Staff participate in case management team meetings to support the needs of the families served	131	257
EL.1 Children have the developmental skills to be	Children participating in early literacy programs	435	514
	Providers will conduct classroom assessments using an established tool such as ECERS or ELLCO	41	41

Table 3. Services Provided by CARES Plus and CSP Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
proficient learners in school	Providers are given resources and early intervention strategies for appropriate early care	165	165
	Providers receive training for the implementation of the CARES Plus program	425	558
EL.2 Schools are ready for children when they enter kindergarten	School readiness and child development teacher trainings	1,145	45
	Provide coaching and in-class training for early educators	74	517
CB.1 Increase sustainability*	Dollar amount received by leveraging Commission dollars	N/A	$38,750
CB.2 Increase access and efficiency, quality and effectiveness	Public information and outreach campaign to increase community awareness to promote access	N/A	29
	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	17
	Providers receive trainings to build the capacity of the agency to increase quality services	1,616	98
	Client data collected and entered into PRO0F for CARES Plus (records)	220	220
	Provider stipends administered for CARES Plus participants	220	220

*CSP match dollars are also reported under other initiatives

Program Highlights and Outcomes

The Child Signature Program (CSP) adopted the Protective Factors Survey in its work during fiscal year 2014/15. First 5 California designed Child Signature Program with three goal areas: 1) instructional strategies and teacher-children interactions, 2) social-emotional development, and 3) parent involvement and support, by providing quality early education to families to afford opportunities to receive services that contribute to building and strengthening protective factors. Many families and children in Child Signature Program come from distressed and low-income neighborhoods. With social-emotional development and parent involvement and support being critical components of children coming to school ready to learn and grow, the Protective Factor Survey is a program evaluation tool that helps gather information about how Child Signature Program strengthened development, involvement, and support.

Serving more than 500 families throughout the school year, the pre-post results of the Protective Factors Survey indicated that, generally, families in Child Signature Program expressed that their protective factors were high, on both the pre and post surveys. There was no significant growth among the overall sample population. However, upon disaggregation based on the Protective Factor Survey suggested cut-off levels (a score of five or below out of seven) of protective factors in the pre-survey, these families showed an increase in their protective factors particularly related to concrete support, and child development and knowledge of parenting in the post-survey. Additionally, among families that reported below cut-off ratings on the pre-test, families that engaged with Child Signature Program programming more frequently reported higher ratings on their post-survey than families who had engaged in the program fewer times.

APPENDIX 13:

Other Early Learning Programs

FY 14/15

Children and Families Commission of Orange County Other Early Learning Programs Report

This program report describes the Commission's investments in the countywide early learning programs and the outcome of those investments. It also documents barriers to early learning programs serving young children and the Commission's actions, programs and recommendations to provide early learning opportunities and early interventions as needed for all young children in Orange County.

Background

The partnerships that round out the Commission's countywide early learning programs include the Boys & Girls Clubs of Garden Grove, OC STEM Initiative, and Providence Speech and Hearing. These partnerships provide specific programs to bring school readiness and health access opportunities to high need communities in the county; encourage on-going interest in science, technology, engineering, and mathematics (STEM); and implement a speech and language therapy model for children with mild to moderate speech delays.

The Importance of Early STEM Learning

Evidence suggests that the achievement gaps that exist between student groups in second grade are foreshadowed at kindergarten entry.[1] Research also suggests that very young children are ready to learn a broad array of mathematics content that will give them a solid base for future learning.[2] Six longitudinal studies showed that early math skills are the most powerful predictor of later school success.[3] And in a survey conducted in 2010, Californians reported seeing early science as foundational to success in high school.[4]

As the United States lags behind other nations in STEM (Science, Technology, Engineering, and Mathematics) education, California is projecting a growth in STEM careers, and over 40% of all jobs vacancies in Orange County in 2014 are STEM-related.

Furthermore, overall STEM occupations pay well at all educational levels. People in STEM occupations with a high school diploma or less have higher lifetime earnings than people in other occupations with similar education levels (approximately $500,000 more). Similarly, STEM majors make substantially more over their lifetime than non-STEM majors.[5] Quality STEM education is important for Orange County's youngest children to be able to succeed in school, as well as for the development of Orange County's future workforce.

Early Intervention for Children with Speech Delays Maximizes Outcomes

In 2014, there were approximately 14,000 children with a speech or language impairment enrolled in, or receiving services from, Orange County public schools and requiring special education. More

[1] California's Math Pipeline: Success Begins Early, July 2011

[2] Duncan, G, Dowsett, C., Claessens, A., Magnuson, K., Huston, A., Klebanov, P., Pagani, L., et al. (2007) School Readiness and Later Achievement. Developmental Psychology, 43, 1428-1446.

[3] *Ibid.*

[4] A Priority for California's Future: Science for Students – Analysis of Public Opinion Research (2010). Sacramento, CA: The Center for the Future of Teaching and Learning at WestEd.

[5] Carnevale, A, Smith, N. and Melton, M. (2011). STEM Science, Technology Engineering, Mathematics – Full Report. Georgetown University Center on Education and the Workforce.

than 4,000 of those were children between the ages of three and five years old.[6] A recent report from the American Speech-Language Hearing Association entitled "Roles and Responsibilities of Speech-Language Pathologists with Respect to Reading and Writing in Children and Adolescents", links a child's speech ability with literacy and ultimately their ability to succeed in their educational careers. Further, a research brief by the RAND Corporation entitled "Proven Benefits of Early Childhood Interventions", states that the cost benefit to early childhood interventions can range up to $17.07 for each dollar spent on the program.

Recent analysis completed by the Commission shows that children who receive speech and language services at an earlier age are exiting special education earlier, resulting in better outcomes for the children as well as reduced special education costs. Finally, research also shows the positive effects of parents working with their children – such as occurs in the Providence Speech and Language program Building Blocks of Communication – in everything from literacy to therapy.

Commission-funded Services in Orange County

The Commission funds countywide programs to expand early learning opportunities and to provide early intervention for children with speech delays. These programs include the Boys and Girls Club of Garden Grove, the OC STEM Initiative, and Providence Speech and Hearing's Building Blocks of Communication.

Boys and Girls Club of Garden Grove

The Boys and Girls Club of Garden Grove provides early learning services as well as health services. The early learning portion of the contract includes the following key elements:

- An evidence-based school readiness program (Readiness on the Road), which uses a modified High Scope curriculum and is located both at Boys and Girls Club sites as well as other early education facilities;
- Developmental screenings, referrals and follow up;
- Parent education classes;
- Professional development classes for early care providers; and
- Support for Learning Links.

The health component, known as Access to Resources for Children's Health, Education, and Support (ARCHES) provides the following key services:

- Links families with young children with health services at the Garden Grove Health Center, including referrals and follow up for general health, dental, vision and family support;
- Assists with insurance enrollment; and
- Provides outreach to homeless families for health services.

OC STEM Initiative

The OC STEM Initiative is a partnership with the Samueli Foundation that began in 2011. The partnership has expanded to a membership organization comprised of 15 business foundations, educational organizations, and content experts. The focus is on the full continuum of learning from preschool through college, with the overarching goal that students are college and career ready in the

[6] California Department of Education, DataQuest (http://data1.cde.ca.gov/dataquest/)

STEM field. Specific programs that support early STEM education include: the Early Childhood STEM Symposium; STEM Ecosystem Institute; and the Lead STEM Practitioner Program.

The OC STEM Initiative has developed a strategic plan that has five goals:

1. Organizational Structure – build a sustainable structure to support the ongoing implementation of successful STEM programs;
2. Communications – promote awareness of STEM competencies and why they are important;
3. STEM Learning – create interest among students, preschool through college, to pursue the development of their STEM knowledge, skills and abilities;
4. Professional Development – promote educators' STEM knowledge, competencies, and pedagogy. Sponsored the Early Childhood STEM Conference in 2014 and 2015, and planning the OC STEM Institute for school district teams to begin in spring 2014; and
5. Workforce Development – bridge the gap between a STEM-educated workforce and Orange County businesses' demands.

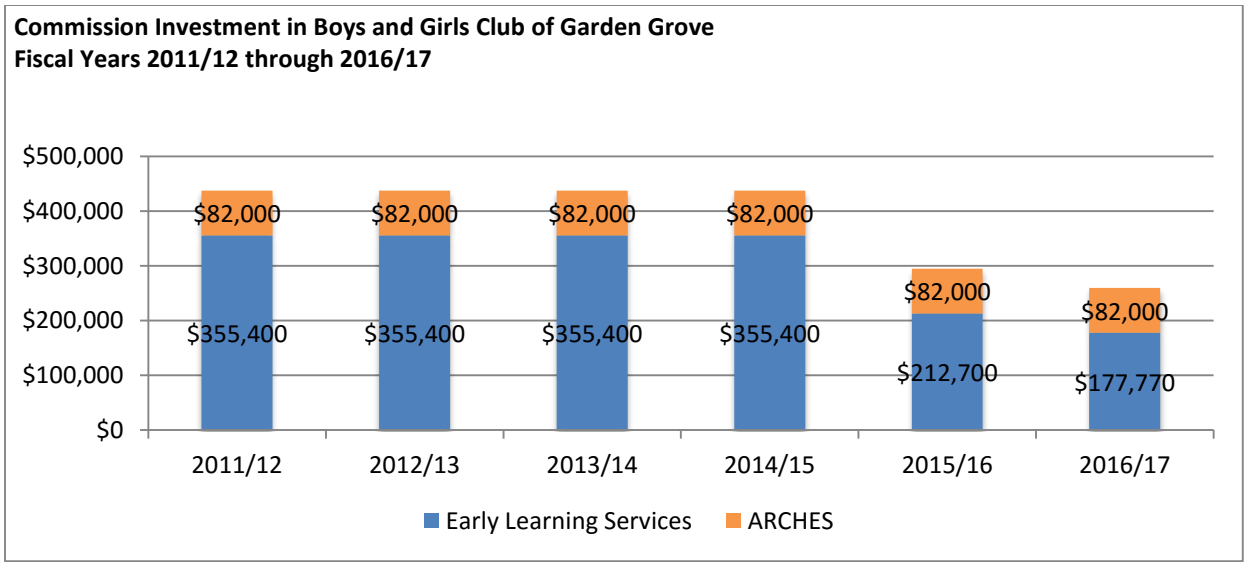
Providence Speech and Hearing

Providence Speech and Hearing Center developed the Building Blocks of Communication™ (Building Blocks), a group therapy model for children with mild to moderate speech delays. Providence implements this model, conducting classes with parents and young children. Additionally, Providence conducts training of professionals (e.g., Early Learning Specialists) so they can, in turn, conduct classes for parents of young children to assist with speech and language development using Building Blocks. Providence has developed an online portal to train professionals on the Building Blocks, and most recently, has made the online portal user-friendly for parents seeking to use the Building Blocks with their children.

Commission Investment

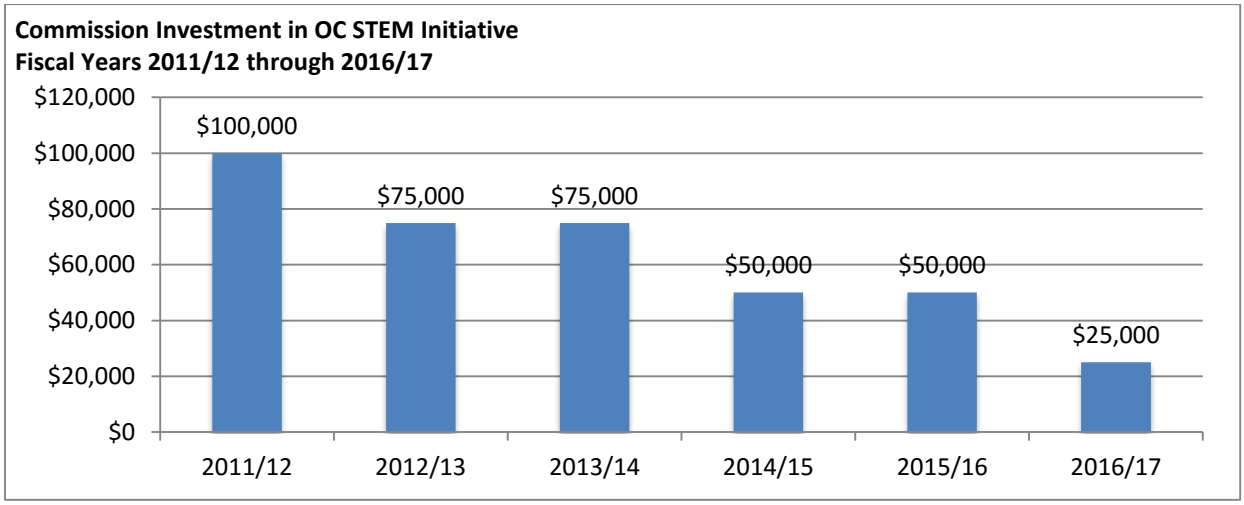
Boys and Girls Club of Garden Grove

The Commission invested $437,400 annually in Boys and Girls Club of Garden Grove from fiscal year 2011/12 through fiscal year 2014/15, with a reduction to $294,700 for fiscal year 2015/16 and $259,700 for fiscal year 2016/17.



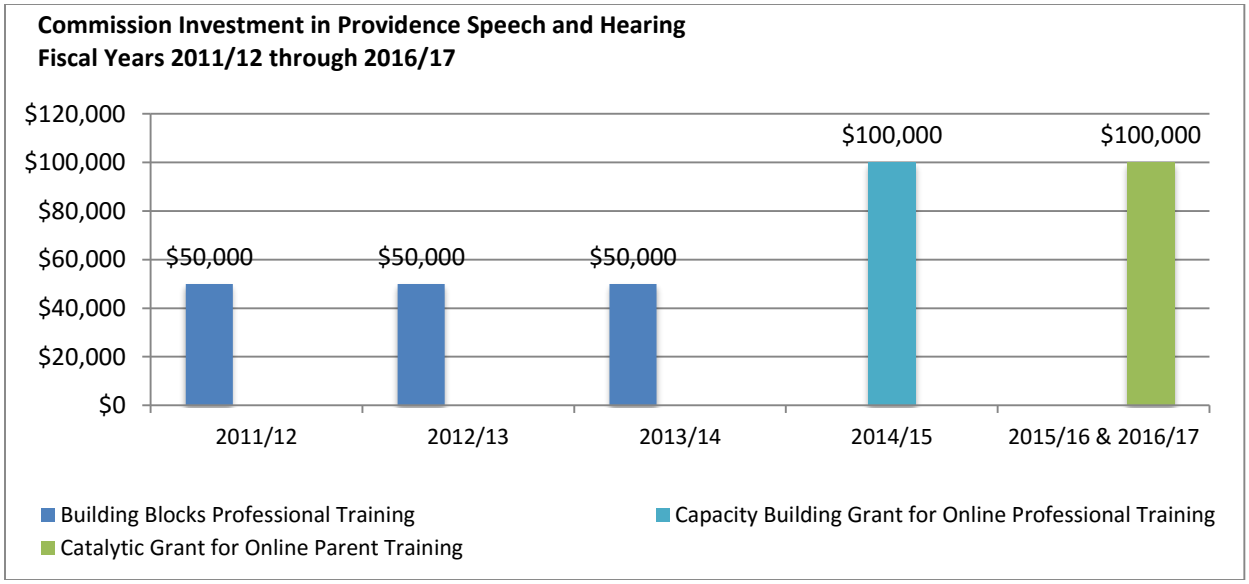
OC STEM Initiative

In fiscal year 2011/12, the Commission allocated $250,000 over three years to the OC STEM Initiative to develop a strategic plan, launch the program and secure other funding partners. In fiscal year 2014/15, funding for the program was renewed at $125,000— again to be spread over three years, to support the implementation of the five goal areas of the OC STEM Initiative Strategic Plan.



Providence Speech and Hearing

The Commission initially funded Providence Speech and Hearing Center to conduct in-person training of professionals (e.g., Early Learning Specialists) so they could, in turn, conduct classes for parents of young children to assist with speech and language development using Building Blocks. In fiscal year 2013/14, Providence received a capacity building grant from the Commission to help create an online portal to train early childhood educators and paraprofessionals to use Building Blocks. The online portal supports the sustainability of the program by increasing access and convenience for providers. For fiscal years 2014/15 and 2015/16, the Commission provided a one-time catalytic grant to further the expansion of the existing online platform to target parents and caregivers.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in the other early learning programs produced the following services for children birth through age five:

Table 1. Aggregate Data for Other Early Learning Programs

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	623	977	102
Number of services provided	4,050	3,803	122

*Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Description of Children Served in FY 14/15 by Other Early Learning Programs

Variable Considered	Category Label	Count[1]	Percent
Total number of children with client-level data		277	100
Age at most recent interview	Under Three	112	40.4
	Three through Five	165	59.6
Ethnicity	Amer. Indian/Alaska Native	0	0.0
	Asian	9	3.2
	Black/African American	3	1.1
	Hispanic/Latino	242	87.4
	Pacific Islander	0	0.0
	White	5	1.8
	Vietnamese	7	2.5
	Multiracial	8	2.9
	Other	0	0.0
	Unknown	3	1.1
Primary Language	English	89	32.1
	Spanish	182	65.7
	Vietnamese	3	1.1
	Other	0	0.0
	Unknown	3	1.1
At or Below 200% Federal Poverty Level		228	92.0

[1]The counts for specific demographic variables may be less than the total number of children entered into the Commission's Data Collection and Reporting System. This typically occurs because survey respondents decline to answer a specific question, or an error in data entry results in an out-of-range value that must be deleted.

Table 3. Services Provided by Other Early Learning Programs

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.2 Children receive early screening and, when necessary, assessment for developmental, behavioral, emotional, and social conditions, and referral and linkage to services as appropriate	Children receive developmental screening using AAP recommended tools (e.g. PEDS, ASQ, ASQ-SE, MCHAT)	290	290
SF.2 Children are safe and well cared for	Parents participate in parenting education classes/series on healthy child development	239	103
SF.3 Caregivers have ready access to family support services and resources	Parents receive follow up on referrals and services are accessed	170	329
EL.1 Children have the developmental skills to be proficient learners in school	Parents participate in a program designed to increase the frequency of reading at home	144	1,407
	Providers are given resources and early intervention strategies for appropriate early care	122	122
	Children receive enhanced school readiness services through other preschool programs	278	2,357
	Parents participate in a drop-in, family-focused early learning program (i.e., Learning Link)	76	1,404
	Children participate in a drop-in, family-focused early learning program (i.e., Learning Link)	84	1,619
EL.3 Parents have the supports that contribute to children's readiness for school success	Parents receive tools, resources, information and/or training needed to transition their child to school	356	1,485
CB.1 Increase sustainability	Dollar amount raised	N/A	$15,841
	CSP match dollars submitted	N/A	$2,558,527
CB.2 Increase access and efficiency, quality and effectiveness	Developing partnerships, coordinating and collaborating with other agencies to improve service delivery	N/A	30

Table 4. Service Outcomes (SOQs) for Other Early Learning Programs

Key Strategic Plan Objectives	SOQ Results
Early Learning	
• 75% of typically developing children are effective learners in literacy	• 29.8% of children knew none of the alphabet letters by name at the beginning of services compared to only 11.7% at the end of services

Key Strategic Plan Objectives	SOQ Results
• 75% of typically developing children are effective learners in literacy	• 76.8% of children could identify his or her written name at the end of services, compared to only 47.7% at the beginning of services
• 75% of typically developing children are effective learners in literacy	• 95.5% of children had familiarity with books at the end of services, compared to 90.4% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 91.2% of children could count a group of three to five objects by touching each object at the end of services, compared to 73.6% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 78.2% of children could correctly name at least two shapes at the end of services, compared to only 65.1% at the beginning of services
• 80% of typically developing children are effective learners in numeracy	• 66.2% of children could recite at least five numbers in order at the end of services, compared to only 56.1% at the beginning of services
• 75% of typically developing children are socially competent	• 96.9% of children could follow simple two-step oral directions at the end of services, compared to 89.8% at the beginning of services
• 75% of typically developing children are socially competent	• 95.4% of children cooperated with the daily classroom routine most of the time at the end of services, compared to 89.7% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 70.3% of parents taught their children letters, numbers, or words at least three times in the prior week at the end of services, compared to 58.5% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 88.1% of parents played with toys or games indoors at least three times in the prior week at the end of services, compared to 85.1% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 64.7% of parents went on outings with their child at least three times in the prior week at the end of services, compared to 63.9% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 86.5% of parents talked with their child about daily activities at the end of services, compared to 80.5% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 73.5% of parents played, games, sports or exercised with their child at least three times in the prior week at the end of services, compared to 71.2% at the beginning of services
• Increase parents' knowledge and involvement in preparing children for school	• 76.2% of parents felt they had sufficient information and support for their child to attend Kindergarten at the end of services, compared to 67.1% at the beginning of services

Program Highlights and Outcomes

One of the most important outcomes of the Boys and Girls Club of Garden Grove's work with young children and families is the developmental screenings that occur in the parent-child classes and the early intervention that results in follow up. Using the American Academy of Pediatrics recommended tool of the Ages and Stages Questionnaire (ASQ), Boys and Girls Club works with parents to assess children in the program, identify issues or concerns, and then teach parents how to navigate the systems in order to help children be healthy and ready to learn.

In fiscal year 2014/15, 290 children received developmental screenings, and 239 parents participated in parenting classes. A total of 170 parents received a follow-up on a referral made for their child, and services were accessed.

Another focus of the Boys and Girls Club of Garden Grove is developing early learning skills including early literacy. In fiscal year 2014/15, 278 children participated in a Boys and Girls Club early learning program; 1,407 parents participated in a program to increase the frequency of reading to their children at home, and 84 children/76 parents participated in a Learning Link (drop-in, family-focused early learning program).

Other Early Learning Program Challenges

Proposition 10 funding, allocated by the Commission, is providing opportunities for children's early learning. Still, challenges remain from sustainability to redefining early learning services.

Redefining Early Learning Services

With public schools providing transitional kindergarten and other state-funded preschool services, enrollment in other agency preschool programs targeted to four and five year olds has been declining countywide. For the Boys and Girls Club of Garden Grove, declining enrollment in school readiness programs has led to the need to reevaluate the services provided. Aligning services with community need, and working with community partners such as the Early Learning Specialists, school districts, and other early childhood providers will be critical as the Boys and Girls Club of Garden Grove modifies their school readiness program. Part of this effort is determining a fee schedule that both supports program sustainability and allows continued programming in communities with high need. Another element is focusing early learning services to a younger population, such as three year olds.

CAPACITY BUILDING

The following appendices document progress made on the Commission goal area of Capacity Building. This includes two funding subcategories:

- Capacity Building / AmeriCorps / VISTA
- Performance Outcomes Measurement System

APPENDIX 14:

Capacity Building / AmeriCorps / VISTA

FY 14/15

Children and Families Commission of Orange County Capacity Building / AmeriCorps / VISTA Programs Report

This program report describes the Commission's investments in the Capacity Building / AmeriCorps / Volunteers In Service To America (VISTA) program and the outcome of those investments. The Capacity Building program area is designed to promote an effective and quality delivery system for young child and families.

Background

In 1999, when Commission funding began, two challenges related to the capacity of the non-profit sector quickly became apparent: 1) there was the need to tailor programs to address the unique and specific needs of families with children from birth through age five, and 2) there was a lack of experienced agencies specifically available to address the critical service gaps. The investments within the Capacity Building program focus on strengthening agencies that address the needs of young children and their families. The support provided through the Capacity Building program includes providing onetime seed funding for a new project or program and providing technical assistance for sustainability.

Commission-funded Services in Orange County

Within the Capacity Building goal area, the Commission supports the following programmatic initiatives:

Leveraging Strategies and National/State Foundation Programs
Leveraging existing programs to serve the needs of young children. For example, Commission-funded AmeriCorps members serve with key community service organizations supporting programs for children and families.

Technical Assistance
Training, technical assistance and administrative support to funded programs to ensure effective, efficient and quality services.

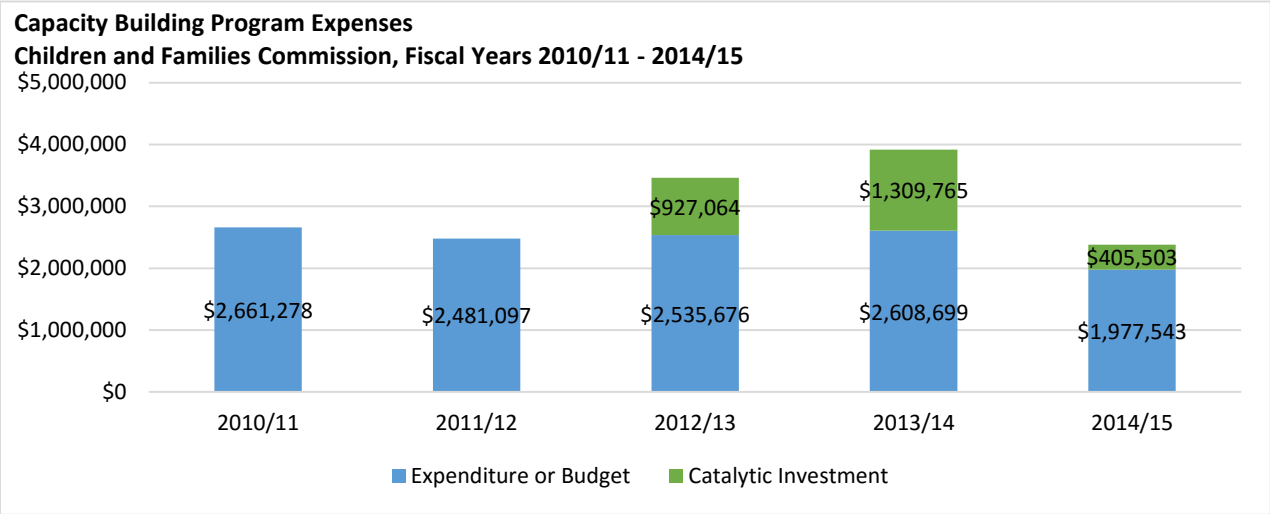
Capacity Building Grants
Providing an opportunity for non-profit organizations to increase their capacity through a competitive grant process. Grant dollars can be used for technology enhancements, new program deployment, sustainability, and/or infrastructure improvements. These investments must be tied to increased quality or services for children from birth through age five.

Evaluation System
Integrating a performance evaluation process that makes outcomes measurement part of the operations for all Commission funded programs.

Commission Investment

The Commission's investment in Capacity Building/ AmeriCorps / VISTA programs has been relatively consistent over the last five years, with the exception of catalytic funds. The addition of catalytic funding, beginning in fiscal year 2012/13, have targeted one-time investments that support

the development of new programs, collaborative, and/or expansion of services. Since fiscal year 2010/11, the Commission has invested nearly $15 million in the Capacity Building/ AmeriCorps / VISTA programs.



The Outcomes

Services Provided

In fiscal year 2014/15, the Commission's investment in Capacity Building/ AmeriCorps / VISTA programs produced the following services for children ages birth through five:

Table 1. Aggregate Data for AmeriCorps/VISTA

	Children Ages 0-5	Family Members	Service Providers
Number of people receiving services*	6,145	3,861	N/A
Number of services provided	6,145	3,861	N/A

*Although each grantee reports an unduplicated count, clients served by more than one program may be counted more than once when data from multiple grantees are added together.

Table 2. Services Provided by Capacity Building / AmeriCorps/ VISTA

Strategic Plan Outcome	Service	Clients Served	Number of Services
HC.3 Children have and use a regular place for medical and dental care	Children are linked with health insurance enrollment	979	979
	Children are linked to a health care home	4	4
CB.1 Increase sustainability	Dollar amount raised	N/A	$19,821
	Dollar amount of in-kind contribution generated	N/A	$48,069
	Number of volunteers recruited	488	N/A

Strategic Plan Outcome	Service	Clients Served	Number of Services
CB.2 Increase access and efficiency, quality and effectiveness	Technical assistance is provided, such as assistance with sustainability plans, evaluation activities, and providing quality services	16	28
	Providers receive trainings to build the capacity of the agency to increase quality services	29	25

Program Highlights and Outcomes

Volunteers In Service To America (VISTA)

The Commission participates in the statewide VISTA collaborative and in fiscal year 2014/15, received an allocation of seven VISTA members. The members are placed within non-profit or public agencies and provide indirect support for projects that benefit low-income families who have children ages five years or younger. The members participated in a number of activities with the organization, such as supporting evaluation work, outreach and education campaigns, collaboration building, and sustainability. In fiscal year 2014/15, VISTA members recruited over 350 volunteers to support the efforts of the non-profits in their communities.

AmeriCorps

Twenty-three AmeriCorps members supported the Commission's Early Learning programs at the Boys and Girls Clubs of Garden Grove and THINK Together. Both agencies receive Commission funding to provide early learning services targeted at low-income children in Orange County. In fiscal year 2014/15, the AmeriCorps provided direct services to over 640 children. Of these children, 84% improved their developmental skills for school readiness. The children who receive the services are assessed on three developmental areas using the Teaching Strategies GOLD assessment. Teaching Strategies GOLD can be used with any developmentally appropriate early childhood curriculum and is based on 38 research-based objectives that include predictors of school success and are aligned with the Common Core State Standards, state early learning guidelines, and the Head Start Child Development and Early Learning Framework.

In addition to providing direct services to children, the AmeriCorps members are charged with assisting agencies with developing long-term sustainability. One way they do this is through the recruitment and support of volunteers. In fiscal year 2014/15, AmeriCorps members recruited 119 short and long term volunteers for the agencies they work with.

Capacity Building Grants

Over the last fiscal year, a survey and focus groups were developed and implemented to better assess the skills, capacity and knowledge of Commission grantees, including:

1. To what extent are Commission grantees implementing evidence-based programs and what is their experience with replicating or expanding evidence-based models?
2. What is the experience of Commission grantees with participating in multi-agency collaboratives, also known as collective impact?
3. How do Commission grantees rate themselves regarding their experience and ability to evaluate their programs?
4. What do Commission grantees consider their best strategies for ensuring sustainability of their programs?
5. What desire, capacity, experience, and success do Commission grantees have with applying for federal grants?

Based on the survey data and focus group findings, it appears that Commission-funded grantees, while achieving positive results and collaborating to grow programs and impact regionally, need to develop competencies in the following areas to increase their competitiveness for national, federal or other discretionary grant competitions:

- Deeper understanding of service coordination and collaboration as they relate to collective impact;
- Implementing and effectively utilizing evaluation systems;
- Federal grant preparedness, grant application procedures, reporting, resources/personnel; and
- Fund development.

Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM)

The Commission's fiscal leveraging program uses Proposition 10 revenue to match other available funds including federal, state, and other grant funding sources. The Commission, in partnership with the County of Orange Health Care Agency, has developed a local capacity for agencies to leverage Commission Proposition 10 grant awards as eligible certified public expenditures to receive federal Medicaid reimbursement for their participation in:

- Medi-Cal Administrative Activities (MAA), in order to outreach and assist individuals to access Medi-Cal and health care services; and
- Targeted Case Management (TCM), which is a case management program targeting high-risk populations in order to assist them in gaining access to needed medical, social, educational, and other services.

Community benefits in using Proposition 10 revenue to leverage Commission funds include:

- Increased access for children to health prevention and medical services. Agencies leveraging dollars can incrementally increase service capacity over time to meet community demands;
- Increased responsiveness of the health care system in providing health care services for young children and their families. Medi-Cal Administrative Activities include developing strategies to increase system capacity, close service gaps, and promote inter-agency coordination;
- Increased overall fiscal stability, flexibility and responsiveness of community-based agencies during fluctuating economic conditions; and
- Commission staff and consultants who work on children's health programs including planning, coordinating work among agencies, and policy analysis can participate in the Medi-Cal Administrative Activities program to allow reimbursement for the cost of their time spent on these activities.

Fiscal Leveraging Program Highlights

Since inception of the program, the Commission and its agency partners have generated close to $47 million in federal funding. In total, 32 Medi-Cal Administrative Activities, and six Targeted Case Management claiming units in addition to the Commission have participated in the fiscal leveraging program.

New Providers Participating in the Fiscal Leveraging Program

In fiscal year 2014/15, Boys and Girls Clubs of Garden Grove, Mission Hospital, Help Me Grow Orange County and the CHOC/UCI Center for Autism and Neurodevelopmental Disorders of Southern California were added to Orange County's community fiscal leveraging plan as additional claiming units.

Fiscal Leveraging Program Investments in the Community

Leveraged funds have been used to reinvest in continued programs and to support community projects. Examples of how leveraged funds have been reinvested in the community include the following projects:

- City of Garden Grove, Magnolia Park Family Resource Center – Expanded the Readiness on the Road Program, an important resource for promoting health access;
- Delhi Center – Supported annual health fair, partnered with existing community resources to make medical, dental and vision screenings available, including a wellness program;
- Institute for Healthcare Advancement (IHA) – Provided health access workshops in the community focused on IHA's "What to Do When Your Child Gets Sick" book;
- Share Our Selves – Support access to pediatric health care at the newly established Children and Families Health Center in Newport Beach; and
- University of California, Irvine – Key investments at the Center for Autism and Neurodevelopmental Services to include enhanced interpreter services, updated the website to facilitate access to the Center, and expanding access for Occupational Therapy service.

The Commission approved its Fiscal Leveraging Plan with the County in December 2001. The fiscal year 2014/15 Community Plan Claiming Units included:

- 16 MAA grantees and Commission staff/consultants;
- 4 TCM grantees; and
- Approximately 125 grantee and Commission staff participated in program training.

The California Department of Health Care Services released new program policies and procedures that required several local program processes to be updated to align with the new procedures including developing new tools and increased trainings. The Fiscal Leveraging Management Team has been adapting the current systems and processes to meet the new requirements. Due to Commission and community efforts to increase the number of children who have and use health coverage, 97% of Orange County's children under the age of six have health insurance (U.S. Census 2014 data). Approximately 40% of these children are enrolled in Medi-Cal (CalOptima Fast Facts, June 2015 and California Department of Finance data).

Capacity Building Challenges

Proposition 10 funding, allocated by the Commission, is making a difference in providing one time seed funding for a new projects or programs, to providing technical assistance for sustainability. The biggest challenges continue to be longer-term sustainable revenue for the programs that are funded. The Commission's declining revenue make it imperative that all efforts are made to fully maximize local, state, and federal leveraging opportunities, strengthen the business practices of the non-profit sector to ensure the most efficient delivery system possible, and continue to invest in new ideas and programs that can make a positive impact on the system of care for families with children from birth through age five.

APPENDIX 15:
Evaluation System
FY 14/15

Children and Families Commission of Orange County Evaluation System Report

This program report describes the Commission's investments in its Evaluation System and the outcome of those investments. It also documents achievement of statutory accountability requirements and the Commission's recommendations and actions to improve programs and strategies for all Orange County children.

Background

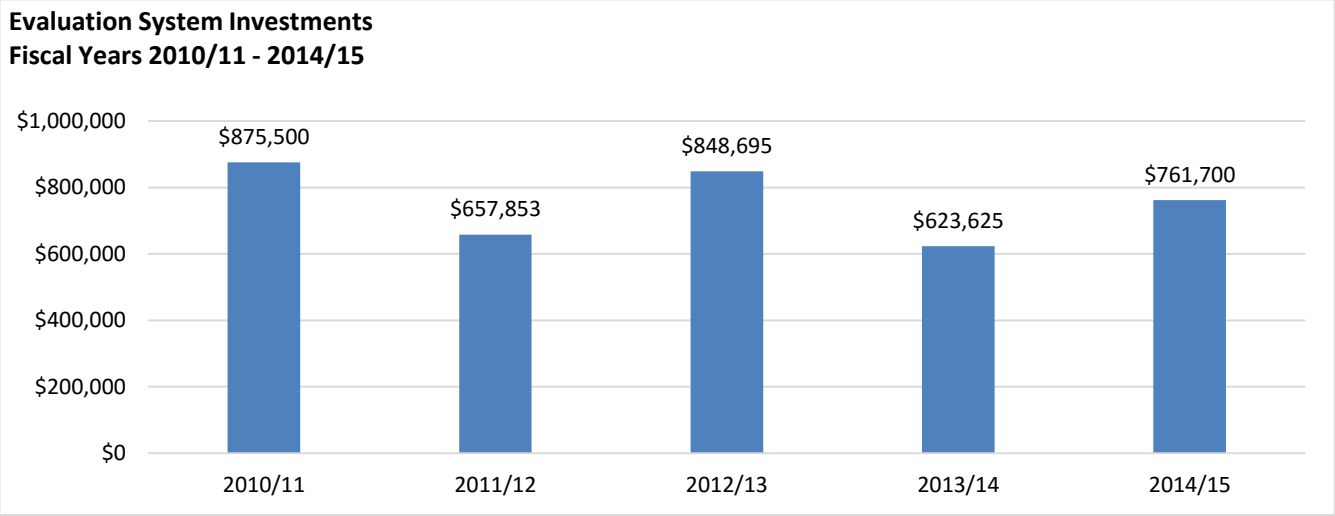
The Commission evaluates the programs it funds to assess their effectiveness in improving the lives of children and families, to guide program improvements and to comply with statutory requirements. The Commission has adopted a comprehensive evaluation plan that includes both process and short, intermediate, and long term outcome measures. The evaluation framework includes both Commission-wide and initiative-specific evaluations. In addition, the Commission participates in the development of community-wide data.

Commission-Funded Services in Orange County

In fiscal year 2014/15, the Commission funded 126 organizations to implement 248 individual programs serving children, families, and providers to ensure young children are healthy and ready to learn. The Commission annually reviews the performance of these investments to document the manner in which the funds were expended and the progress toward and the achievement of program goals and objectives.

Commission Investment

Evaluation activities are implemented primarily by the Commission's Evaluation Manager and evaluation consultant along with leveraging the Commission's evaluation relationships in collaborative projects. The annual work plan, approved by the Commission, includes activities and leveraged funding from grants, foundations and other community collaborative projects. Since fiscal year 2010/11, the Commission has invested more than $3.75 million on evaluation expenses.



Services Provided

In fiscal year 2014/15, the Commission's investment in its Evaluation System produced the following services:

Table 1. Services Provided by Evaluation System

Strategic Plan Outcome	Service	Number Completed
CB.2 Increase access and efficiency, quality and effectiveness	Community-wide Evaluation Reports	2
	Program Specific Evaluation Reports	4
	Community Data Reports	2

Program Highlights and Outcomes

The Commission's Evaluation System measures progress toward achievement of the Commission's goals and objectives. Initiatives as well as individual programs are evaluated. The evaluation reports developed in fiscal year 2014/15 are summarized below.

Community-wide Evaluation Reports

Early Development Index (EDI)

Since 2007, the Commission has partnered with school districts to implement the Early Development Index (EDI) to collect information about kindergarten aged children and measure developmental progress in five areas: physical health and well-being; social competence; emotional maturity; language and cognitive skills; and communication skills and general knowledge. This year marked the first year of 100 percent public school participation, representing almost 35,000 children. Key findings from data collected between fiscal year 2011/12 and 2014/15 indicate that:

- Countywide, 24.2% of students with an EDI were vulnerable (bottom 10th percentile) on one or more developmental areas; 27.6% were at-risk (10th-25th percentile) on one or more developmental areas; and 48.2% were on track (above 25th percentile) on all five developmental areas.
- Kindergarten students who participated in transitional kindergarten (TK) were less likely to be vulnerable on one or more developmental areas than those without a TK experience (15.3% versus 24.1%).
- More children who were English Language Learners (ELL) had vulnerabilities on one or more developmental areas than non-ELL students (31.0% versus 18.5%, respectively).
- Children eligible to receive free or reduced price lunch were more likely to be vulnerable on one or more developmental area than those not eligible for free or reduced price lunch (25.3% versus 23.3%, respectively).
- Children whose parents volunteered at school tended to be less vulnerable on one or more domains than those whose parents did not volunteer (16.5% versus 29.5%, respectively).
- Hispanic students were more likely to be vulnerable on one or more developmental area than Asian or White students (30.8%, 18.4%, and 16.5%, respectively).

Early Childhood Learning and Innovation Network for Communities (EC-LINC)

The Commission, in partnership with the Center for the Study of Social Policy and other national early childhood experts, participates in the leadership team for the national Early Childhood Learning and Innovation Network for Communities (EC-LINC). EC-LINC is dedicated to improving results for young children by accelerating the development of community-based, integrated early childhood systems including:

tackling shared challenges, building and disseminating knowledge of strategies used, and developing opportunities for local leaders and state and federal policy makers to work together to accelerate deployment of strategies. In fiscal year 2014/15, EC-LINC received Commission support for the development and analysis of standardized measures across nine sites in the U.S., including Orange County.

Program Specific Evaluation Reports

Learning Link

Since 2002, the Commission has provided funding for Learning Link programs. The goal of the Learning Link program is to provide an accessible and creative learning environment that helps young children to be better prepared for kindergarten and guides parents in their role as their children's first teachers. The Learning Link evaluation is being carried out in two phases. In fiscal year 2014/15, the Phase I evaluation report for Learning Link was completed.

Phase I documented the Commission-funded Learning Link programs and models, including program structure, services provided, annual costs, ways parents access program, and data collection processes. It also provided proposed research questions to explore in Phase II, which will evaluate the effectiveness of the Learning Link programs by addressing the overarching question: is the Learning Link program an effective strategy for improving child and family outcomes?

Catalytic Funding

The Commission's Catalytic funding strategies provide an opportunity for the Commission to impact outcomes for children without requiring ongoing investments. This is key in a climate where revenue is forecasted to continue to decline between 3-5% annually over the next 10 years. The Evaluation System work plan includes the development of an evaluation process to manage accountability of the Catalytic funding investments to ensure the ability to communicate the results and impact of these investments to the Commission. In fiscal year 2014/15, an evaluation plan was developed, which lays out a strategy for documenting and highlighting successes, challenges, and lessons learned as well as offering recommendations for ongoing quality improvement and initiative refinement. The overall question to be addressed by the Catalytic evaluation is: Is Catalytic Investment a successful strategy for maximizing diminishing Commission resources?

THINK Together, Early Literacy and Math Program

The 2014/15 school year marked the fourth year of the collaborative partnership between the Commission and THINK Together. Through this collaboration, the Early Literacy and Math Program (ELMP) promotes early literacy and math readiness in Orange County. The ELMP report indicates that most programmatic objectives for each service provided through the program were met and, in many cases, exceeded. The 2014/15 report provides insight into the successes and lessons learned, including key recommendations for fiscal year 2015/16 year. Highlights include:

- **Book Bank Program** again successfully exceeded book collection and distribution goals, with 90,371 children's books being redistributed to multiple communities across Orange County.
- **Read for the Record** again exceeded the targeted number of children read to. In addition, strong relationships were maintained with signature programs, particularly the Festival of Children Foundation.
- **Raising a Reader** program continued as an integrated program component at the Center-Based Program sites, and has expanded to new external partner sites.
- **Center-Based Programs** implemented the High Scope curriculum based on the documented validity and alignment to programmatic goals set for ELMP students. The Early Developmental Index (EDI) continues to serve as a valuable resource in identifying areas of high-need and allocating resources.

- **Reach Out and Read** program has undergone several significant changes throughout the previous two years, as part of the strategic downsizing of the program. THINK Together hired a Reach Out and Read facilitator to go deeper with literacy-rich environments at the existing clinics, and also to focus on recruiting and placing volunteers at the 13 sites that have agreed to sign the Memorandum of Understanding. Furthermore, THINK Together is reviewing the National Reach Out and Read program model and will be making strategic attempts to align their programming to that of the national model.

Pay for Success

The Bridges Maternal Child Health Network supports children's success by identifying health and developmental concerns during the critical first years of life, and providing families with education, screening, and linkage to services including referrals for home visitation services by public health nurses and other professional staff. With decreasing Commission revenues, innovative approaches to program sustainability are being explored to diversify the program's funding base, including innovative funding mechanisms such as "*Pay for Success*" contracts. In fiscal year 2014/15, Third Sector Capital Partners completed a Phase 1 Feasibility report on the Commission's efforts to implement a Pay for Success funding strategy for sustainability of the Bridges Network. The final phase of feasibility will continue to progress towards Pay for Success project construction. This final phase will focus on gaining additional commitment from CalOptima and designing a robust evaluation that captures the value of the Bridges Network.

Community Data Reports

Child Signature Program-3 (CSP-3)

In fiscal year 2014/15, local evaluation tools were developed in order to collect information not gathered through First 5 California's evaluation. Tools included surveys for teachers (intake and exit), nutrition survey, and a survey to capture information on the teachers and children served.

Comprehensive Approaches for Raising Educational Standards (CARES) Plus

In fiscal year 2014/15, tools were developed and refined to collect provider information, including intake and exit surveys for both new and returning participants. In addition, a write up was developed, which analyzed the intake and exit surveys and measured the impact of the CARES Plus program.

The Bridgespan Group
Collaborating to accelerate social impact

Children & Families
Commission of Orange County

Children & Families Commission of Orange County: Looking Back and Looking Forward

The Bridgespan Group

June 1, 2016

We assessed Commission progress against 2008 recommendations

1. More closely align the Commission's resources with community needs by directing a greater proportion of resources to address the **education achievement gap**

2. More closely align the Commission's resources with community needs by directing a greater proportion of resources to the county's **neediest children**

3. Shift the Commission's measurement and evaluation system from one focused primarily on program outputs to one focused on **child-level outcomes**

4. Shift a greater percentage of the Commission's funding from supporting program or organization operations to various forms of **"catalytic" funding** capable of delivering long-lived impact from temporary funding

The Commission employs a set of valuable practices

Valuable practices	• A focus on evidence-based programs and approaches • A rigorous, data-driven commitment to continuous improvement • A persistent focus on program sustainability

The Commission has developed a set of valuable competencies

Valuable competencies	• The ability to access other public funding sources • The ability to integrate research into programming • Strong data and evaluation capabilities • The ability to play value-added convening role

The Commission has built a set of valuable relationships and a trusted reputation

Valuable relationships	• Creating an innovation platform for others in Orange County • Playing a trusted role in identifying programs worthy of investment • Collaborating directly with other funders

We offer six recommendations for the Commission moving forward

1. Use the Early Development Index as a summative indicator of progress
2. Sustain the catalytic orientation to investment
3. Accelerate the transition from funding programs to building sustainable services
4. Continue to bring supplemental financial resources to bear
5. Leverage the Commission's reputation and non-financial assets
6. Use the Early Development Index to guide the allocation of the Commission's own resources