March 22, 2018
PowerPoint Presentations and Handouts

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Sacramento County

Early Learning Roadmap

Prenatal Through Age Eight



Promoting Excellence and Equity



2017–2022


A Message from the Superintendent

We hold a vision where each member of our community works collaboratively to support all children's learning and development, starting with prenatal care and extending through the critical early elementary age of eight. There is a powerful body of research that highlights the lasting impact of investing in high-quality early learning settings and experiences. While research provides compelling evidence of the powerful impact, availability of and access to high-quality programs continues to be a challenge. Data regarding the need and access to high-quality public and private early learning programs are limited. According to a report released in spring 2016 by the American Institutes for Research, 59% of three- and four-year-old children who are eligible are not currently served in state preschool, other Title 5 programs, Head Start, or transitional kindergarten. As a community, we must work together to provide greater access for all children. On behalf of our many stakeholders, it is with great pride that we are launching the *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight, 2017–2022*.

The *Sacramento County Early Learning Roadmap* reflects a deeply collaborative and intensive planning effort that began in spring 2016 and took place over a 15-month period. A broad range of stakeholders including school districts, the Sacramento County Office of Education (SCOE), private early learning providers, city and county agencies, First 5 Sacramento, social service agencies, providers, and family resource organizations contributed to the *Roadmap*. Building upon the information provided by stakeholders, a Steering Committee of 13 members met regularly to guide the development of the plan by the Superintendent's Early Learning Committee (SELC).

The SELC participated in a series of planning meetings from spring 2016 through summer 2017 to develop a multi-year plan that focuses on the following priority areas:

- Comprehensive services and supports for children and families
- Early learning and development for all children
- Family and community outreach and engagement
- Program structures and environments
- Early learning workforce, recruitment, retention, and professionalism

The five priority areas in the *Sacramento County Early Learning Roadmap* are presented in a matrix that provides specific recommendations, suggested approaches to implementing the recommendations, and proposed milestones for years one, three, and five.

We recognize the powerful impact of early childhood experiences on future academic achievement and social development. Please join us in creating a community where all of Sacramento County's children, prenatal through age eight, have an opportunity for a strong early start that sets the foundation for success in school and in life. This plan is intended to build momentum and garner support for our youngest learners.
We can—and must—all play a role in helping to prepare our children and families to reach this goal.

David W. Gordon
Sacramento County Superintendent of Schools

Sacramento Office of Education County

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Table of Contents

Sacramento County Early Learning Roadmap

Background

Introduction

As the Superintendent's Early Learning Committee worked to develop recommendations for the *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight*, committee members held extensive discussions to come to consensus about and clarify the terms "ALL children," and "community." The collective vision to serve ALL children includes children with disabilities/special needs and those from diverse social, economic, ethnic, cultural, and linguistic backgrounds. Central to this concept is the definition of "community" which is broad and inclusive of individuals who are committed to the well-being and care of children and their families. Community reflects families, children and youth, educators, business leaders, elected officials, policymakers, health professionals, and others.

It is important to recognize that the range of early learning settings serving Sacramento County's young children is inclusive of both public and private entities. In addition, young children are often in the care of family members, friends, and neighbors. The *Roadmap* reflects Sacramento County's commitment to ensure that all children thrive in a variety of settings (public, private, licensed, and license-exempt) and receive the highest quality of care.

The following summary statement reflects the collective vision and commitment that guided the development of the *Roadmap*:

We, the "Community," seek to support ALL children, from prenatal through age eight, through a continuum of learning and development.

We have articulated an ambitious approach—one that calls for supporting ALL children from prenatal through age eight.

We are committed to

- empowering and partnering with families to enhance children's social, emotional, physical, and cognitive skills so that they are successful in life and prepared to compete in a global economy;
- developing and sustaining high-quality, inclusive early learning programs and services that will support children's well-being;
- engaging with the wide range of public and private programs and other stakeholders on behalf of young children and their families.

Throughout the *Roadmap* development process, members of the Superintendent's Early Learning Committee utilized nine principles to guide its collaborative effort and aligned vision. These principles are grounded in early learning research, promising practices, and the knowledge and expertise of early learning professionals.

Guiding Principles

Parents and families are the primary teachers of their children and are authentically valued as partners in promoting children's growth and development.

All programs will provide a safe, high-quality, equitable, and inclusive learning environment.

Early learning programs will cultivate meaningful relationships between family-child, teacher-child, child-child and family-teacher, and significant others in the child's life.

Teachers will actively promote children's social-emotional, physical, and cognitive development.

Curricula will include research based, developmentally appropriate teaching and learning experiences that align with current California state foundations and standards.

Families will have access to a wide range of programs and services that meet the individual and diverse needs of all children and families.

Programs will be designed to promote inclusion of children with disabilities and children from a variety of socio-economic backgrounds who are also socially, culturally, ethnically, and linguistically diverse.

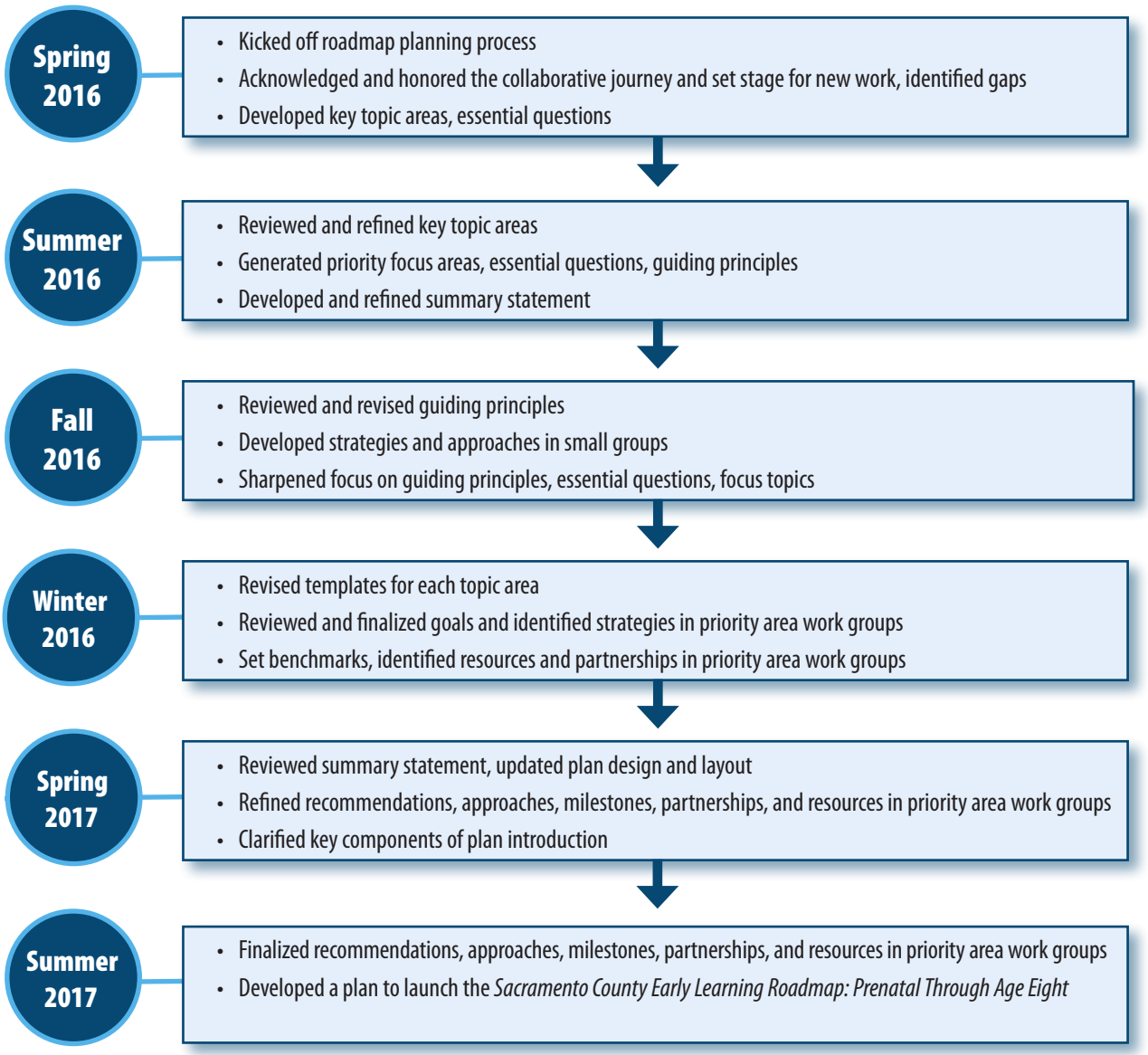
Programs wil be designed to provide seamless transitions and articulation from infancy to early grades.

All programs will incorporate a multi-tiered system of support for children and families.

Overview of the Planning Process

The *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight* reflects a collaborative commitment by the early learning community to the support, development, and continuation of high-quality early learning practices and experiences critical to all children. This *Roadmap* was developed over a 15-month period by the Superintendent's Early Learning Committee, guided by the Steering Committee. These committees consisted of a diverse group of early learning professionals representing family care homes, center-based care, school districts, community agencies, and the Sacramento County Office of Education.

Throughout its work, the Committee reflected on a collective vision to promote excellence and equity for Sacramento County's children, families, and early learning community. The goal was to develop recommendations to increase access to high-quality early learning experiences within Sacramento County.



Why Prenatal Through Age Eight?

In the past two decades, fascinating and complex insights on how the human brain develops have emerged through scientific research. Children begin learning at birth. The early years are a period of rapid growth when the environments and relationships children experience form a critical foundation for their future learning and development. Furthermore, the presence of frequent, ongoing stress affects biological processes within the developing brain. Experiences during these years of life can shape a child's long-term trajectory.

High-quality early learning experiences and resources lay a strong foundation for social-emotional development and learning. During this critical window of opportunity, a seamless, consistent, coherent, and coordinated support for young children and their families is of primary importance. For these reasons, we have chosen to focus this *Roadmap* on the needs of children prenatal through age eight.

Sacramento County Landscape

An estimated 358,835 children ages 0–17 live in Sacramento County. Approximately 177,721 children are ages 0–8.[1]

Sacramento County is a highly diverse community—racially, culturally, ethnically, linguistically,

- Sacramento County child population: 35% white; 31% Latino; 15% Asian/Pacific Islander; 10% African American; and 9% Multiracial[2]
- 17% of public school students are English Learners[3]

and economically.

- 25% of children live in poverty[4]
- 58% of students eligible for Free/Reduced Price School Meals[5]

Access to high-quality early learning programs is limited.

- 43% of 3- and 4-year-olds attend preschool[6]
- 28% of potential need for licensed child care is met in Sacramento County[7]

Health care and basic needs are available to some, but not all.

- 80% of women receive early prenatal care[8]
- Substantiated cases of abuse and neglect: 11.4 per 1,000 Sacramento County children[9]
- County child death rate: 32.3 per 100,000 children/youth ages 1–14[10]

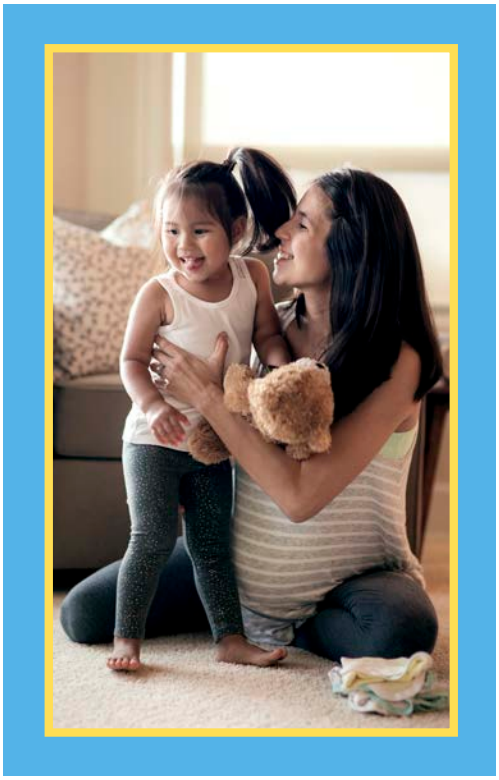
It is imperative that we work together to increase access and quality early learning opportunities for ALL children to achieve the goal of building a strong foundation for current and future success in school and life.

- 13% of students have identified special education needs[11]
- 40% of 3rd grade students met or exceeded English language arts/literacy standards on the Smarter Balanced Assessments[12]
- 43% of 3rd grade students met or exceeded mathematics standards on the Smarter Balanced Assessments[13]

- 81% of 12th grade students graduated on time[14]
- 42% of 12th grade students completed coursework requirements for admission to University of California and California State University[15]

(Notes provided on page 43)

Building on Existing Work



This *Roadmap* builds on previous and ongoing efforts that commenced more than a decade ago when the Sacramento County Office of Education convened the Superintendent's Preschool Committee. Nearly 100 different collaborative organizations began their work on the *Sacramento County Preschool Plan 2010-2015* to expand and enhance existing high-quality preschool programs in Sacramento. Since the *Plan* was launched, Sacramento County has honored the community-wide collaborative work through countywide implementation, and a desire to build upon and leverage the momentum. In the past decade, key partners such as First 5 Sacramento, First 5 California, and the California Department of Education have made major commitments and investments in early learning and care.

Significant progress has been made in improving partnerships between schools and other community organizations that prepare children for the rigor of kindergarten. This was a major focus of the *Sacramento County Preschool Plan 2010-2015*. First 5 Sacramento continues to provide substantial funding to support the healthy development of children birth through five, empower families, and strengthen communities. In addition, Sacramento County was initially awarded federal Race to the Top–Early Learning Challenge (RTT–ELC) funds, followed by subsequent funding from the California Department of Education and First 5 California, to implement quality improvement efforts at the local level. As brain development research created a heightened awareness of the importance of early learning, federal, state, and local initiatives have increased investments to expand high-quality environments and experiences for ALL children birth through age five.

Many key organizations in Sacramento County and across the state of California have also articulated goals highlighting the importance of improving outcomes for children from prenatal through age eight. The initiatives from these local and state organizations are illustrative of the widespread recognition of the importance of early learning experiences and support for ALL children. A document entitled "Building on Local, State, and Federal Initiatives" (see Appendix A) provides a list of some key organizations as well as links to more detailed information on specific early learning initiatives.

Another key contributor to local collaboration in Sacramento County is the Local Child Care and Development Planning Council (LPC) which is comprised of members appointed by the County Board of Supervisors and the County Superintendent of Schools. The Council collaborates with community partners and is dedicated to supporting early care and education programs and services that are accessible, affordable, and high-quality for all of Sacramento County's children and their families. LPC members contributed to the development of the *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight*. Moreover, the Council developed the *Sacramento County Child Care and Development Strategic Plan 2017-2022* (see Appendix B) that targets three key focus areas: Increase Accessibility, Increase Availability, and Improve Quality. This plan is aligned with county wide efforts and will be implemented in collaboration with the early learning community.

Overview of the Quality Rating and Improvement System

In 2012, Sacramento County was one of 16 California counties awarded federal Race to the Top–Early Learning Challenge funds to improve early learning and development for young children so that those most in need are ready to succeed in kindergarten and beyond. This funding was allocated to support the Quality Rating and Improvement System (QRIS).

QRIS has become a cornerstone of California's quality improvement efforts. In 2014, Governor Brown approved legislation for annual funding of a QRIS Block Grant to support quality improvement efforts that increase the number of children in high-quality California State Preschool Programs (CSPP). Sacramento County also received funding for Infant/Toddler and Migrant Education QRIS Block Grants. These QRIS Block Grants are administered by the California Department of Education (CDE). Introduced in the fall of 2017, Quality Counts California–Raising the Quality of Early Learning and Care aligns early learning resources and supports into a cohesive statewide plan of QRIS that encompasses the collaborative efforts between the California Department of Education, First 5 California, and QRIS work in counties across the state.

In addition, First 5 California allocated funding to support and align statewide QRIS efforts through IMPACT (Improve and Maximize Programs so All Children Thrive). In collaboration with CDE, First 5 California provides an opportunity for private centers, family child care homes, faith-based centers, and family, friends, and neighbors to participate in quality improvement efforts.

Raising Quality Together (RQT) is Sacramento County's Quality Rating and Improvement System. The QRIS is a comprehensive system that establishes uniform quality standards for early learning programs. RQT is voluntary and provides research-based resources and support for early learning providers serving children prenatal through age five.

Moving forward, RQT will be integrated into the recommendations, approaches, and milestones in the *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight*. The countywide approach will promote seamless coordination with other efforts that are also underway to support high-quality, early learning experiences in Sacramento County. This plan seeks to align community efforts to Raise Quality Together.

raising QUALITY together

Sacramento County Early Learning Roadmap

Priority Areas and Recommendations

Five Priority Areas: Summary

To improve the quality early learning experiences for ALL children, the Superintendent's Early Learning Committee established five priority areas, including recommendations, approaches, and milestones.

Below is a summary of the five priority areas which span the range from prenatal through age eight. The complete priority area descriptions are on the following pages.

Priority Area: Comprehensive Services and Supports for Children and Families

Recommendation: *Promote, develop, and implement an integrated system of comprehensive services for children and families.*

Priority Area: Early Learning and Development for ALL Children

Recommendation: *Provide quality universal early learning experiences and services that support ALL children served in public and private early learning environments.*

Priority Area: Family and Community Outreach and Engagement

Recommendations: *Engage families as vital partners in children's learning and development* ***AND*** *develop and expand community partnerships that increase outreach and access to services and resources for ALL children and their families.*

Priority Area: Program Structures and Environment

Recommendations: *Improve the quality of early learning programs* ***AND*** *establish communication systems to ensure seamless transitions from prenatal through age eight.*

Priority Area: Early Learning Workforce Recruitment, Retention, and Professionalism

Recommendation: *Promote recruitment, retention, and professionalism of a diverse early learning workforce.*

Priority Area:

Comprehensive Services and Supports for Children and Families

From prenatal through age eight, families need comprehensive services that meet their individual and diverse needs. These services and supports for children and families in Sacramento County should be grounded in an approach that includes screenings, referrals, and services and supports that ensure healthy development and social-emotional well-being. There are a wide variety of rich resources available to families in Sacramento County. It is critical that families are knowledgeable and have access to resources and services available in the community.

Recommendation: *Promote, develop, and implement an integrated system of comprehensive services for children and families.*

Approaches

- Identify available resources and barriers in order to facilitate families' connection and access to comprehensive services. Implement Help Me Grow and Black Child Legacy Campaign in Sacramento County to support children's optimal development.
- Communicate needs of families and children with stakeholders and policymakers to prioritize and invest in comprehensive services and supports.
- Build awareness of the range of services throughout the community.

Proposed Milestones

YEAR 1

- Conduct community assessment, survey clients to map assets, and identify needs for comprehensive services and supports.
- Identify stakeholders, policymakers to prioritize and invest in comprehensive services.
- Develop and regularly update comprehensive list of resources and supports for families by geographic area.

YEAR 3

- Develop plan of action based on findings from community asset mapping.
- Build relationships and share information with new and existing stakeholders to foster buy-in.
- Utilize venues such as conferences to highlight community organizations and services.
- Regularly update comprehensive list of resources and supports based on needs.

YEAR 5

- Work with partners to implement a coordinated system of comprehensive services, which may potentially include data system for assessment and monitoring.
- Convene stakeholders annually to keep them informed, motivated, and committed.
- Make comprehensive list of resources and supports for families accessible online and on mobile devices, in print-friendly format and in key languages.

Priority Area:

Early Learning and Development for ALL Children

Central to Sacramento County's vision is a recognition that high-quality early learning and development experiences for all children happens everywhere—in the home, the classroom, playgrounds, libraries, and across a variety of other settings. A wide range of research findings indicate that quality early learning and development programs result in improved outcomes for children. California has an existing Early Learning and Development System that is the cornerstone of the Quality Rating and Improvement System (see Appendix C). Additionally, a Multi-Tiered System of Supports (MTSS) offers the potential to create needed systematic change through intentional design and redesign of services and supports that quickly identify and match the needs of all children. The implementation of an MTSS (see Appendix D) meets the social-emotional and cognitive needs of ALL children through an integrated, comprehensive framework that focuses on core components necessary for children's cognitive, behavioral, and social success.

Recommendation: *Provide quality universal early learning experiences and services that support ALL children served in public and private early learning environments.*

Approaches

- Ensure all ECE programs have access to elements of Quality Rating and Improvement System (QRIS). The System contains components including: 1) California Learning and Development Foundations and California State Standards; 2) Curriculum Frameworks; 3) Desired Results Assessment System; 4) Professional Development, Supports, and Competencies; and 5) Program Guidelines and Resources.
- Create a multi-tiered system of support (MTSS) to meet social-emotional and cognitive needs of ALL children.
- Implement Help Me Grow in Sacramento County to support children's optimal development.

Proposed Milestones

YEAR 1

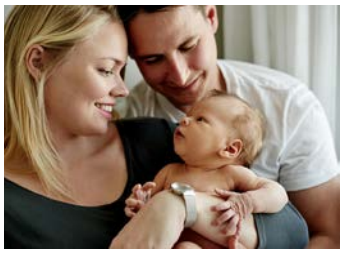
- Support understanding of elements and alignment of QRIS and other state resources to improve outcomes for children and families.
- Identify potential resources to support a prenatal through age eight continuum.
- Develop MTSS. Identify resources and begin development of MTSS universal supports.
- Launch Help Me Grow and explore potential partnerships and funding to expand this model.

YEAR 3

- Continue to support understanding of elements of the QRIS and other statewide resources.
- Begin the development of resources to support a prenatal through age eight continuum.
- Develop and implement MTSS.
- Expand the Help Me Grow model to develop a coordinated and systematic approach to conduct developmental screenings and increase access to early identification and intervention services.

YEAR 5

- Implement approach that connects QRIS to improving outcomes for children and families.
- Disseminate resources to support a prenatal through age eight continuum.
- Continue to implement, refine, and broaden implementation of MTSS.
- Continue to expand Help Me Grow to develop a robust system that will lead to greater access for developmental screenings, referrals, and early intervention services for all children.



Priority Area:

Family and Community Outreach and Engagement

As their children's first and most important teachers, families are critical partners in supporting learning and development for children. Recognizing that it takes a village to raise a child, families, early learning professionals, and the community all fulfill critical roles and contribute uniquely to supporting the development of each child. Coordination of the knowledge, services, and resources contribute to family engagement and development of the whole child. Parents and families contribute a deep understanding of children, including information about their growth and development. Early learning professionals contribute their knowledge of child learning and development. The community contributes resources and services to support the healthy development of the child and the family. Resources and services that include *Strengthening Family Protective Factors Framework* (see Appendix E), *Dual Capacity-Building Framework for Family-School Partnerships* (see Appendix E), and Black Child Legacy Campaign (see Appendix A) will contribute to effective family and community outreach and engagement.

Recommendations: *Engage families as vital partners in children's learning and development* ***AND*** *develop and expand community partnerships that increase outreach and access to services and resources for ALL children and their families.*

Approaches

- Use strength-based approach to partner with families by utilizing Strengthening Families Program, Protective Factors Framework, and Trauma Informed Care.
- Partner with families to co-create high-quality early learning experiences that are responsive to ALL children.
- Conduct outreach to engage community partners to support high-quality early learning experiences that are responsive to and inclusive of ALL children and their families.

Proposed Milestones

YEAR 1

- Build awareness of Strengthening Families Program, Protective Factors Framework, and Trauma Informed Care.
- Engage families to identify barriers and potential opportunities to actively promote their child's early learning and development.
- Develop countywide strategies to engage early learning programs and community partners in building a network of services and resources for ALL children and their families.

YEAR 3

- Utilize Strengthening Families Program, Protective Factors Framework and Trauma Informed Care training and resources with families and ECE professionals.
- Identify and implement promising family engagement practices that are responsive and inclusive of ALL children and their families.
- Collaborate with community partners to implement identified strategies to increase access to services and resources for ALL children and their families.

YEAR 5

- Conduct evaluation to measure impact and benefits of Strengthening Families Program, Protective Factors Framework and Trauma Informed Care.
- Conduct evaluation to measure family-identified barriers and impact of implementing promising family engagement practices.
- Continue to implement and refine collaboration approaches with community partners.

Priority Area:

Program Structures and Environments

Sacramento County is invested in continually improving the quality of early education for ALL children. To ensure that classrooms and child care environments support the optimal development of children, a voluntary assessment program was created that establishes uniform standards for program quality for early childhood, the Quality Rating and Improvement System that includes core tools and resources (see Appendix C). These standards measure areas such as curriculum, nutrition, teachers and teaching, safety, and environment. California has also developed curriculum frameworks, standards and guides, spanning from infancy through age eight and beyond, which provide guidance to support the growth and development of each child in safe and caring learning environments (see Appendices F and G). These California standards, frameworks, and guides are designed to establish a seamless transition from early learning programs into elementary schools to facilitate optimal experiences for children and families.

Recommendations: *Improve the quality of early learning programs **AND** establish communication systems to ensure seamless transitions from prenatal through age eight.*

Approaches

- Engage ECE professionals in developing high-quality early learning environments that incorporate research-based resources, tools aligned with state/national quality improvement systems.
- Develop pathways within and across programs to support seamless transitions for children from birth through age eight.

Proposed Milestones

YEAR 1

- Build awareness and understanding of statewide quality improvement core tools and resources to enhance quality of early learning programs and environments.
- Engage early learning partners in identifying promising practices and recommendations to support communication between and among programs serving children from prenatal through early elementary grades.
- Explore opportunities for a coordinated database and assessment system for Sacramento County.

YEAR 3

- Expand access to quality improvement core tools, resources, and professional learning opportunities to enhance quality of early learning programs and environments.
- Pilot recommended practices for a system of communication, including a countywide school readiness tool to support seamless transitions for children.
- Pilot a coordinated child information and assessment system to promote and support seamless and articulated transitions.

YEAR 5

- Implement a comprehensive quality improvement system and ensure seamless transitions from prenatal through age eight.
- Implement a system of communication, including a countywide school readiness tool to support seamless transitions for children.
- Expand access to and utilization of a coordinated database and assessment system to support articulation and transitions for young learners in Sacramento County.

Priority Area:

Early Learning Workforce Recruitment, Retention, and Professionalism

Children's brains develop rapidly from prenatal through age eight. Experiences and relationships with parents, families, caregivers, and other educators who support their learning and growth form the foundation for their future development. Providing consistency and continuity across systems and services as the needs of young children are addressed during this critical period is closely linked to the professional learning of those who provide the services. Given what research shows about the critical role educators play in the early years of children's lives, expectations for these educators have increased. Institutions of higher education, which include public and private community colleges and four-year institutions, are critical in preparing students to educate young children. Additionally, ongoing professional learning opportunities are needed to develop and maintain a diverse early learning workforce. Against this backdrop, Sacramento County must consider issues of compensation, affordability, requirements, and expectations as it seeks to recruit, retain, and support quality educators working in public or private settings serving children from prenatal to age five.

Recommendation: *Promote recruitment, retention, and professionalism of a diverse early learning workforce.*

Approaches

- Recruit early learning workforce that meets or exceeds qualifications, certification and/or credentialing requirements for California.
- Retain early learning workforce by supporting ongoing and/or advanced professional learning opportunities which includes mentoring and coaching for ECE professionals.
- Increase recognition of early learning workforce as professionals by educating and influencing policy makers and decision makers on the need to increase compensation for ECE professionals.

Proposed Milestones

YEAR 1

- Highlight importance and benefits of early learning as a profession by developing outreach materials.
- Organize ECE Pathways events to recruit and retain highly qualified workforce.
- Identify gaps and promote the utilization of statewide professional learning opportunities, including the California Workforce Registry, QRIS, and other resources, to ECE professionals.
- Collect and review local and/or statewide data on current compensation rates (salary and benefits) for ECE professionals.

YEAR 3

- Finalize development of outreach materials for dissemination.
- Expand ECE Pathways events.
- Plan and host events such as ECE Career Fairs, the Early Learning Summit, and other countywide events.
- Develop countywide plan for a communication system to widely disseminate professional learning opportunities and other resources to ECE professionals.
- Build awareness, identify champions for the need to increase compensation for ECE professionals with policy makers and elected officials.

Recommendation, continued: *Promote recruitment, retention, and professionalism of a diverse early learning workforce.*

Approaches	Proposed Milestones
See previous page.	**YEAR 5** • Continue to disseminate and refine local outreach materials and resources to assist individuals in exploring and navigating career options. • Continue to schedule events such as ECE Pathways, or other opportunities, that are responsive to changes in professional requirements. • Implement a communication system to disseminate professional learning opportunities and other resources to the ECE professionals. • Advocate for legislation for increased compensation with local and statewide partners being mindful of the potential impact on families and programs.

Sacramento County Early Learning Roadmap

Conclusion

Next Steps

The Sacramento County Early Learning Roadmap: Prenatal Through Age Eight, 2017-2022 provides guidance and direction to promote excellence, collaboration, and equity. This work builds a solid foundation to expand and enhance early learning experiences and opportunities for ALL children prenatal through age eight.

The convening of the Superintendent's Early Learning Committee to collaboratively develop a roadmap for expanding and enhancing early learning experiences in Sacramento County was an exciting opportunity to reflect on, honor, and build upon previous success. This collaborative approach broadened recognition of and commitment to the importance of early learning. The *Sacramento County Early Learning Roadmap: Prenatal Through Age Eight, 2017-2022* provides opportunities for the community to engage in this vital work to positively impact the lives of ALL children prenatal through eight. As the work moves forward, the recommendations and approaches found within the *Roadmap* will align efforts to achieve milestones, resulting in excellence, equity, and high quality in early learning.

A Call to ACTION

Now that you are familiar with this *Roadmap*, **we challenge you to ask these questions**:

- What can you and your organization contribute to this collective community effort?
- How can you and your organization support efforts to promote excellence, equity, and high quality in early learning?

Resources

CALIFORNIA DEPARTMENT OF EDUCATION (CDE) RESOURCES	
The Alignment of the California Preschool Learning Foundations with Key Early Education Resources	http://www.cde.ca.gov/sp/cd/re/documents/psalignment.pdf
Standards and Curriculum Frameworks	
• Common Core State Standards	http://www.cde.ca.gov/re/cc/
• Content Standards	http://www.cde.ca.gov/be/st/ss/index.asp
• Curriculum Frameworks	http://www.cde.ca.gov/ci/cr/cf/allfwks.asp
California Preschool Program Guidelines	
This CDE publication provides administrators, teachers, and college instructors with guidance on the essential elements of high-quality preschool programs.	http://www.cde.ca.gov/sp/cd/re/documents/preschoolproggdlns2015.pdf
Guidelines for Early Learning in Child Care Home Settings	https://www.cde.ca.gov/sp/cd/re/documents/elguidelineshome.pdf
Infant/Toddler Learning & Development Foundations	https://www.cde.ca.gov/sp/cd/re/itfoundations.asp
Kindergarten in California	
• Transitional Kindergarten Frequently Asked Questions • Amendment to California Education Code 48000(c)	http://www.cde.ca.gov/ci/gs/em/
• Transitional Kindergarten Implementation Guide	http://www.cde.ca.gov/ci/gs/em/documents/tkguide.pdf
Preschool Curriculum Frameworks	
Aligned with the foundations, the curriculum frameworks provide guidance on planning learning environments and experiences for young children.	
• Volume 1 (Social-Emotional Development, Language and Literacy, English-Language Development, and Mathematics)	http://www.cde.ca.gov/sp/cd/re/documents/psframeworkkvol1.pdf
• Volume 2 (Visual and Performing Arts, Physical Development, and Health)	http://www.cde.ca.gov/sp/cd/re/documents/psframeworkvol2.pdf
• Volume 3 (History-Social Science and Science)	http://www.cde.ca.gov/sp/cd/re/documents/preschoolframeworkvol3.pdf
Preschool English Learners: Principles and Practices to Promote Language, Literacy, and Learning A resource guide to educate preschool English learners	http://www.cde.ca.gov/sp/cd/re/documents/psenglearnersed2.pdf
Preschool Learning Foundations	
The foundations for preschool-age children identify key domains of learning and guide instructional practice.	
• Volume 1 (Social-Emotional Development, Language and Literacy, English-Language Development, and Mathematics)	http://www.cde.ca.gov/sp/cd/re/documents/preschoollf.pdf
• Volume 2 (Visual and Performing Arts, Physical Development, and Health)	http://www.cde.ca.gov/sp/cd/re/documents/psfoundationsvol2.pdf
• Volume 3 (History-Social Science and Science)	http://www.cde.ca.gov/sp/cd/re/documents/preschoolfoundationsvol3.pdf

RESOURCES, *continued*

LOCAL, STATE, and NATIONAL RESOURCES	
Black Child Legacy Campaign Black Child Legacy Campaign is a community-driven movement established by the Steering Committee on the Reduction of African American Child Deaths (RAACD) to reduce deaths of African American children in Sacramento County.	http://blackchildlegacy.org/
California Child Care Resource and Referral Network	http://www.rrnetwork.org/about-the-rr-network
• **Child Action, Inc.** Child Action, Inc. is a private, non-profit corporation. The services provided include child care resources and referrals, child care subsidies, recruitment and training of child care professionals, and parent education and support in Sacramento.	https://wp.childaction.org/
California County Superintendents Educational Service Association (CCSESA)	
• Transitional Kindergarten Professional Development Modules	http://ccsesa.org/special-projects/tk-professional-development-modules/
• Transitional Kindergarten (TK) Planning Guide – A Resource for Administrators of California Public School Districts	http://www.ccsesa.org/wp-content/uploads/2013/12/TKGuide_11311_Web.pdf
• Transitional Kindergarten Professional Resource Guide for Administrators	http://ccsesa.org/wp-content/uploads/2015/08/TK_Adm_Guide_July_15_Final.pdf
California ECE Workforce Registry The California ECE Workforce Registry is a state, regional, and local collaboration designed to track and promote the education, training, and experience of the early care and education workforce for the purpose of improving professionalism and workforce quality to positively impact children.	https://www.caregistry.org/
California Inclusion and Behavior Consultation A network of experienced, local consultants provides on-site consultation to build the capacity of the programs and providers to respond effectively to children with special needs or challenging behaviors.	https://www.cibc-ca.org/wp/
California Preschool Instructional Network (CPIN) CPIN, funded by CDE, conducts professional development on CDE publications such as the *Preschool Learning Foundations*, *Preschool Curriculum Framework* and Preschool English Learners Guide.	http://www.cpin.us
California State University (CSU) Transitional Kindergarten Modules Supporting Young Learners	http://teachingcommons.cdl.edu/tk/modules_teachers/index.html
Family Resource Centers	
• **Birth and Beyond Family Resource Centers** Family Resource Centers are located across Sacramento County and offer a range of services, activities, and opportunities.	https://www.birth-beyondfrc.com/
• **Warmline Family Resource Center** Warmline provides free support, training, and consultation to families of children with disabilities birth to age 26 in Northern California.	http://www.warmlinefrc.org

LOCAL, STATE, and NATIONAL RESOURCES, *continued*	
First 5 California Created by voters under Proposition 10, First 5 California is dedicated to improving the lives of California's young children and their families through a comprehensive system of education, health services, child care, and other crucial programs.	http://www.ccfc.ca.gov
First 5 Sacramento First 5 Sacramento Commission is committed to supporting the healthy development of children zero to age five, the empowerment of families, and the strengthening of communities.	http://www.first5sacramento.net/
Help Me Grow California Help Me Grow connects the dots across healthcare, early education, community resources, and the family to ensure children achieve their optimal, healthy development through early identification and intervention.	http://helpmegrowca.org/
National Association for the Education of Young Children (NAEYC) Resources to promote Developmentally Appropriate Practice (DAP) birth through age eight	http://www.naeyc.org/DAP http://www.naeyc.org/DAP/kindergarteners http://www.naeyc.org/DAP/primary
Sacramento County QRIS: Raising Quality Together Resources and information for early learning professionals	http://www.sacramentocountyearlylearning.org/
Sacramento Employment and Training Agency (SETA) Head Start SETA Head Start improves the lives of income eligible families by providing child development and school readiness services including education, health, nutrition, and mental health.	http://headstart.seta.net/early-head-start/
Sacramento Public Library Sacramento Public Library welcomes and supports families from birth through adulthood. The Library enhances the role of parents as their children's first teacher by providing storytime programming, early literacy information, rich early learning environments and play spaces, and access to free books and materials at all 28 locations throughout Sacramento County.	http://www.saclibrary.org/
Transitional Kindergarten (TK) California Online resources to support the successful implementation of transitional kindergarten	http://www.tkcalifornia.org/
Women, Infants, Children (WIC) The Sacramento County WIC program helps pregnant women, new moms, and young children eat well, stay healthy, and be active. WIC provides free, healthy foods, nutrition education for you and your family, referrals to community services, and information and support for breastfeeding.	http://www.dhhs.saccounty.net/PRI/WIC/pages/women-infants-and-children-home.aspx
211 Sacramento 211 Sacramento puts you in touch with the services you need with referral to more than 1,600 community services in the Sacramento area.	http://www.211sacramento.org/211/

APPENDIX A:
Building Upon Local, State, and Federal Initiatives

In Sacramento County and across the state of California, several organizations have articulated goals that highlight the importance of improving the quality of early care and education programs and services for children from prenatal through age eight. A summary of several key initiatives are identified below.

Local Initiatives

- The Steering Committee on Reduction of African American Child Deaths (RAACD) established the Black Child Legacy Campaign as a community driven movement to reduce the disproportionate deaths among African American children in Sacramento County by 10-20% by 2020. The Committee's *Implementation Plan for Sacramento County 2015-2020* identifies five priority strategies. The Steering Committee is funded by the County of Sacramento, City of Sacramento, and First 5 Sacramento, and is managed by the Center at Sierra Health Foundation.

  Web site address: http://blackchildlegacy.org

- Help Me Grow is a system that collaborates with families, providers, and agencies to help ensure children birth to age five reach their optimal development. To achieve this, it provides free and confidential support in early childhood development, promotes early identification of developmental concerns, helps families access resources, and builds the capacity of early childhood providers.

  Web site address: http://helpmegrowca.org

- First 5 Sacramento Commission's *Strategic Plan for Fiscal Years 2015–16 through 2017–18* and the *2015 Implementation Plan* identify commitments and investments to support children ages birth through five in areas that include: health, dental, nutrition, early care, school readiness, effective parenting, and community connections.

  Web site address: http://www.first5sacramento.net

- Raising Quality Together: Sacramento County's Quality Rating and Improvement System (QRIS) is an improvement and recognition system designed to engage licensed early learning centers and family child care homes in continuous quality improvement. Sacramento County's QRIS is an affiliate of Quality Counts California and is focused on "Raising the Quality of Early Learning and Care."

  Web site address: http://www.sacramentocountyearlylearning.org

State Initiatives

- The California Department of Education's Early Education and Support Division has established an early learning and development system comprised of resources to support professional learning, teaching and learning, and assessments.

  Web site address: https://www.cde.ca.gov/sp/cd

- California's content standards, adopted by the California State Board of Education, were designed to encourage the highest achievement of every student in grades K–12 by defining the knowledge, concepts, and skills students should acquire at each grade level.

  Web site address: https://www.cde.ca.gov/be/st/ss

State Initiatives, *continued*

- California Resource and Referral Network is made up of Child Care Resource and Referral (R&R) agencies from every county in California. R&R services support parents, providers, and local communities in finding, planning for, and providing affordable, quality child care. In addition, R&R agencies provide supports in topics as diverse as health, safety, child development, and sound business practices. R&R agencies work with providers to improve the quality of child care as well as maintain and expand the supply of child care in each county. Services are free and available to all parents and child care providers.

  Web site address: http://www.rrnetwork.org

- The Commission on Teacher Credentialing has convened the Child Development Permit Advisory Panel to review and update its requirements for issuance and renewal of permits which authorize service in the care, development, instruction, and supervision of children.

  Web site address: https://www.ctc.ca.gov/educator-prep/early-care

- The Speaker's Blue Ribbon Commission on Early Childhood Education is a policy-driven body tasked with developing strategic solutions to improve outcomes for some of California's youngest learners and their families. This Commission serves as a platform to discuss ways to improve the early learning system in California and to inform future policy and budget actions.

  Web site address: https://speaker.asmdc.org/blue-ribbon-commission-early-childhood-education

- The State Advisory Council on Early Learning and Care is a governor-appointed leadership body that ensures statewide collaboration among early childhood programs and will help to define future policy direction for early learning and related services for young children in California.

  Web site address: https://www.cde.ca.gov/sp/cd/ce/stateadvisorycouncil.asp

- Experts and leaders from across California created an implementation plan to improve the education, training, and support of those who work with children. Their work stemmed from the Institute of Medicine and the National Research Council's 2015 report, *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation*, which offers research about early childhood development and the competencies and supports that professionals working with young children need.

  Web site address: http://twb8-ca.net/files/CA_TWB8_Implementation_Plan.pdf

Federal Initiatives

- The *Non-Regulatory Guidance: Early Learning in the Every Student Succeeds Act (ESSA)—Expanding Opportunities to Support Our Youngest Learners*, identifies opportunities to support early learning as a means of addressing education equity in order to eliminate disparities in student achievement and support students' success in school.

  Web site address: https://www2.ed.gov/policy/elsec/leg/essa/essaelguidance10202016.pdf

APPENDIX B:
Sacramento County Child Care and Development Strategic Plan (2017–2022)

Sacramento County Child Care and Development Strategic Plan 2017–2022

The Sacramento County Child Care and Development Strategic Plan 2017–2022 identifies goals and strategies to address the accessibility, availability, and quality of early care and education needs within Sacramento County. The plan will be implemented through the collaboration of community partners, including child care providers, families, school districts, public agencies, businesses, and community-based organizations. The Sacramento County Local Child Care and Development Planning Council developed a five-year strategic plan to address three goal areas.

Goal 1: Increase Accessibility

Promote access to child care and development programs for all children and families.

Strategies

1. Support programs and services which meet the child care and development needs of underserved populations, including low income, infant/toddler, nontraditional hours, school age, and special needs.
2. Promote a mixed-delivery system of high-quality early care and education providers, including family, friends, and neighbors; family child care homes; private centers; and school district programs.
3. Disseminate child care subsidy resources and information to families.
4. Support and conduct research on status of and factors that affect the accessibility of child care and development programs and services.
5. Develop, collect, and provide information about accessible high-quality early care and education programs and services that meet the needs of families.

Goal 2: Increase Availability

Provide support to state, municipal, county, and provider (private and public) stakeholders regarding the planning and expansion of child care and development programs and services.

Strategies

1. Collaborate with stakeholders to increase the availability of child care and development programs and services.
2. Disseminate information regarding funding opportunities to expand child care and development programs and services.
3. Bring community awareness of the need to expand early care and education programs and services.

Goal 3: Improve Quality

Promote participation in quality building initiatives.

Strategies

1. Encourage a collaborative relationship between state licensing and licensees to support all types of child care to meet and surpass health and safety regulations.
2. Support license-exempt child care providers (e.g., family, friends, and neighbors) to build their child development knowledge and skills and to provide quality care and education.
3. Promote the acquisition of higher education by early care and education providers.
4. Disseminate information to early care and education providers to build awareness of professional learning opportunities designed for continuous quality improvement.
5. Disseminate information about the Quality Rating and Improvement System (QRIS) to early care and education providers and the community.
6. Share information regarding elements of quality with families and community partners.
7. Collaborate with institutions of higher education, child care providers, community organizations, and other community partners to increase the number of qualified early childhood education professionals.

The Council is comprised of members appointed by the County Board of Supervisors and the County Superintendent of Schools. The Council collaborates with community partners and is dedicated to supporting early care and education programs and services that are accessible, affordable, and high quality for all of Sacramento County's children and their families.

Established through California *Education Code* § 8499.3–8499.7, Local Child Care and Development Planning Councils are in each of California's 58 counties. The primary roles of the Sacramento County Local Child Care and Development Planning Council (LPC) are:

- to assess child care and development services based on the needs of families in the local community.
- to advise the Sacramento County Board of Supervisors and the Sacramento County Board of Education with respect to child care needs of families.
- to serve as a forum to address child care needs both subsidized and non-subsidized child care.
- to develop annual priorities for potential state funding for child care for infants, toddlers, preschoolers, and school age children.
- to develop a five-year plan identifying local needs, gaps, and recommendations.
- to oversee the AB 212 Teacher Stipend and California Transitional Kindergarten Stipend programs.

Membership categories include: Child Care Consumer, Child Care Provider, Public Agency Representative, Community Representative, and Board Discretion. For further information about the LPC and membership, please contact Linnea Hathaway, Project Specialist, (916) 228-2556 or lhathaway@scoe.net.

APPENDIX C:
Quality Rating and Improvement System (QRIS)

An emergence of research and data provides evidence of the benefits of early learning for children, family, and society. A collective focus on increasing access to high-quality early learning programs is essential.

The **Quality Rating and Improvement System (QRIS)** assists early learning professionals in identifying areas to improve and/or maintain quality. It also provides families with information to identify and access high-quality early learning experiences. QRIS is a voluntary program with a focus on a comprehensive system that establishes uniform standards of quality and provides quality research-based support for early learning programs serving children birth through age five.

The following are components of a Quality Rating and Improvement System:

- Quality standards for programs and practitioners
- An infrastructure and supports to meet quality standards
- Monitoring and accountability protocols to ensure compliance with quality standards
- Block grants and incentives linked to achievement of quality standards
- Engagement and outreach strategies

Quality Counts California—Raising the Quality of Early Learning and Care

In 2012, California received a highly competitive Race to the Top–Early Learning Challenge (RTT–ELC) federal grant to implement a QRIS. The goals of RTT–ELC were to improve the quality of early learning programs and to close the achievement gap for young children with high needs. From January 2012 through June 2016, California took a unique approach, which built upon local and statewide successes. Through a collaborative effort between the 17 RTT–ELC Regional Leadership Consortia (RTT–ELC Consortia), the California Department of Education (CDE), and First 5 California (F5CA), the RTT–ELC Consortia agreed to align their local QRIS to a common "Quality Continuum Framework." This framework includes a common rating matrix.

The Rating Matrix uses the terms "core" and "elements," which refer to the three overarching categories and the indicators or components within these categories. The seven elements support the three core categories. Elements five and seven apply to early learning centers only, as shown below.

CORE ELEMENTS	Core 1: Child Development and School Readiness	Core 2: Teachers and Teaching	Core 3: Program and Environment
	Element 1. Child Development and School Readiness **Element 2.** Developmental and Health Screenings	**Element 3.** Early Childhood Educator Qualifications: Minimum Qualifications for Lead Teacher/Family Child Care Home **Element 4.** Effective Teacher–Child Interactions	**Element 5.** Licensing and Regulatory Requirements: Ratios and Group Size (Centers Only) **Element 6.** Program Administration and Leadership: Environment Rating Scale(s)—ECERS-R, ITERS-R, FCCERS-R **Element 7.** Program Administration and Leadership: Director Qualifications (Centers Only)

Adapted from California Department of Education California Quality Rating and Improvement System (CA–QRIS) Consortium Implementation Guide. https://www.cde.ca.gov/sp/cd/rt/documents/caqrisimplementguide.pdf

Sacramento County's Quality Rating and Improvement System: Raising QUALITY Together (RQT)

Sacramento County was one of 16 counties and 17 agencies that participated in California's Race to the Top–Early Learning Challenge (RTT–ELC) federal grant. The RTT–ELC grant provided funds for Sacramento County to pilot a local Quality Rating and Improvement System—Raising QUALITY Together (RQT).

The primary purposes of RQT are to

- assist families in identifying high-quality early learning settings;
- support early learning programs, directors, and staff to improve the quality of early care and education;
- offer research-based resources, information, and professional learning opportunities to early learning program administrators and staff.

RQT uses the following seven elements grouped under three core areas that are foundational for the Quality Rating and Improvement System.

Core 1: Child Development and School Readiness

- Element 1: Evidence-based child assessment or observation tool
- Element 2: Developmental and health screenings

Core 2: Teachers and Teaching

- Element 3: Qualifications for Lead Teachers/Family Child Care Homes
- Element 4: Effective adult–child interactions

Core 3: Program and Environment

- Element 5: Ratios and group size
- Element 6: Program environment ratings
- Element 7: Director qualifications

The *Sacramento County QRIS Quality Continuum Framework Rating* describes the elements of a high-quality early learning setting. It also identifies a five-point tier rating continuum that can be utilized to develop a plan for increasing or maintaining quality in early learning programs. The *Core Tools and Resources* highlights key resources and support available for meeting program goals identified through the use of the Matrix. These documents are found on the following pages.

RAISING QUALITY TOGETHER: SACRAMENTO COUNTY'S QUALITY RATING AND IMPROVEMENT SYSTEM
QUALITY CONTINUUM FRAMEWORK – RATING MATRIX WITH ELEMENTS AND POINTS FOR CONSORTIA COMMON TIERS 1, 3, AND 4

ELEMENT	BLOCK (Common Tier 1) Licensed In-Good Standing	2 POINTS	3 POINTS	4 POINTS	5 POINTS
CORE I: CHILD DEVELOPMENT AND SCHOOL READINESS					
1. Child Observation	☐ Not required	☐ Program uses evidence-based child assessment/observation tool annually that covers all five domains of development	☐ Program uses valid and reliable child assessment/observation tool aligned with CA Foundations & Frameworks[1] twice a year	☐ DRDP (minimum twice a year) and results used to inform curriculum planning	☐ Program uses DRDP twice a year and uploads into DRDP Tech and results used to inform curriculum planning
2. Developmental and Health Screenings	☐ Meets Title 22 Regulations	☐ Health Screening Form (Community Care *Licensing form LIC 701 "Physician's Report - Child Care Centers" or equivalent*) used at entry, then: 1. Annually OR 2. Ensures vision and hearing screenings are conducted annually	☐ Program works with families to ensure screening of all children using a **valid and reliable developmental screening tool** at entry and as indicated by results thereafter AND ☐ Meets Criteria from point level 2	☐ Program works with families to ensure screening of all children using the ASQ at entry and as indicated by results thereafter AND ☐ Meets Criteria from point level 2	☐ Program works with families to ensure screening of all children using the ASQ & ASQ-SE, if indicated, at entry, then as indicated by results thereafter AND ☐ Program staff uses children's screening results to make referrals and implement intervention strategies and adaptations as appropriate AND ☐ Meets Criteria from point level 2
CORE II: TEACHERS AND TEACHING					
3. Minimum **Qualifications for** Lead Teacher/Family Child Care Home (FCCH)	☐ Meets Title 22 Regulations [Center: 12 units of Early Childhood Education (ECE)/Child Development (CD) FCCH: 15 hours of training on preventive health practices]	☐ Center: 24 units of ECE/CD[2] OR Associate Teacher Permit ☐ FCCH: 12 units of ECE/CD OR Associate Teacher Permit	☐ 24 units of ECE/CD + 16 units of General Education OR Teacher Permit AND ☐ 21 hours professional development (PD) annually	☐ Associate's degree (AA/AS) in ECE/CD (or closely related field) OR AA/AS in any field plus 24 units of ECE/CD OR Site Supervisor Permit AND ☐ 21 hours PD annually	☐ Bachelor's degree in ECE/CD (or closely related field) OR BA/BS in any field plus/with 24 units of ECE/CD (or Master's degree in ECE/CD) OR Program Director Permit AND ☐ 21 hours PD annually
4. **Effective Teacher-Child** Interactions: CLASS Assessments **(*Use tool for appropriate age** group as available)	☐ Not Required	☐ Familiarity with CLASS for appropriate age group as available by one representative from the site	☐ Independent CLASS assessment by reliable observer to inform the program's professional development/improvement plan	☐ Independent CLASS assessment by reliable observer with minimum CLASS scores: Pre-K • Emotional Support - 5 • Classroom Organization - 5 • Instructional Support - 3 Toddler • Emotional & Behavioral Support - 5 • Engaged Support for Learning - 3.5 **Infant** • Responsive Caregiving (RC) - 5.0	☐ Independent assessment with CLASS with minimum CLASS scores: Pre-K • Emotional Support - 5.5 • Classroom Organization - 5.5 • Instructional Support - 3.5 Toddler • Emotional & Behavioral Support - 5.5 • Engaged Support for Learning - 4 **Infant** • Responsive Caregiving (RC) - 5.5

[1] Approved assessments are: Creative Curriculum GOLD, Early Learning Scale by National Institute of Early Education Research (NIEER), and Brigance Inventory of Early Development III.

[2] For all ECE/CD units, the core 8 are desired but not required.

Note: Point values are not indicative of Tiers 1–5 but reflect a range of points that can be earned toward assigning a tier rating (see Total Point Range).

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ELEMENT	BLOCK (Common Tier 1) Licensed In-Good Standing	2 POINTS	3 POINTS	4 POINTS	5 POINTS
CORE III: PROGRAM AND ENVIRONMENT - Administration and Leadership					
5. Ratios and Group Size (Centers Only beyond licensing regulations)	☐ Center: Title 22 Regulations **Infant** Ratio of 1:4 Toddler Option Ratio of 1:6 Preschool Ratio of 1:12 ☐ FCCH: Title 22 Regulations *(excluded from point values in ratio and group size)*	☐ Center - Ratio: Group Size **Infant/Toddler** - 4:16 Toddler - 3:18 Preschool - 3:36	☐ Center - Ratio: Group Size **Infant/Toddler** - 3:12 Toddler - 2:12 Preschool - 2:24	☐ Center - Ratio: Group Size **Infant/Toddler** - 3:12 or 2:8 Toddler - 2:10 Preschool - 3:24 or 2:20	☐ Center - Ratio: Group Size **Infant/Toddler** - 3:9 or better Toddler - 3:12 or better Preschool - 1:8 ratio and group size of no more than 20
6. Program Environment Rating Scale(s) (Use tool for appropriate setting: ECERS-R, ITERS-R, FCCERS-R)	☐ Not Required	☐ Familiarity with ERS and every classroom uses ERS as a part of a Quality Improvement Plan	☐ Assessment on the whole tool. Results used to inform the program's Quality Improvement Plan	☐ Independent ERS assessment. All subscales completed and averaged to meet overall score level of 5.0	☐ Independent ERS assessment. All subscales completed and averaged to meet overall score level of 5.5 ☐ When ERS sub-scale, "Provision for Parents" is less than 6.0 a quality improvement plan will be developed AND Provider offers links to community-based resources that support families with young children must be visible or available in writing from provider and provides information on family strengthening protective factors related to social and emotional competence of children. * OR Current National Accreditation approved by the California Department of Education
7. **Director Qualifications** (Centers Only)	☐ 12 units ECE/CD+ 3 units management/ administration	☐ 24 units ECE/CD + 16 units General Education +/with 3 units management/administration OR Master Teacher Permit	☐ Associate's degree with 24 units ECE/CD +/with 6 units management/administration and 2 units supervision OR Site Supervisor Permit AND ☐ 21 hours PD annually	☐ Bachelor's degree with 24 units ECE/CD +/with 8 units management/ administration OR Program Director Permit AND ☐ 21 hours PD annually	☐ Master's degree with 30 units ECE/CD including specialized courses +/with 8 units management/ administration, OR Administrative Credential AND ☐ 21 hours PD annually AND ☐ 4 years management or supervisory experience AND with at least 50% of the 21 annual hours of PD in Leadership and Management **

TOTAL POINT RANGES					
Program Type	Common-Tier 1	Local-Tier 2[3]	Common-Tier 3	Common-Tier 4	Local-Tier 5[4]
Centers 7 Elements for 35 points	Blocked (No Point Value) – Must Meet All Elements	Point Range 8 to 19	Point Range 20 to 25	Point Range 26 to 31	Point Range 32 and above
FCCHs 5 Elements for 25 points	Blocked (No Point Value) – Must Meet All Elements	Point Range 6 to 13	Point Range 14 to 17	Point Range 18 to 21	Point Range 22 and above

***Element 6 - Participant will receive 5 points for an overall ERS score of 5.5; however, to achieve an overall tier rating of 5, participant must meet all Sacramento County QRIS requirements as stated.**

****Element 7 - Participant will receive 5 points without 50% of PD hours in Leadership and Management; however, to achieve an overall tier rating of 5, participant must meet all Sacramento County QRIS requirements as stated.**

[3] Local-Tier 2: Local decision if Blocked or Points and if there are additional elements

[4] Local-Tier 5: Local decision if there are additional elements included California Department of Education, February 2014 Updated May 28, 2015: Effective July 1, 2015

UPDATED August 2017

California QRIS Continuous Quality Improvement Pathways Core Tools and Resources[5]

CORE I: CHILD DEVELOPMENT & SCHOOL READINESS	
School Readiness	
Goal (Pathway)	All children receive individualized instruction and support for optimal learning and development informed by child observation and assessment data.
Related Element(s)	Core I.1 Child Observation and Assessment
RTT-ELC Core Tool(s) & Resources	• CA Foundations and Frameworks: http://www.cde.ca.gov/sp/cd/re/cddpublications.asp • Preschool English Learner Guide: http://www.cde.ca.gov/sp/cd/re/documents/psenglearnersed2.pdf • Desired Results Developmental Profile Assessment (DRDP) Tools: http://desiredresults.us/ • National Data Quality Campaign's Framework: http://www.dataqualitycampaign.org/ • Ages and Stages Questionnaire (ASQ): http://agesandstages.com/
Social-Emotional Development	
Goal (Pathway)	Children receive support to develop healthy social and emotional concepts, skills, and strategies.
Related Element(s)	Core I.2 Developmental and Health Screenings
RTT-ELC Core Tool(s) & Resources	• CA CSEFEL Teaching Pyramid Overview and Tiers 1–4 (Modules 1–3): http://www.cainclusion.org/teachingpyramid/ • CA Foundations and Frameworks - Social-Emotional Development: http://www.cde.ca.gov/sp/cd/re/cddpublications.asp • Ages and Stages Questionnaire: Social-Emotional (ASQ-SE): http://agesandstages.com/asq-products/asqse/
Health, Nutrition, and Physical Activity	
Goal (Pathway)	Children receive support for optimal physical development, including health, nutrition, and physical activity.
Related Element(s)	Core I.1 Child Observation and Assessment and Core 1.2 Developmental and Health Screenings
RTT-ELC Core Tool(s) & Resources	• CA Preschool Foundations and Frameworks– Health and Physical Development: http://www.cde.ca.gov/sp/cd/re/cddpublications.asp • Infant/Toddler Program Guidelines: http://www.cde.ca.gov/sp/cd/re/documents/itguidelines.pdf • CA Infant/Toddler Foundations and Frameworks-Perceptual/Motor: http://www.cde.ca.gov/sp/cd/re/cddpublications.asp • USDA Child and Adult Care Food Program Guidelines: http://www.fns.usda.gov/cacfp/
CORE II: TEACHERS AND TEACHING	
Effective Teacher–Child Interactions	
Goal (Pathway)	Teachers are prepared to implement effective interactions in the classroom.
Related Element(s)	Core II.4 Effective Teacher–Child Interactions
RTT-ELC Core Tool(s) & Resources	• Classroom Assessment and Scoring System (CLASS) for relevant age grouping: http://www.teachstone.com/the-class-system/ • Program for Infant/Toddler Care (PITC): http://www.pitc.org/pub/pitc_docs/home.csp. Program Assessment Rating Scale (PARS), as applicable and available: http://www.pitcpars.org/

5. This document accompanies the Hybrid Matrix as part of the Quality Continuum Framework. These are the tools and resources listed in the Federal application that the Consortia are required to include in their Quality Improvement plan. Data will be gathered regarding how these tools and resources are used by the Consortia. Optional companion tools will also be developed, including the Enhanced Pathways Continuum, Pathways Implementation Guide, and Additional Pathways Tools and Resources.

California QRIS Continuous Quality Improvement Pathways Core Tools and Resources, *continued*

Professional Development	
Goal (Pathway)	Teachers are lifelong learners.
Related Element(s)	Core II.3 Minimum Qualifications and Core II.4 Effective Teacher–Child Interactions
RTT-ELC Core Tool(s) & Resources	• Common Core 8[6]: http://www.childdevelopment.org/cs/cdtc/print/htdocs/services_cap.htm • Early Childhood Educator (ECE) Competencies: http://www.cde.ca.gov/sp/cd/re/ececomps.asp • ECE Competencies Self-Assessment Tool: http://ececompsat.org/ • Professional Growth Plan
CORE III: PROGRAM AND ENVIRONMENT	
Environment	
Goal (Pathway)	The program indoor and outdoor environments support children's learning and development.
Related Element(s)	Core III.6 Program Environment Rating Scale(s) (ERS)
RTT-ELC Core Tool(s) & Resources	• Environment Rating Scales: http://www.ersi.info/index.html (Harms, Clifford, Cryer): ○ Infant-Toddler Environment Rating Scale (ITERS), ○ Early Childhood Environment Rating Scale (ECERS), ○ Family Child Care Environment Rating Scale (FCCERS)
Program Administration	
Goal (Pathway)	The program effectively supports children, teachers, and families.
Related Element(s)	All
RTT-ELC Core Tool(s) & Resources	• Business Administration Scale (Family Child Care) – (BAS): http://mccormickcenter.nl.edu/program-evaluation/business-administration-scale-bas/ • Program Administration Scale (Centers) – (PAS): http://mccormickcenter.nl.edu/program-evaluation/program-administration-scale-pas/ **OR** • Self-Assessment using the Office of Head Start (OHS) Monitoring Protocols: http://eclkc.ohs.acf.hhs.gov/hslc/grants/monitoring/fy-2014-pdfs/fy-2014-ohs-monitoring-protocol.pdf and continuous improvement through a Program Improvement Plan (PIP)
Family Engagement	
Goal (Pathway)	Families receive family-centered, intentional supports framed by the Strengthening Families™ Protective Factors to promote family resilience and optimal development of their children.
Related Element(s)	All (III.6 ERS *Provision for Parents* Indicator)
RTT-ELC Core Tool(s) & Resources	• Strengthening Families™ Five Protective Factors Framework: http://icfs.org/pdf/FiveProtectiveFactors.pdf

6. Recommended.

APPENDIX D:
Multi-Tiered System of Supports

Multi-Tiered System of Supports

A framework that aligns Response to Instruction and Intervention with the Common Core State Standards and the systems necessary for academic, behavior, and social success.

What is a Multi-Tiered System of Support?

California's MTSS focuses on aligning initiatives and resources within an educational organization to address the needs of all students. It is an integrated, comprehensive framework for local educational agencies (LEA) that aligns academic, behavioral, and social-emotional learning in a fully integrated system of support for the benefit of all students. MTSS offers the potential to create systematic change through intentional integration of services and supports to quickly identify and meet the needs of all students.

California's vast and complex Prekindergarten through grade twelve (Prek–12) educational system requires a multifaceted approach that is scalable and sustainable. The California Department of Education's (CDE) vision of "one coherent system of education" offers an opportunity to build the foundation for educational excellence. Through the use of Implementation Science, Universal Design for Learning, and the Whole Child approach, among other evidence-based interventions, MTSS affords a full range of academic, behavioral, and social support for all students to achieve.

View a quick primer video on MTSS (Video; 3:50), created by the Orange County Department of Education (OCDE), for an overview of MTSS.

RTI², PBIS, and MTSS **Statewide Initiative** **Training and Resources**

APPENDIX E:
Family Engagement

Strengthening Families Protective Factors Framework

The *Strengthening Families* protective factors are attributes and conditions that support a pathway of healthy development and well-being. These five factors are characteristics that demonstrate positive outcomes for young children and their families, including a reduction in the likelihood of child abuse and neglect.

Strengthening Families Protective Factors Framework
https://www.cssp.org/young-children-their-families/strengtheningfamilies/about/protective-factors-framework

Partners in Education: A Dual Capacity-Building Framework for Family–School Partnerships

Based on existing research and best practices, *Partners in Educaton: A Dual Capacity-Building Framework for Family–School Partnerships* is designed to act as a scaffold for the development of family engagement strategies, policies, and programs. The *Framework* is designed to act as a compass, laying out the goals and conditions necessary to chart a path toward effective family engagement efforts that are linked to student achievement and school improvement.

Partners in Education: A Dual Capacity-Building Framework for Family–School Partnerships
https://www2.ed.gov/documents/family-community/partners-education.pdf

APPENDIX F:
California Standards and Curriculum Frameworks

California Frameworks, Standards, and Program Guidelines

California Curriculum Frameworks and Standards provide guidance for educators to ensure that children are provided the information and opportunity to master identified standards.

Infants/Toddlers: Birth to Age Three

California Infant/Toddler Learning and Development Foundations

The *California Infant/Toddler Learning and Development Foundations* presents 28 foundations within the four domains: social-emotional, language, cognitive, and perceptual and motor development. These foundations are based on the research and evidence-based expectations for the way most infants and toddlers make progress. The descriptions of competencies are enriched with examples of typical behaviors at each age level in each of the four domains as well as behaviors leading up to attainment of those competencies.

Infant/Toddler Learning & Development Foundations
http://www.cde.ca.gov/sp/cd/re/itfoundations.asp

Guidelines for Early Learning in Home Care

The *Guidelines for Early Learning in Home Care* are specifically designed for licensed family child care and license-exempt providers to support them in creating positive, nurturing environments for the children in their care.

Guidelines for Early Learning in Home Care
http://www.cde.ca.gov/sp/cd/re/documents/elguidelineshome.pdf

Preschool Age: Ages Three Through Five

The *California Preschool Learning Foundations* and the *California Preschool Curriculum Frameworks* act as companion publications.

California Preschool Learning Foundations

The *California Preschool Learning Foundations*, volumes one through three, outline key knowledge and skills that most children can be expected to achieve when provided with research based instruction reflecting best practices in early childhood education.

Preschool Learning Foundations
http://www.cde.ca.gov/sp/cd/re/psfoundations.asp

California Preschool Curriculum Frameworks

The *California Preschool Curriculum Frameworks* consists of three volumes that provide an integrated approach to planning activities by highlighting principles, strategies and vignettes for each domain of learning.

California Preschool Curriculum Frameworks
http://www.cde.ca.gov/sp/cd/re/psframework.asp

Alignment of the California Preschool Learning Foundations with Key Early Education Resources

Providing the developmental continuum of learning for children from birth through kindergarten, the *Alignment of the California Preschool Learning Foundations with Key Early Education Resources* highlights the domains, strands, and areas of alignment of the Infant/Toddler Foundations, the Preschool Learning Foundations, and the Kindergarten Common Core State Standards and California Content Standards.

The Alignment of the California Preschool Learning Foundations
with Key Early Education Resources
http://www.cde.ca.gov/sp/cd/re/documents/psalignment.pdf

School Age: Ages Five Through Eight

The *California State Curriculum Standards* and *Frameworks* provide guidance for implementing the standards developed by the California State Board of Education.

California Curriculum Frameworks
http://www.cde.ca.gov/ci/cr/cf/allfwks.asp

California State Standards
http://www.cde.ca.gov/re/cc

APPENDIX G:
Professional Standards

California Standards for the Teaching Profession (CSTP)

The *California Standards for the Teaching Profession* (CSTP) provides common language and a vision by which all teachers can define, develop, and extend their practice.

California Standards for the Teaching Profession
https://www.ctc.ca.gov/docs/default-source/educator-prep/standards/cstp-2009.pdf

California Professional Standards for Education Leaders
https://www.ctc.ca.gov/docs/default-source/educator-prep/standards/cpsel-booklet-2014.pdf

California Early Childhood Educator (ECE) Competencies

The *California Early Childhood Educator (ECE) Competencies* provides a coherent structure and content for the professional development of California's early childhood workforce. Courses of study in higher education as well as guidance in credentials and certifications are also included.

California Early Childhood Educator (ECE) Competencies
http://www.cde.ca.gov/sp/cd/re/documents/ececompetencies2011.pdf

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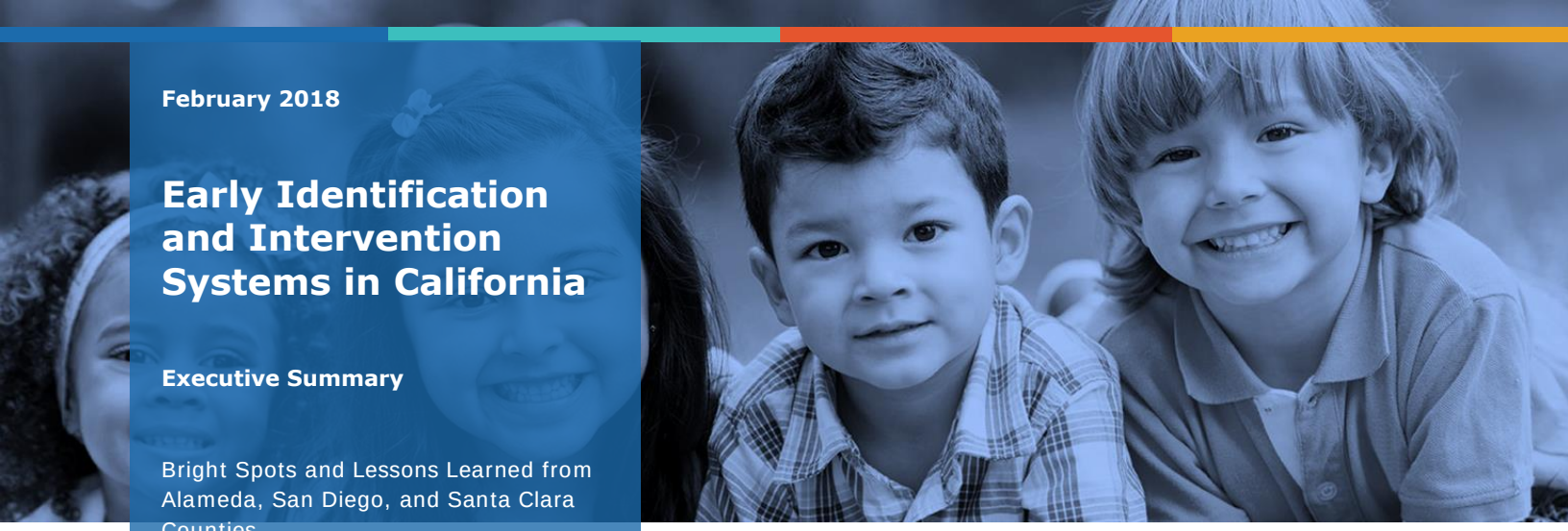


February 2018

Early Identification and Intervention Systems in California

Executive Summary

Bright Spots and Lessons Learned from Alameda, San Diego, and Santa Clara Counties

Throughout the country, there is growing recognition of the importance of healthy child development in fostering school readiness and, by extension, social and economic success as adults. At the front end of the early identification and intervention systems—the topic of this report—is the need for a system to monitor young children so as to raise flags when developmental concerns are observed. With the support and coordination of a robust system, families successfully guide their young children to whatever supports and services are most appropriate within the constellation of early intervention care providers. Without a robust system, it is far too easy for families—particularly those facing language and cultural barriers—to fall through the cracks.

Experts in the field, including the Centers for Disease Control and Prevention and the American Academy of Pediatrics, have published studies making the case for early identification and intervention. However, there is little documentation on what it takes to support this work on the ground and the role that early care and education has played. This report, funded by the David and Lucile Packard Foundation, presents case studies of the successes and lessons learned in three California counties—Alameda, San Diego, and Santa Clara. The purpose of this study is to support the growing conversation around early identification and intervention in California. While counties throughout California are doing this important work, these three counties were identified as bright spots in early identification and intervention, with other counties across the state interested in learning about their efforts and experiences to date.

The three county case studies were developed in close partnership with local First 5 agencies,[1] and provide a glimpse into real-life approaches for strengthening early identification and intervention systems within each county's local context, opportunities, and constraints. The case studies highlight the processes, thinking, and decisions made in each county with the goal of supporting learning and spurring new ideas. The approaches described are unique to each county, and responsive to the needs voiced by their particular stakeholder communities. As such, they should not

[1] In California, First 5 county agencies are charged with creating integrated, comprehensive, collaborative systems of information and services to enhance child development and school readiness.

harder + co | community research

be taken as replicable templates. Rather, they provide insights and inspiration for those seeking to strengthen systems in their own communities.

Case Study Highlights

Alameda County: Families Front and Center | Alameda County's case study highlights the principal role of meaningful family engagement in building a culture of early identification and intervention. In particular, Alameda County has found that:

- **Developmental screening serves as a tool to educate and engage parents on child development.** Alameda County aims to meet families where they are. The approach of embedding developmental screening in the context of familiar events and activities normalizes it. As First 5 Alameda County staff described, [developmental screening should feel] "as normal as getting your child's height and weight checked."
- **Embedding parents as experts strengthens the system of support.** Alameda County leaders recognize the value and expertise parents offer through their lived experiences, and thus have advanced a set of strategies that include: (i) staffing parents in Early Childhood Mental Health clinics and programs, (ii) recruiting parent champions as ambassadors in hard to reach communities, and (iii) reserving a seat at the table for parents through Help Me Grow Alameda County's Family Advisory Committee.
- **Collaboration on early identification and intervention improves families' experiences.** Alameda County's early identification and intervention system builds upon a long history of collaboration in support of young children and families. This willingness to work together stems from a collective focus on children and families, as well as a shared vision.

San Diego: Coordination from the Ground Up | San Diego County's case study describes a long-standing cross-sector collaborative system, called Healthy Development Services (HDS), that was built through a decade of relationship-building and partnership. San Diego County's experience speaks to:

- **The importance of also addressing mild-to-moderate delays.** First 5 San Diego looked to HDS as a platform for cross-sector partnership aimed at addressing mild-to-moderate developmental delays. This was a critical population whose life trajectory could be changed with early identification and intervention—by addressing those developmental and behavioral delays early, these children are in a better position to enter kindergarten ready to achieve long-lasting academic and social success.
- **The potential to expand and sustain developmental screening efforts through active and ongoing coordination across health and early education.** HDS has strong relationships with both health providers and First 5 San Diego's network of community partners. This broad-based network enables extensive outreach to families and referrals for children with developmental concerns—including for developmental screenings. The majority of developmental and behavioral screenings in San Diego County are conducted in pediatricians' offices and preschools, in many cases through HDS and the Quality Preschool Initiative (QPI).
- **The role of cross-agency coordination in connecting families to the right services and the right stream of funding.** A notable feature of San Diego County's expanded early intervention system is the level of coordination and collaboration that goes into referrals for children with

Key Terms

Some terms may take on a different meaning in different venues or contexts. For the purposes of this report, we define some key terms below.

Early identification and intervention refers to the system of support needed to identify and address developmental and behavioral concerns and delays. Includes efforts to identify children for deeper assessment and to provide care coordination and treatment across a range of settings.

System refers to the actors, agencies, and infrastructure needed to support this work. Includes the many organizations and agencies that support children and families, efforts to coordinate and collaborate among partners, policies that facilitate or hinder access to services, and more.

identified needs. The referral process matches children to services based on their identified level of need as well as their eligibility for coverage—based on provider and health insurance requirements—across the many early intervention partners.

Santa Clara: Starting with Services | Santa Clara County's case study reports on successful efforts to build the capacity and close service gaps within their network of early intervention service providers, called the KidConnections Network (KCN). Santa Clara County's experience highlights lessons learned in bolstering early intervention services, particularly:

- **The value of leveraging existing Medi-Cal eligible providers to serve young children.** By building the capacity of existing Medi-Cal eligible providers to serve children ages 0-5, Santa Clara County was able to leverage Medi-Cal resources in service of early intervention and treatment. Last year, First 5 Santa Clara County invested over $2 million, and working with Behavioral Health Services Department, was able to use those funds to leverage an additional $12 million in Medi-Cal reimbursement.
- **The long term investment needed to build and sustain early identification and intervention capacity.** First 5 Santa Clara County has continually focused on ongoing professional development and capacity-building for KCN partners. The trainings are designed to emphasize evidence-based, parent-child therapeutic intervention models for infants, toddlers, and young children; parent-focused intervention and education programs; and trauma-informed approaches.
- **The critical role of coordinating care, and an ongoing challenge inherent to this work.** Santa Clara County saw a need for greater coordination and communication in support of children and families. KCN plays an important role in linkage and coordination, and is a resource for health and social service providers, early educators, and families. It also supports referrals and care coordination for children with identified developmental needs, connecting them with Family Resource Centers, Early Start, school districts, preschools, and other resources as needed. Though KCN has helped to coordinate referrals in this complex system, Santa Clara County has found that the task of following up with each service referral, let alone coordinating between services, is formidable.

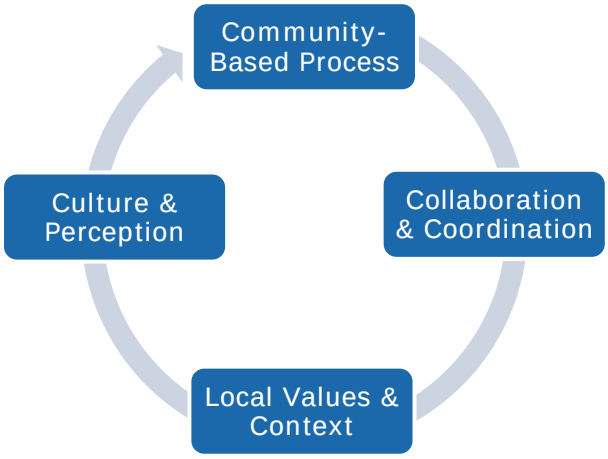
What Have We Learned?

The successes of these three counties are compelling. They have developed close partnerships across sectors, they have bolstered their capacity and reach to families, and they have changed the culture of how this work is done. Yet none of these approaches can simply be copied and pasted into other communities. These case studies are not meant to prescribe solutions; rather, they are offered to spark new ideas on what is possible.

Bolstering Early Identification and Intervention Systems

The early identification and intervention system of each county is unique to its local context, yet there are commonalities in what county stakeholders identified as key ingredients to success. The key ingredients they identified speak to the importance of a community-based process, collaboration and coordination, and the local values and culture that guide this work.

Exhibit ES1. Key Ingredients to Strengthening Systems



- **Transformational change is rooted in community voice and responsive to community need.** By grounding system development priorities in community input, these counties were able to build cross-sector buy-in and collaboration, and ultimately transform the culture and practice around early identification and intervention.

- **Cross-sector collaboration is critical due to the breadth of skills and expertise needed in each part of the system.** Many have highlighted the need for cross-sector collaboration because of the diversity of developmental concerns a child may have, related to a wide range of issues including physical health, social-emotional and behavioral health, and special education. No one organization or sector can do it all. Across the three counties, First 5 agencies have had a central role in envisioning and supporting the cross-sector collaboration needed. They have also supported shared training and standard practices so that the diverse partners develop common approaches and language to ensure alignment.

- **Data systems that speak across sectors are critical to facilitating coordination and collaboration.** Many spoke of a clear need for cross-sector data systems to better serve children and families at the provider level, and also support internal accountability and learning at the system level.

- **The windows of opportunity regarding where to start are dictated by local values, context, and dynamics.** The impetus of where to start or where to focus systems development efforts looks different in each county. The successes highlighted for each county responded to a locally-defined problem statement, which was defined by the values, context, and public will of that county.

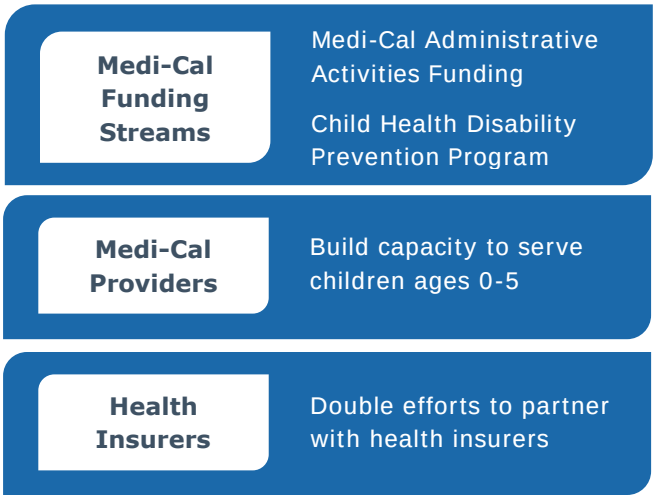
- **Systems change must go hand-in-hand with culture change.** Across the three counties, normalizing early identification as standard practice is a common goal. Stakeholders noted that this goal extends beyond regular implementation of developmental screening—it involves a recalibration of how providers talk about early identification and engage families, and it involves reframing how communities perceive this work (for example, how the conversation contrasts with that of immunizations).

Financing Early Identification and Intervention

For the most part, state and federal funding for early identification and intervention efforts in California is limited. As such, counties rely largely on local funding sources to support services and connections within their early intervention systems, with First 5 agencies as a significant support across California. Even at its peak, First 5 funds were never enough to address the developmental needs of all children. To make matters worse, First 5 revenues have been decreasing since 2000 and are expected to decline by nearly 40% by 2020.[2] The experiences of the three counties highlight a number of potential strategic levers for consideration:

- **Medicaid Administrative Activities (MAA) Funding.** Medicaid Administrative Activities funding could offset administrative costs related to early identification and intervention. MAA can partially pay for the costs to provide a child development call center or other related early

Exhibit ES2. Financing: Strategic Levers



[2] http://first5association.org/policy-areas/

identification and intervention supports.

- **Child Health and Disability Prevention (CHDP) Program.** The Child Health and Disability Prevention Program is a Medi-Cal program that funds health assessments for the early detection and prevention of disease and disabilities for children and youth. By creating or modifying a Local Plan Amendment, counties can apply CHDP funds to their early identification and intervention systems.

- **Medi-Cal providers.** Counties may be able to leverage their network of existing Medi-Cal providers to tap into funding for early intervention services. Investment in (i) the development of core competencies for this age group and (ii) trainings for Medi-Cal providers has the potential to open access to a broader set of providers and resources to fund early intervention services.

- **Health insurance plans.** Although they are vital partners with a shared interest, health insurance plans have not yet played a major role in funding early identification and intervention. Stakeholders spoke of the need to develop strong partnerships (and buy-in) with health insurers, and make the case that robust systems of early identification pay off in the long run.

Where Do We Go from Here?

The challenge that communities face in identifying young children with developmental concerns and intervening early is formidable, and the barrier of navigating complex systems and paying for these services is even more so. Conversations with stakeholders across Alameda, San Diego, and Santa Clara Counties speak resoundingly to this. Though important successes have been made, there is much more to do in the road ahead. We hope that this report may create new insights or inspiration for those who—across California and the country—are working to strengthen the systems of early identification and intervention for their communities.

Acknowledgements

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San Diego County | *Gloria Corral-Terrazas* of First 5 San Diego County; *Pradeep Gidwani* of the American Academy of Pediatrics - California Chapter 3

Santa Clara County | *Jolene Smith, Thanh Do, and Crystal Nava* of First 5 Santa Clara County; *Nancy Pena*, Behavioral Health Consultant

Finally, this project would not have been possible without our dedicated research team. We especially thank Fontane Lo and Raúl Martínez for their leadership of this project; and our analysis team, Tim Morrison, Lauren Stein, and Julianne Perez, for tirelessly conducting outreach and data collection as well as supporting the case study development and writing.

First 5: Champions for Children

2018 POLICY AGENDA

FIRST 5 ASSOCIATION OF CALIFORNIA

First 5 builds the early childhood systems and supports needed to ensure California's young children are healthy, safe, and ready to succeed in school. This is accomplished by:

RESILIENT FAMILIES

VISION:
Promote parental resilience, social connections, concrete support in times of crisis, and knowledge of parenting and child development.

POLICY GOALS:

- Expand access to evidence-based family strengthening programs, including home visiting and parent education, to optimize child development and reduce the risk of abuse and neglect.
- Strengthen the social safety net to build family resiliency and promote self-sufficiency.
- Support community hubs for integrated services and crisis supports for children and families.
- Support parent engagement on child brain development, including Talk. Read. Sing.

COMPREHENSIVE HEALTH AND DEVELOPMENT

VISION:
Build a family-centered health system that prioritizes prevention.

POLICY GOALS:

- Ensure all pregnant mothers and children ages 0–5 have affordable and comprehensive health insurance.
- Increase use of essential Medi-Cal services, especially dental, mental health, and vision services.
- Increase coordination across systems of care to connect young children to screening and early intervention, including through the expansion of Help Me Grow.
- Expand availability and geographic spread of health care providers and professionals.

QUALITY EARLY LEARNING

VISION:
Ensure children are healthy and have the social-emotional and cognitive skills to enter kindergarten ready to learn.

POLICY GOALS:

- Increase supply of high-quality early learning programs for children 0–5.
- Embed high-quality standards in all state-funded early learning programs and support state and local efforts to meet them.
- Promote affordability of early learning programs, while ensuring fair workforce compensation.

SUSTAINABILITY AND SCALE

VISION:
Fulfill the voter-approved Proposition 10 mandate: *"To create a comprehensive and integrated delivery system of information and services to promote early childhood development."*

POLICY GOAL:

- Explore and advance alternative revenue sources for children's services.
- Improve and integrate county data systems to track and evaluate children's outcomes.
- Regulate tobacco products.
- Mitigate public health risks that widely affect children's health and wellbeing.

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Enhancing Opportunities for Prevention and Early Intervention

Testimony of Ronald J. Powell, Ph.D.

Mental Health Services Oversight and Accountability Commission

March 22, 2018

Good Morning. My name is Ron Powell and for the last 20 years of my career, I was the administrator of the Desert/Mountain SELPA. Because of our demographics, we had the opportunity to develop several programs to address the needs of children who were significantly impacted by trauma, so I am deeply honored to be asked to be a part of this panel and to engage in this discussion.

The Desert/Mountain SELPA is a consortium of school districts and LEA charter schools in San Bernardino County. San Bernardino County contains 6 SELPAs, three multi-district SELPAs and 3 single-district SELPAs. While the Desert/Mountain SELPA includes only about 20% of the student population within the county, geographically it is the largest SELPA in the state. Covering over 20,000 square miles, the Desert/Mountain SELPA extends from the San Gabriel mountains to the border of Arizona and is one of the poorest and most rural areas in California. The demographics of the Desert/Mountain SELPA were an important catalyst to our current pattern of mental health services. Distributed across an area that is larger than 9 New England states, with little resources and few available public services, school district and community leaders have historically had to rely on an ethos of cooperation in order to "get things done". The "one for all, all for one," spirit in concert with the SELPA mission of "the relentless pursuit of whatever works in the life of a child" laid the foundation for creative thinking to address the mental health needs of our communities.

With the passage of AB 3632, the County Department of Mental Health offered clinic-based mental health services for children with disabilities. However, because of the vast geography of our region, transportation to a clinic for service was not a feasible option. So, the SELPA began to provide itinerant school-based mental health services funded on a fee-for-service basis out of district funds. After several years, the County Department of Behavioral Health (DBH) issued an RFP soliciting community-based partners interested in providing school-based EPSDT mental health services in areas throughout the county. Since the SELPA already had 8 therapists serving 270 children, the SELPA Board decided to compete for the RFP. To the great surprise of many, including ourselves, this resulted in the Desert/Mountain SELPA securing a 2.5 million-dollar EPSDT contract. With the new money, however, came new responsibilities and new levels of accountability. The SELPA established the Desert/Mountain Children's Center, a Medi-Cal certified community-based DBH clinic and hired 25 therapists to serve every EPSDT-eligible child in every district in the SELPA. Operating under the administrative umbrella of the SELPA and utilizing the Office of the San Bernardino County Superintendent of Schools as the Administrative Unit, the DBH medical model prompted us to become rapid learners. We had to learn quickly about billing and data management using the county DBH reporting systems. We

had to navigate personnel issues through a human resources department that only had job descriptions that met education code requirements. We had to design policies and procedures that met DBH criteria for compliance with HIPAA. And we had to learn to chart and document services in a way that satisfied strict county and state audit requirements. Our first DBH audit was abysmal which caused the elected County Board of Education to question their potential exposure to medical liability. We were criticized by fellow educators for taking on responsibilities that were seen as primarily medical rather than educational.

Despite all of the administrative hurdles, however, the impact of the availability of school-based mental health services was evident immediately. Caseloads grew quickly, and therapists were in every school in every district in our SELPA and within a year, we were passing DBH audits with zero disallowances. Over the course of the following decade, thousands of children received services through the Desert/Mountain Children's Center. But our contract was limited to the provision of services to school-aged children, and we knew that we were not catching them early enough.

Unknown to us at the time, San Bernardino County was concerned about the same thing, but for a different reason. Eager to stem the flow of children placed into foster care in the county, the Children's Network, under the direction of the County Board of Supervisors, invited Ira Chasnoff, a pediatrician from the Children's Research Triangle in Chicago to speak before the Children's Policy Council. Dr. Chasnoff presented a multi-agency model for screening, assessment, referral, and treatment (SART) that involved blended funding and service commitments from multiple agencies. The SART model had been broadly implemented in other states as well as in communities throughout California. It called for a transdisciplinary assessment involving medical, educational, and therapeutic professionals working together as equal partners in the quest for a complete understanding of the child's social, emotional, and behavioral health needs.

Six months later, San Bernardino County expanded our DBH contract to start the first SART clinic in the county. The 1.5 million-dollar SART contract was funded primarily through EPSDT funds with First 5 putting up the local match. Additional funding for non-billable services such as occupational therapy and speech therapy were provided through First 5 and ultimately through EIIS under Prop 63. We also leveraged dollars 3 to 1 through the Department of Public Health for the provision of public health nurses to be part of the team. Children and Family services put CAPIT dollars in play and the juvenile court offered contracts for services as well. And while not all of these contracts ultimately proved to be beneficial or sustainable sources of funding to support the SART Center, the "Stone Soup" approach to funding illustrated the level of commitment that agency partners felt toward involvement in collaborative approaches to service delivery in order to meet shared goals.

There are now four SART centers in San Bernardino County operated by three different agencies. All SART centers follow the same transdisciplinary service delivery model utilizing the same blends of EPSDT, First 5, EIIS and Department of Public Health dollars. Last year the SART centers served over 3,000 clients under the age of 6. Children referred to SART are screened and those considered to be at risk receive a transdisciplinary assessment which may

include a psychosocial, academic and developmental evaluation, as well as medical, neurological, audiological, speech and sensory profile assessments. Depending on the identified needs of the child, recommended services may then include such therapeutic modalities as Parent Child Interaction Therapy (PCIT), Theraplay, play therapy, sand tray and adapted CBT, as well as speech and language therapy, sensory integration, and medication management as needed.

In addition, for children with the most intensive emotional and behavioral health needs, the Desert/Mountain SELPA developed a 10-week intensive program patterned after the partial-hospitalization program at UCLA. The program is designed to capture children under the age of 6 who have significant emotional or behavioral health needs, developmental delays or who otherwise might fall on the autism spectrum. The CARE program runs 4 hours each day for 10 weeks. It is operated as a medical model within a developmentally appropriate early education environment. During the ten-week period, we employ everything that we know from the research that works for young children with significant emotional and behavioral disorders (i.e. discrete trial, PCIT, sensory integration, PECS, intensive speech and language development, and visual schedules). The program is intensive and requires the daily participation of parents or caregivers. But because of the intensity of the CARE model, we have witnessed amazing success in a short period of time. And, because of its success, CARE has now been replicated in other communities across the state.

In spite of the successes of collaborative services like SART and CARE, however, we are still barely scratching the surface of the need. Among the total population of 0-5-year-old children in San Bernardino County, 50,000 children are living in high-risk trauma-endangered environments. For every child that we serve, there are still 17 more children, under the age of six who are living in households where at least one parent has experienced such significant trauma that they are at lifetime risk for physical and mental health problems, addictions, incarceration and poor life outcomes.

For this reason, with the support of First 5, we have launched a pilot program that embeds a mental health therapist within a state preschool program to determine if we can foster trauma-informed practice as an integrated model of developmentally appropriate early childhood instruction. Utilizing an embedded coaching and collaborative learning model, the pilot is designed to create felt safety in the presence of caring and supportive adults. Within this environment, children are taught strategies and given tools to identify and self-regulate “big feelings”. The pilot includes training for parents in the same skills taught to their children so that they can reinforce their use at home. It also focuses on the adoption of common practices and positive language models among all the staff as they seek to support children who are in need of care and unconditional regard. By being embedded in the program, the therapist is able to identify those children who need more intensive services, in a timelier manner and thereby reduce the lag time between the identification of symptoms and the qualification for services. A report on the outcomes of this pilot, which we call Mini-Miracles, will be presented to First 5 in August 2018 with the intention to expand the program to other early education programs throughout the county in the next year.

So what lessons have we learned from these patterns of service over the years. There are many, but let me limit them to three.

The first is that EPSDT funding is essential for the provision of mental health services to children. As a federal entitlement for children who meet medical necessity as well as financial eligibility requirements, EPSDT funds are the backbone of sustainable programs. Funding to supplement EPSDT can come from a variety of programs, First 5, EIIS, AB 114, PEI. And although each source has restrictions, our experience is that with proper accounting procedures, they can be woven together to provide comprehensive services.

The second lesson is that there needs to be one agency that operates the program and one administrator who has the overall responsibility to make it work. Blended personnel from multiple agencies will work as long as the contributing agencies agree that there is only one boss regardless of which agency issues the paycheck.

The third lesson is that the magnitude of the need exceeds our capacity to provide services. And since there aren't enough resources to provide the services that are necessary, we need to look for ways to increase community capacity to build resilience, so that children from hard places won't require intensive levels of service.

There is no magic to any of the programs that we have highlighted today. All involve existing resources drawn from partnerships with existing agencies. Whether school-based mental health, SART, CARE or Mini-Miracles, all have been replicated in counties and states across the country. But none would be in existence without a clear understanding and commitment to the importance of this work. We may not be able to control what happens to a child, but we can control how we respond to it. That response cannot be limited, however, to new patterns of service or collaborative efforts designed to do a better job of serving those children that have already been swept over the waterfall. Efforts must also be directed toward the installation of safety nets all the way up the river. And that responsibility falls on us individually. Research is very clear. There is one single antidote that has the hope of stopping the intergenerational transmission of toxic stress. One single variable that has been shown repeatedly to be the most powerful predictor of resilience in children of trauma. That one thing is the presence of a stable, caring and supportive adult in the child's life. And if a child does not experience that within their home or extended family, then we have a responsibility to ensure that they find that in the community through those agencies that are tasked with engaging in the lives of children on a consistent basis—in our day care and child care settings, in our courts, law enforcement, and child and family service agency interactions, and most importantly, perhaps, in our schools.

VOLUNTARY EVIDENCE-BASED HOME VISITING IN CALIFORNIA

Research shows relationships fuel early brain development and provide the foundation for lifelong health and success. Yet we also know that parenting a very young child places enormous physical and emotional demands on adults. Some families may not have what they need, or know where to turn for support if they want it, even when it is within reach in their own community.

Voluntary evidence-based home visiting programs match new and expectant parents with trained professionals who provide ongoing, individualized support during critical points in pregnancy through a child's first year(s) of life.

- **Home visitors are social workers, registered nurses, or parent educators** formally trained in a particular home visiting program model.

- **Home visitors work with families on a regular basis**, often beginning in pregnancy or shortly after the birth of a child, and continuing for up to 3 years. Visits typically last an hour, and range in frequency from weekly to monthly according to particular program guidelines.

- **Families are in the driver's seat –** they set the program pace, their own personal goals, and focus their home visit on their own interests and questions.

- **Home visitors offer parenting advice**, coach parents toward their goals, and assist families in securing needed health screenings and safety net resources.

What California families say about voluntary evidence-based home visiting:

"It changed my views on a healthy relationship. Helped me grow as a person and my knowledge on how to keep my baby and myself healthy physically and mentally."

"It's made me a better person and mom, helped me make better decisions for myself and my family. Helped motivate and empower me to get back in school, get a job, etc."

Voluntary evidence-based home visiting is an umbrella term for certain program models that are backed by rigorous research studies, and meet federally established criteria for effectiveness, replicability, and quality. Although programs are distinct from one another, they share common core principles and features:

- **Voluntary:** Parents always opt in, and all visits are arranged in advance, according to a family's schedule, preferences, location of choice, and needs.

- **Comprehensive:** Programs are multifaceted and designed to foster the physical health, mental health, and education of both parents and children.

- **Family-centered:** Home visitors focus on recognizing and reinforcing clients' strengths and are trained to partner with families in culturally responsive ways.

- **Purposeful:** Informed by science on child development and attachment, programs empower and equip parents with the tools and skills to manage parenthood, foster strong family relationships and be their child's first and most important teacher.

- **Replicable:** Programs have formal training, fidelity mechanisms to monitor how programs are aligned to intended outcomes, and established evaluation protocols.

- **Flexible:** Programs are designed to work within a variety of local agency settings and can leverage and optimize many existing child and family serving systems

- **Effective:** Backed by decades of research, evidence-based home visiting is proven to boost both parents and children across a range of domains.

  - Support the optimal development of children
  - Prevent child abuse and neglect
  - Promote healthy family relationships
  - Increase the confidence and competence of parents
  - Promote family economic self-sufficiency
  - Maximize utilization of safety net supports

Two-thirds of California families with babies and toddlers face substantial challenges, yet voluntary evidence-based home visiting programs reach fewer than 2% of California babies and toddlers. In California, the four largest evidence-based home visiting programs (listed below) are funded by various federal and local means, and locally anchored within a diverse variety of public and private organizations across the state.

Model	Counties	Families	Funding
EARLY HEAD START HOME-BASED OPTION (EHS) **Goals:** Provides early, continuous, intensive, and comprehensive child development and family support services according to Head Start Performance Standards. **Eligibility:** Low-income pregnant women and families with children birth to age 3, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act. **Structure:** Weekly 90-minute home visits and two group socialization activities per month for parents and their children. **Home Visitor Staff Requirements:** Knowledge and experience in child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics.	36	10,181	Federal-to-local Administration for Children and Families grants; various matching funds
HEALTHY FAMILIES AMERICA (HFA) **Goals:** Focuses on reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness. **Eligibility:** Women begin during pregnancy or within the first three months after a child's birth and continue until children are between 3 and 5 years old. **Structure:** At a minimum, weekly hour-long home visits until children are 6 months old, with the possibility for less frequent visits thereafter. **Home Visitor Staff Requirements:** Paraprofessional parent educators with at least HS completion and relevant experience; Associate or Bachelor degree preferred.	15	2,516	California Home Visiting program (federal MIECHV funding); First 5 Commission funding, various matching funds
NURSE-FAMILY PARTNERSHIP (NFP) **Goals:** Designed to improve prenatal health and outcomes, child health and development, and families' economic self-sufficiency and/or maternal life course development **Eligibility:** First-time, low-income mothers and their children. Enrollment begins during pregnancy (no later than the 28th week of gestation) and concludes when the child turns 2 years old. **Structure:** One-on-one home visits. **Home Visitor Staff Requirements:** Registered public health nurses.	21	4,501	California Home Visiting program (federal MIECHV funding); First 5 Commission funding, various matching funds
PARENTS AS TEACHERS (PAT) **Goals:** Provide parents with child development knowledge and parenting support; early detection of developmental delays and health issues; prevent child abuse and neglect; and increase children's school readiness. **Eligibility:** Program enrollment may occur anytime between pregnancy and kindergarten for at least two years. PAT affiliate programs select the target population they plan to serve and the program duration. **Structure:** One-on-one hour-long home visits occurring at a minimum monthly, with more frequency for higher-need families; monthly group meetings. **Home Visitor Staff Requirements:** Paraprofessional parent educators with at least HS completion and 2 years' relevant experience; Associate or Bachelor degree preferred.	11	2,774	First 5 Commission funding; Tribal MIECHV funding; various matching funds

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CH1LDREN NOW

Health Homes Policy Brief

Child-Centered Health Homes in California:

An Opportunity to Better Coordinate Care and Improve Outcomes for the State's Most Vulnerable Kids

February 2014

Health Homes Policy Brief

Child-Centered Health Homes in California:

An Opportunity to Better Coordinate Care and Improve Outcomes for the State's Most Vulnerable Kids

Executive summary

Too many California children are failing to get the well-coordinated mix of health care services that they need to thrive. This represents a huge area of opportunity to improve outcomes for kids and the state as a whole, given healthy children and families are more productive.

Fortunately, a new twist on an old idea is poised to provide the better, more holistic care for kids and their families that's needed: health homes. A health home is a team-based model for delivering a comprehensive range of health care services in a personalized and coordinated manner, including medical, dental, and mental health, and support services.

While all children can benefit from the health home approach, the greatest returns health homes offer to individuals, families, communities and the state are expected to come from serving those with complex health and living conditions, such as children with special health care needs and foster youth.

Successful child-centered health home models already exist in California as does the statewide infrastructure that can be leveraged to serve these populations. However, the state has not yet taken advantage of opportunities, provided in part by the Affordable Care Act to support and expand access to health homes. Statewide efforts can take advantage of lessons learned from existing models in California and other states.

The opportunity to expand health homes is within reach

We're closer than ever before to ensuring that every child in California has affordable health insurance coverage but an insurance card alone does not guarantee quality health care or a healthy child. Often times, children with health coverage still lack access to high-quality health care. Their access may be limited because (1) care is not available where they live or at a time that works for their families, (2) it is not culturally or linguistically appropriate and/or (3) care may be incomplete, lacking the coordination needed for follow up with different providers. Without adequate access to health care, children are less likely to establish healthy developmental trajectories and more likely to acquire diseases and chronic conditions that can last a lifetime.

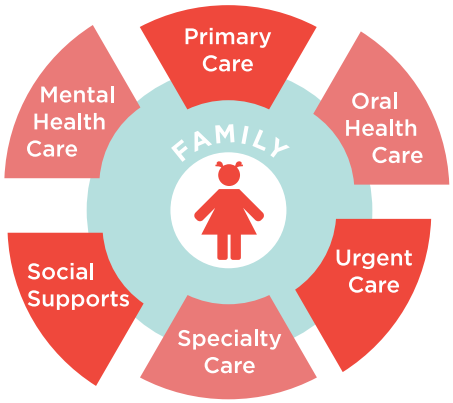
Well-coordinated, accessible health care is critical for whole-child development and well-being. Children with access to health care have generally better health throughout their childhood and into their teen years. They get preventive care to keep them well, can see a doctor when they are sick, and receive well-child care so they can attend school and participate in activities. Healthy students can more easily focus on school work and have a better chance at succeeding in life. Children's health care builds on itself over a lifetime; by providing high-quality preventive and early-onset disease management, we make an investment in a healthy future.

Moreover, the historic federal health care reform law, the Patient Protection and Affordable Care Act (ACA), and accompanying major state reforms in health care delivery provide significant opportunities to develop and expand the health homes model, which has been increasingly used as a vehicle to improve health care quality and control costs. Access to a health home can be one of the most effective methods to provide the high-quality health care and social supports that California's children need to thrive.

This brief defines the health home model and provides examples of existing child-centered health homes in California. It also covers the potential for child-centered health homes to improve health outcomes and care quality while, at the same time, lowering costs to the state, particularly when it comes to children with special health care needs and foster youth. Finally, an assessment of the opportunities provided by the ACA and other policies to create a child-centered health homes program is followed by a set of recommendations.

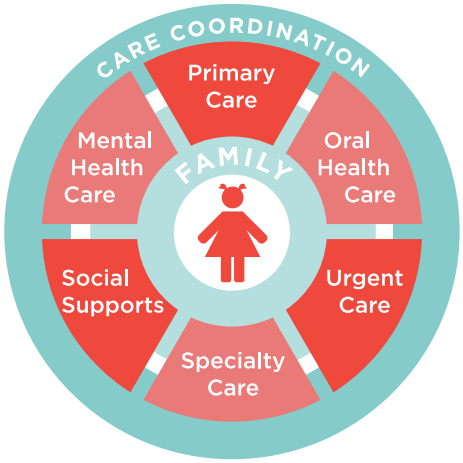
Without a Child-Centered Health Home

Families navigate a fragmented health care system where care by different providers is often uncoordinated and families are unsure where to turn for help.



With a Child-Centered Health Home

Families know where to go for their health care and an explicit emphasis on care coordination helps ensure that children receive all needed services in a timely fashion.



What exactly is a health home?

A health home is a team-based model for delivering a comprehensive range of health care services in a way that is personalized and coordinated across many areas including medical, dental, oral, and mental health, in addition to social support services. Even though it is called a "health home," it is not a physical location, but rather an approach to health care delivery. We define a child-centered health home to be a health home that focuses on children and their families.

The concept of a health home arose from the "medical home" concept, which the American Academy of Pediatrics developed to address the problem of duplicative records and gaps in services resulting from inadequate communication and care coordination, but has since been adapted to additionally be patient- and family-centered, accessible and compassionate. The health home approach expands on the medical home model by aiming to provide "whole person" care that focuses on prevention and follow-up services to minimize acute disease episodes, delivered in community settings, when possible, to maximize community connections and social supports while minimizing the disruption of routines (for more, see box on "Why health homes?")[1]

While there is no single accepted definition of a health home, the way it is defined in the Affordable Care Act (ACA) has important implications – discussed further below – for the growth of the model in California. The ACA definition is: "…*comprehensive and timely high-quality services… that are provided by a designated provider, a team of health care professionals operating with such a provider or a health team.*"[2] Services included in the ACA definition are:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- Patient and family support (including authorized representatives);
- Referral to community and social support services; and
- Use of health information technology to link services.[3]

Why health homes?

Due to a fragmented health care system, most Americans must navigate a complex web of health care providers and payers to get the care their children need. This fragmentation contributes to the inefficiency and high cost of our health care system, and also is a barrier for families to effectively coordinate their children's health care. The health home model, with its emphasis on care coordination and family empowerment, addresses these problems.

The design of health homes reflects how children actually live. Just as a child's life exists in the context of a family and community, so too does a child's health. Scientists have found that the conditions in which we live, learn, work and play have enormous health impacts before we ever seek medical attention.[5] Health homes can contribute to our seeing and addressing health issues in this broader context by focusing on education and prevention, the integration of mental and physical health, and the identification and provision of needed social supports. By adding a focus on how to improve factors outside the traditional health care system, the health home concept broadly benefits the health of the community.[6]

A health home team can include anyone who provides coordinated services and support, such as hospitals and health plans; physicians, nurse practitioners, social workers, community health workers and other health professionals; clinical practices, group practices, community clinics, community health centers and school-based health centers.

The child-centered health home model of care can include other "family friendly" components like enhanced and increased access to care providers through techniques including open scheduling, expanded hours and more communications options (e.g., email). In addition, health homes include families as health team members – often making them the center of the team. Family engagement, education and empowerment give families greater opportunities to participate in key decisions about the health care of their children.[4]

How children benefit from health homes

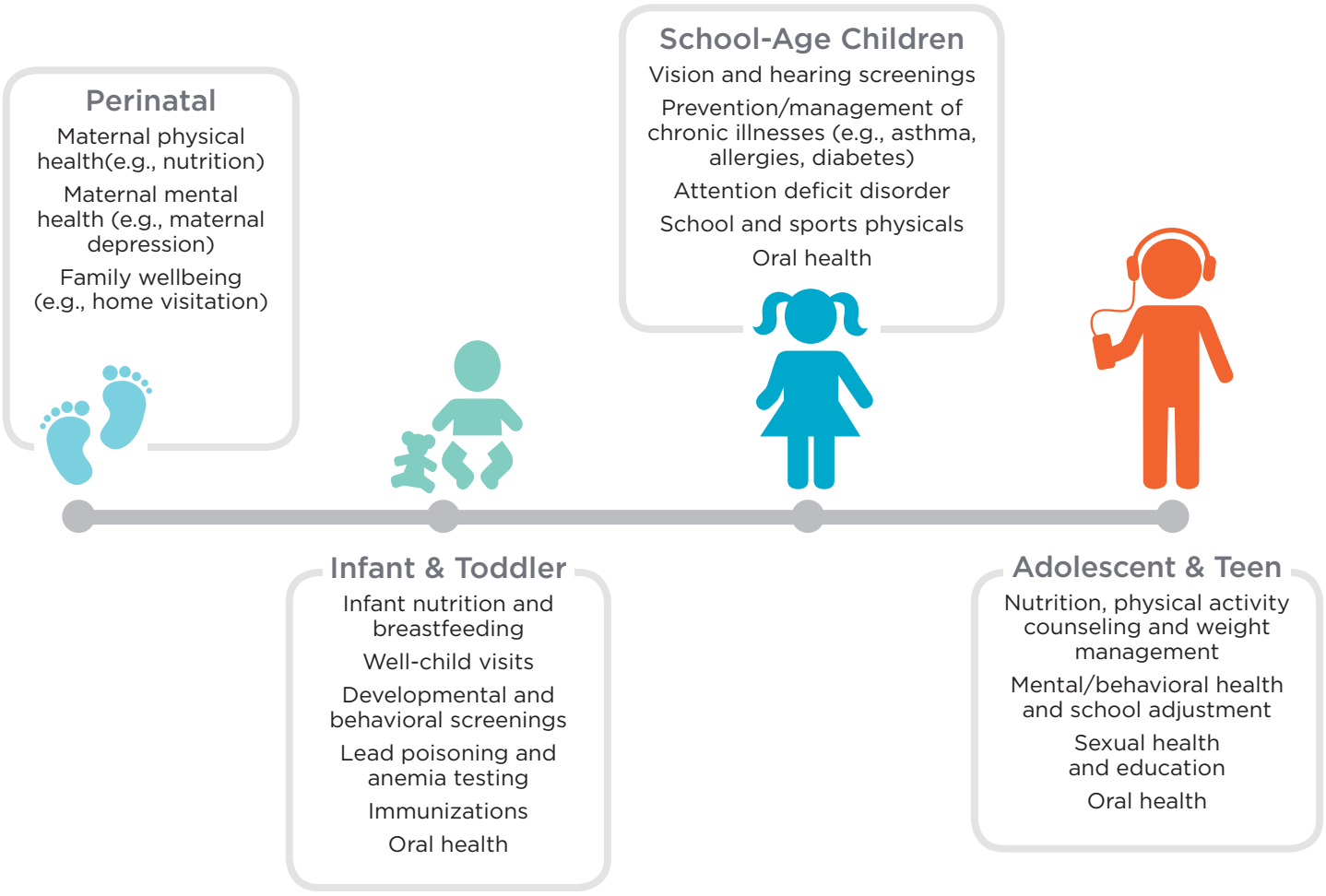
Health homes can offer improved quality of care compared to alternate models through stronger cross-provider coordination and information-sharing. This means that primary care doctors and specialists as well as other service

providers can coordinate and take a more holistic approach to care for an individual, more effectively addressing interrelated health and wellness needs comprehensively.

Additionally, by improving communication and coordination within the health care system, a health home can reduce the access to care hurdles many families face – a benefit that is especially valuable for families with children with special health care needs who are uniquely vulnerable to falling through the cracks. These families often need help accessing and integrating services from a complex system of providers, specialists, hospital and community services and supports, and a wide variety of disjointed programs.[7] According to a recent report from the Commonwealth Fund, "A child's health, ability to participate fully in school and capacity to lead a productive, healthy life depends on access to preventive and effective health care – starting well before birth and continuing throughout early childhood and adolescence"[8] (for more, see box on "Examples of benefits of health homes across a child's development").

While all populations can potentially benefit from receiving care in a health home,[9] the benefits of the model for vulnerable children and their families are paramount. This is due to the following reasons. First, any improved health outcomes and corresponding cost savings associated with inclusion in a health home will accrue over a longer period of time for a child than for an adult. Second, children are not independent and therefore stand to particularly benefit from the health home model's focus on caregiver supports and empowerment. Ample evidence indicates that child outcomes can be improved by attending to the capacity and needs of their caregivers.[10] Third, since children are developing, they have more complex and changing needs that need to be coordinated among primary care providers and specialists, and even across sectors. States such as Colorado and Rhode Island have recognized these benefits, are leveraging the opportunities of the health homes model to both improve the quality of children's health care and lower costs, and can serve as useful models for California (for more, see box on "Health homes in other states".)

Examples of benefits of health homes across a child's development



Health homes in other states

The Colorado Medical Home Initiative provides a compelling example of a program that aims to serve all children in a state. Currently, all health and medical practitioners serving children and youth enrolled in the state's Medicaid program and Children's Health Insurance Program are required to meet a set of standards that was developed by a broad coalition of agencies, families, hospitals, organizations, policymakers and other stakeholders and has been endorsed by the state through legislation as well as by state and national professional organizations such as the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).[11] Among other requirements, practices must provide care coordination, have 24/7 access to a provider or trained triage service, and have systems for families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers in order to be eligible for extra pay-for-performance payments that are indexed to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) metrics. An evaluation of the program revealed a dramatically positive quality outcome: 72 percent of children in Colorado's medical home practices had had well-child visits, compared to 27 percent of children in control practices.[12] The Initiative has also proven to be cost effective: an evaluation of the program found a 21.5 percent reduction in median annual costs for children with a medical home ($785, compared to $1000 for non-medical home children) in 2009. The subpopulation of children with chronic conditions also showed cost savings, with lower median annual costs for children in medical homes ($2,275) than for those not enrolled ($3,404).[13]

Rhode Island also has created a statewide health homes program, using federal funds under the ACA to provide for its population of children with special health care needs. To do so, the state took advantage of an existing model of care delivery called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). At CEDARR centers, a variety of licensed clinicians coordinate children's care to ensure they are receiving appropriate, family-centered and community-based medical and support services, including the provision of an Initial Family Intake and Needs Determination and the development and regular review of a Family Care (or Treatment) Plan with specific child goals. Goals of the program include improved care coordination, decreased emergency department use and preventable admissions, and improved quality of transitions from inpatient/residential care to the community. Turning the CEDARR model into a health home model required adjustments to structures for communication and information sharing among service providers, and its success can prove instructive for other states facing similar hurdles.[14]

Particular sub-populations of children stand to benefit the most

Children with special health care needs

"Children with special health care needs" is a term used to describe individuals under age 18 who have chronic physical, developmental, behavioral and/or emotional conditions, and need health care and related services beyond those required by children generally. Examples of chronic conditions include asthma, attention deficit disorder, sickle cell disease, cleft palate or cerebral palsy. Approximately 1 million children in California – or 1 in 10 – have special health care needs.[15]

The need for a health homes program for this population is underscored by a series of recent reports by the Lucile Packard Foundation for Children's Health that examined how well California's health care system is serving children with special health care needs. These reports found that the state has considerable room for improvement. For example, nearly half of California children with special health care needs do not receive effective care coordination, ranking the state 46th in the nation on this measure. The state fares even worse in the percentage of these children that have problems getting needed referrals for specialty care: it ranks last among the states.[16]

A survey of the California Advocacy Network for Children with Special Health Care needs identified improving care coordination as the most pressing issue among members, with the top three barriers to improvement being California's fragmented health care system, inadequate communication among health care providers and inadequate payment for care coordination.[17] For these children who face serious health problems, a regular source of care like that

provided by a child-centered health home can dramatically improve treatment outcomes, mitigating the impact of chronic conditions. For example, the American Academy of Family Physicians (AAFP) has found that health homes particularly improve the management of chronic illnesses such as asthma, preventing episodes of acute illnesses and unnecessary ER visits.

In contrast, children without a regular source of professional, family-centered treatment and care coordination are less likely to receive high-quality asthma care and more likely to use inhaled bronchodilator medications rather than control medications, to be treated by general providers rather than asthma specialists and to have irregular medical follow-up.[18] Since research shows that asthma is the leading cause of school absences due to a chronic disease and accounts for three times more lost school days than any other cause – an estimated 1.9 million missed days of school in California in 2005 – health homes can potentially improve both health and educational outcomes.[19]

Foster youth

In 2012, over 55,000 children and youth under age 21 were in foster care in California.[20] These children have significant health care needs and poorer long-term outcomes compared to peers who have not been in foster care. Nearly 90 percent of young children entering the foster care system have physical health issues such as asthma, anemia, malnutrition and manifestations of abuse. More than half have two or more chronic conditions.[21]

Moreover, removal from the home and the preceding abuse and/or neglect are traumatic experiences that create toxic stress, which interferes with healthy brain development and emotional well-being. Examples of conditions that are linked to early trauma include heart disease, obesity, alcoholism and drug use.[22] For these reasons, the American Academy of Pediatrics (AAP) has defined children in foster care as children with special health care needs and recommended that they be provided with health homes.[23]

Foster care is an incredibly complex system and foster youth face unique barriers stemming from the diffusion of responsibility among multiple parties such as caseworkers, courts, agencies, foster caregivers and parents. In the context of health care provision, challenges include obtaining consent for health care, obtaining health information, coordinating care, sharing information across systems, obtaining timely referrals and health care workers needing to navigate the child welfare system.[24] For these children, the intensive case management, care coordination and social supports of a child-centered health home can be especially beneficial. Evidence suggests that enhanced care coordination in a health home model may increase access to services and decreased emergency room visits for foster youth.[25]

Examples of existing child-centered health homes in California

The following innovative and nationally-recognized programs highlight the diversity of health home models – in terms of services provided, populations served and geography – and how health homes are already positively impacting the lives of California's children and families.

Center for Youth Wellness, San Francisco[26]

Nadine Burke Harris, MD, FAAP, MPH, Founder and CEO: "The Center for Youth Wellness is a health organization embedded with a primary care pediatric home serving children and families in Bayview Hunters Point, San Francisco. We were created to respond to a new medical understanding of how early adversity harms the developing brains and bodies of children. This is not just an issue for kids in Bayview, but across the state and around the world. Our integrated pediatric care model allows us to screen every young person we see for adverse experiences that we know can lead to toxic stress and poor health outcomes in life. We heal children's brains and bodies, piloting the best treatments for toxic stress and sharing our findings nationally. We're seeing first-hand that this integrated approach—one that takes the whole child into account and addresses children's physical and neuro-developmental needs—is hugely beneficial to the children and families that we treat."

Pediatric Medical Home Program at Mattel Children's Hospital, University of California, Los Angeles[27]

Thomas Klitzner, MD, PhD, Director: "The Pediatric Medical Home Program at UCLA serves medically complex children and is designed to deliver care that is accessible, family-centered, continuous, comprehensive, coordinated, culturally sensitive and compassionate. Currently, the Program serves over 200 children. Many of the families are poor, come from minority or immigrant backgrounds, live in overcrowded apartments and have limited access to transportation. They often miss medical appointments and tend to use emergency rooms to get their care, when their children become too sick to wait to see a doctor. The program helps these children and their families manage care and cope more effectively, and has demonstrated significant reductions in emergency room utilization. The mother of a 12-year-old patient with a rare chromosomal abnormality says, 'The Medical Home Program offers hope and kindness to my son. It gives him hope to feel better and kindness to help him feel better. My son has very special needs, and now we have a wonderful doctor and a home for his care. They say it takes a village, and we say it takes a Medical Home! There is no place like home!!!'"

University of California, Davis' Pediatric Telemedicine Program, Sacramento[28]

James Marcin, MD, FAAP, MPH, Director: "UC Davis' pediatric telemedicine program was the first of its kind in the United States. We provide real-time remote specialty consultations and evaluations using video conference technology for children throughout California. UC Davis emergency medicine physicians, neonatologists, critical care specialists, geneticists, cardiologists, neurologists and others connect directly to remote hospital emergency departments, newborn nurseries, inpatient wards and outpatient clinics to provide care and consultation for infants, children and adolescents who experience traumatic injuries, life-threatening infectious diseases or other critical illnesses. By leveraging telemedicine technologies, the Program serves children who do not have access to specialty care and has thus positioned itself to be a critical member of pediatric health home teams across the state. Children are receiving their specialty consultations in their primary care providers office or their local hospital with all providers present, making it a true team approach. Ample research has demonstrated the benefits of the Program in terms of parent satisfaction of care, provider satisfaction of care, health outcomes, patient safety, and cost savings."

Family Outreach and Support Clinic, Children's Hospital Research Center, Oakland[29]

Peggy Pearson, MFT, Director: "The FOSC is a collaboration of the Primary Care Center and case managers from the Center for the Vulnerable Child of Children's Hospital Research Center Oakland, serving the San Francisco Bay area. Our mission of over 25 years has been to provide comprehensive and culturally sensitive medical care and case management to children in foster or kinship care, as well as to those in the adoption or reunification process. Many areas of need are addressed including sub-specialty care, dental care, developmental assessments, mental health and psychiatric care, foster parent continuing education and care giver support. The children range from infants to teens and the services have no time limit. The children are referred by foster parents, kinship care givers, child welfare workers, doctors and public health nurses. A similar model was created for homeless families in our community with the Encore Medical Clinic in 2006 at the same site."

California can benefit from child-centered health homes

Many policymakers, health care delivery organizations and advocates have embraced the "Triple Aim" health care goal of improving the individual experience of care, improving the health of populations and reducing the per capita costs of care to populations. This concept recognizes the need for "integrator" entities – individual organizations that recognize and respond to patients' individual needs and preferences, and link health care, public health and social service organizations.[30] Health homes fulfill these requirements and can thus significantly contribute to advancing the Triple Aim.

California is already benefiting from the aforementioned nationally-renowned programs that provide or contribute to creating child-centered health homes and have proven to be effective at advancing the Triple Aim. For example, a comprehensive study of the Pediatric Medical Home Program at Mattel Children's Hospital, UCLA, found a

55 percent reduction in Emergency Department (ED) utilization for children – a phenomenal result that reflects an improvement in care quality and a reduction in costly crisis intervention services.[31] Likewise, studies of the UC Davis Pediatric Telemedicine Program have demonstrated impressive improvements in care quality measures, clinical outcomes and cost savings,[32] including a significantly reduced risk of physician-related ED medication errors among seriously ill and injured children in rural EDs[33] (for more, see box on "Examples of existing child-centered health homes in California").

Furthermore, the current Administration has embraced the Triple Aim goal and health homes as a means of achieving it. In February 2013, the California Health and Human Services Agency was awarded a State Innovation Model (SIM) Design grant by the Center for Medicare and Medicaid Innovation (CMMI), to be used to develop a State Health Care Innovation Plan (SHCIP) to improve health care quality by changing payment structures. The SHCIP is intended to complement the goals of the Governor's Let's Get Healthy Task Force Report – which outlines a ten-year plan to improve the health of Californians while reducing health care costs – and form the basis for an application for a three-year State Innovation Model Testing award in 2014.[34] The SHCIP, which at the time of publication of this brief was in the form of a working draft, is organized into initiatives that center on care coordination and include a health homes initiative for complex patients. The vast majority of cost savings to the state are estimated to come from the health homes initiative, though only a fraction is presumably attributable to savings from serving children.[35] However, depending on how a health home model is crafted and the extent to which populations are served, there could be considerable cost savings, especially when looked at across sectors and over time.

How can California expand health homes for children?

Given the health benefits and potential cost savings resulting from the health homes approach to care, California should pursue all opportunities to support and expand health homes. One attractive option is to take advantage of the systems changes and opportunities associated with federal health care reform and considerable federal resources for states that wish to move forward with this model. However, California can also move ahead and develop its own health homes model using lessons learned within the state and elsewhere.[36]

Health homes in the Affordable Care Act

The ACA provides an unprecedented opportunity for California to expand the health homes model of care for Medicaid (known as Medi-Cal in California) enrollees with chronic conditions.[37] By pursuing this option, California could receive additional federal funds to test some of the innovative practices designed to improve access to high-quality care that children and their families need, while reducing costs needed to provide expensive and state-funded institutional and crisis-driven care. Specifically, to encourage states to explore this option, the law provides a 90 percent federal matching rate for two years so long as the funding is used to coordinate care service provided in conjunction with a health home.[38] Therefore, by choosing this option, California would only have to cover 10 percent of the costs during the start-up phase of a health homes program.

Through the ACA, the federal government established broad eligibility criteria, which allows states flexibility in the ultimate creation of their health home pilots. While the law is clear that states cannot develop a pilot that limits access to a health home by age or aid category, it allows states to make choices that would enable them to serve many of their most vulnerable children.

States are allowed to choose the type of population to apply the health home option to by selecting patients suffering from two chronic conditions, patients with one chronic condition who are at risk for another and/or patients with one serious and persistent mental health condition. States may also determine what chronic conditions the health home option should be applied to. Examples include mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight.[39] Therefore, while the ACA precludes a health home option from being tailored just for children, the state could select chronic conditions that affect children, such as asthma, attention deficit disorder and pediatric diabetes, or certify as health home providers those whose licenses allow them to serve children.

While the state has been occupied with large deadline-driven systems changes associated with implementing federal health reform, it is expected to move forward in creating a health home pilot program in 2014. The recent passage of Assembly Bill 361 (Chapter 642, Statutes of 2013), authored by Senator Holly Mitchell, signals the desire of the California legislature and governor to take advantage of the ACA's health homes option.[40] The statute authorizes the California Department of Health Care Services (DHCS) to create a California Health Home Program and submit appropriate applications to the Centers for Medicare and Medicaid Services in order to draw down the available 90 percent federal matching dollars, specifies eligible health home providers and services, and requires DHCS to complete and report on an evaluation of the Health Home Program within two years after its implementation.

Expanding health homes for children with special health care needs

DHCS is assessing how best to explore the ACA's health homes option.[41] One option that was deemed by DHCS's consultants to be both feasible and cost effective is to create a health homes pilot program around the existing California Children's Services (CCS) program.[42] CCS is a state program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to over 150,000 children under 21 with certain diseases or health conditions whose parents are unable to afford these services.[43] CCS-eligible conditions include cerebral palsy, hemophilia, epilepsy, heart disease and chronic lung disease.[44]

Advantages of a health homes pilot program built around the CCS program include (1) the ability to treat children with special health care needs who would benefit the most from the integrated care provided by a health home, (2) an existing statewide infrastructure of CCS Special Care Centers that use multi-specialty teams to evaluate a patient's medical condition and develop a comprehensive, family-centered health care plan and (3) anticipated cost savings to the state General Fund. The ample benefits of pursing such a program were recognized by a recommendation to prioritize a CCS Special Care Center Health Home option over all other health homes options analyzed.[45]

Perhaps the most vulnerable children with special health care needs are high-risk infants from birth to three years of age who are experiencing developmental delays or have a diagnosed condition that has a high probability of resulting in developmental delays. In California, nearly 5,000 infants per year are served by the CCS High Risk Infant Follow Up (HRIF)[46] program. Under the program, each CCS-approved Neonatal Intensive Care Unit (NICU) is required to ensure the follow-up of discharged high-risk infants and either have an organized program to provide diagnostic services or a written agreement for provision of services by another CCS-approved NICU.[47] HRIF clinic teams often include collaborations of specialists such as neonatologists, nurse practitioners, pediatric development specialists, dieticians, occupation and physical therapists, and social workers.[48]

Not only are high-risk infants in particular need of care coordination to address their complex health requirements,[49] but (1) a large proportion of high-risk infants who would benefit from early intervention do not receive referrals,[50] (2) a statewide evaluation mechanism is already in place[51] and (3) since high-risk infants are particularly expensive patients,[52] improved prevention efforts would be expected to yield significant cost savings to the state General Fund.

Expanding health homes for foster youth

Just as a health homes program for children with special health care needs can be built around the existing CCS program, health homes for foster youth can leverage existing reform efforts and programs intended to provide and coordinate services for those in the child welfare system. Many existing reform efforts in California intend to change systems to better support foster youth without rotating them through programs and placements while maintaining cost effectiveness. Child-centered health homes are well suited to play a significant role in these efforts.

California's Continuum of Care Reform (CCR) is an ongoing effort to develop recommended revisions to California's current rate setting system, services and programs in order to ensure better outcomes for youth in the child welfare system and to reduce the reliance on group care.[53] CCR, along with other recent and ongoing reforms such as implementation of the Katie A. Settlement Agreement,[54] recognizes that many families in or at risk of entering the child welfare system face mental and behavioral health issues. One national study, for example, showed that while children in foster care represented only three percent of the Medicaid child population, they accounted for 29 percent of total behavioral health spending for children, and that behavioral health expenses for children in foster care were double those of physical health.[55]

Given that care for this population is relatively costly, health homes for foster youth have the potential to provide significant savings to the state. Furthermore, child-centered health homes can link families with substance abuse and mental illness challenges to needed services and supports – a critical feature since healthy child development depends on the availability of responsive and supportive relationships.[56] Another potential benefit of two-generational care is the facilitation of reunification through the coordinated provision of services and supports for children who are reunifying with their parents.

The goals of existing programs that are targets for expansion or reform often converge with those of the child-centered health home model and include a focus on addressing the high rates of behavioral health and service coordination challenges faced by this population. "Wraparound" is a planning process that focuses on providing children in the foster care system with alternatives to group home care by engaging the family to identify their needs and create methods to meet those needs. Funds that would otherwise go to group homes are used to pay for Wraparound services and supports that are intensive, individualized and community-based – the kind of supports and services that child-centered health homes also seek to provide.[57] An example of a service provided through Wraparound is Therapeutic Behavioral Services, one-on-one behavioral mental health services that are Medi-Cal reimbursable under EPSDT and are provided to foster youth with serious emotional challenges. As of February 2012, 47 of California's 58 counties have developed California Wraparound Services Programs and one is actively planning a program.[58]

Recommendations for a child-centered health homes program for California

With the recent passage of authorizing legislation, California is poised to create one or more statewide health home models that can help the state achieve the Triple Aim of improved health outcomes, care quality and cost savings. The following recommendations for a child-centered health homes program arise from an evaluation of the needs of California's children, the capacity of existing state infrastructure,[59] and the efficacy of health home models and related health care delivery reform efforts in other states.

Create a health homes program that includes children with special health care needs. The gaps in care coordination and other critical services for California's children with special health care needs are well documented[60] and a health homes program to serve this population could be designed around the CCS program, just as Rhode Island designed its health homes program around its existing CEDARR program.[61] Among children with special health care needs, medically fragile infants deserve special attention because of their particularly complex and costly health care needs and the well-suited existing state infrastructure of the HRIF program and the California Prenatal Quality Care Collaborative.

Create a health homes program that includes current and former foster youth. Given the complex physical and behavioral health challenges and care coordination needs typically faced by this population, a statewide health homes program should include foster youth and former foster youth at least up to age 26, at which age they are no longer categorically eligible for Medi-Cal coverage. Agencies should collaborate to support more coordination across the child welfare, mental health, juvenile justice and education systems; facilitate the use of blended funding streams; and leverage existing programs such as Wraparound. Coordinated two-generation services can help address persistent substance abuse and mental health challenges that are barriers to healthy child development. Given the high incidence of adverse childhood experiences,[62] all child-centered health homes should provide trauma-informed care.

Develop a provider education and support system as a critical component to the successful development of a health home program. Focusing training and resources of the developing care teams; recruiting parent partners;[63] creating comprehensive patient registries; collaborating with local, community-based organizations; and connecting with relevant statewide efforts and practices will help ensure that providers have the skills, tools and supports necessary to transition from a traditional health delivery system to a true health home.

Support families in their care coordination, in accordance with recommendations made by the AAP for the provision of care for children with special health care needs.[64] This support could come in the form of an initial care coordination needs assessment to determine immediate needs, followed by families being offered tools to coordinate

their child's care in conjunction with the health home team.[65] Home visiting programs that provide supports for new and expectant parents have ample, well-demonstrated benefits that far outweigh the costs.[66] Another valuable support could be provided by the development of a parent/peer navigator model, in which trained parent consultants assist families in accessing community resources, assist physicians and families in accessing specialty services, and help identify barriers to coordinated care.[67]

Close the feedback loop on care coordination to ensure that, at a minimum, when primary care provider (PCP) referrals are made to community service providers, these providers follow up with the child's PCPs to provide feedback and PCPs ensure that these interactions are documented to close the feedback loop in a timely fashion. For example, the results of developmental screenings used to identify children at risk for developmental disorders should be used for referrals to Early Intervention (EI) providers, and EI services provided should be tracked by PCPs. Based on experiences in other states, California would benefit from developing or promoting mechanisms to track closed feedback loops.[68]

Craft payment policies to leverage funding sources and provide desired incentives. To create health homes programs that deliver on their promise to improve health care quality and health outcomes, incentives must be designed to (1) reward more capable and better performing child-centered health homes; (2) enable the delivery of appropriate services to children facing health challenges of varying severity; and (3) foster collaboration among primary care, specialty care and other service providers.[69] To create health homes that are cost-effective for the state, blended funding policies should be designed and the state should offer assistance to enable health homes to make the best use of available funding streams. For example, health homes for foster youth may employ health and social services funds, while school-based health centers could use health and education funds. Payers should be encouraged to create financial incentives for providers to employ cost-effective services such as telehealth, which can help children in under-served communities.

Incorporate a rigorous program evaluation to ensure that the state adequately measures the benefits of a health home program and fosters a culture of evidence-based continuous improvement.[70] A child-centered health home should be evaluated against California- and child-specific standards that are developed by health care providers, state agency staff, advocates and other stakeholders,[71] and that take into account expert recommendations on quality measures.[72] An evaluation would demonstrate program impact and value to the public and decision makers who influence fiscal resources and engage in long-term planning to transform our health care delivery system. An evaluation is also critical for identifying areas where changes such as additional support and training are needed to maximize positive health outcomes, care quality and cost savings.

Conclusion

We know that remedial medical care alone is insufficient to ensure good health; children need preventive care, follow up after illnesses, screenings and access to broader support services. Child-centered health homes can provide children – especially those with special health care needs and those in foster care – with access to effective, child-centered, holistic treatment and health care. While California has been a leader in implementing federal health reform, it has fallen behind in leveraging the health home model to improve health outcomes and care quality for children and families while reducing health care costs. California policymakers must capitalize on current and future opportunities to make significant progress toward the vision of every child in the state having a health home that provides the comprehensive and integrated health care they need needed to grow, learn and thrive.

Footnotes

1 Though the terms "medical homes" or "patient-centered medical home" might seem new to some, the concept actually originated in the 1960's by the American Academy of Pediatrics (AAP) and is experiencing a great resurgence of interest given its strong evidence base of improving care coordination and increasing patient satisfaction. Since the AAP's promotion of the concept, several organizations including the World Health Organization and the Institute of Medicine have endorsed this model of care. In 2010, the Centers for Medicare and Medicaid Services (CMS) issued a state Medicaid Director Letter to bring the "medical home" concept into the Affordable Care Act and rebrand it as "health homes." CMS states that they expect "health homes to build on the expertise and experience of medical home models and when appropriate, to deliver health home services. In this brief, the health home model is considered to be broader and thus encompass the medical home model. In some cases, e.g. when discussing AAP recommendations, the terms are used interchangeably.

2 ACA, Section 2703/Social Security Act, Section 1945(h)(3).

3 ACA, Section 2703/Social Security Act, Section 1945(h)(4)(B).

4 American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA), "Joint Principles of the Patient-Centered Medical Home," 2007. http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf, retrieved January 2014.

5 Robert Wood Johnson Foundation, "How does where we live, work, learn and play affect our health?" 2011. http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/09/how-does-where-we-live--work--learn-and-play-affect-our-health-.html, accessed January 2014.

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7 Ziring P.R. et al., "Care coordination: integrating health and related systems of care for children with special health care needs," Pediatrics 104, 1999.

8 Sabrina K. H. How et al., "Securing a Healthy Future: The Commonwealth Fund State Scorecard on Child Health Performance, 2011," February 2011. http://mobile.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Feb/Child%20Health%20Scorecard/1468_How_securing_a_healthy_future_state_scorecard_child_hlt_sys_performance_2011_web_final_v8.pdf, accessed January 2014.

9 While in this brief we focus on evidence specific to children's health care, due to the larger number of programs that don't specifically serve children there is a much larger body of evidence demonstrating the value of medical home and health home models in adult or non-age-specific populations. For reviews, see 1) Kevin Grumbach and Paul Grundy, "Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States," Patient-Centered Primary Care Collaborative, November 16, 2010 and 2) Sara S. McMillan et al.. "Patient-Centered Approaches to Health Care: A Systematic Review of Randomized Controlled Trials," Medical Care Research and Review, 70, 2013.

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12 Grumbach and Grundy. Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. Patient-Centered Primary Care Collaborative. Updated November 16, 2010.

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29 Children's Hospital & Research Center Oakland, "Family Outreach & Support Clinic." http://www.childrenshospitaloakland.org/main/departments-services/family-outreach-support-clinic-24.aspx, retrieved January 2014.

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33 Madan Dharmar et al., "Telemedicine Consultations and Medication Errors in Rural Emergency Departments," Pediatrics 132, 2013.

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TRINITY COUNTY INNOVATION PRESENTATION TO THE OAC MARCH 22, 2018

2

Assessing the local capacity to serve the consumer in crisis;

- Trinity County has spent several years identifying the gaps in our crisis service.
- Unquestionably, it has been determined that the greatest need is a safe resource for consumers to spend the night when critical support is needed.
- Once we identified the need, a vision for Peer Respite was established.

Assessing the local capacity to serve the consumer in crisis;

- Trinity County determined that our preferred program would be a peer respite at no cost to the consumer.
- We developed a strong vision, and data to support our plan.
- CHFFA did award Trinity $750,000. to build a 1800 square foot Peer Respite Home in May, 2016.
- Trinity is currently focusing on the operational manual, policies and community stakeholder education.

Trinity County's Peer Respite-Cedar Home

- The home will house six adults that need an intervention but clearly not hospitalization.
- This facility will be staffed 24/7 by County Peer Specialists, and under the immediate oversite of the Behavioral Health Crisis Team.
- The home will be managed by a Day Time MHSA Innovation Coordinator who will be a Rehabilitation Specialist with lived experience.

Putting It All Together

- The addition of a peer respite in Trinity County not only reduces the need for out of county placements it furthers the county's efforts to demonstrate the efficacy of peer support and to further embed recovery and resiliency programming as 'cornerstone' to successful behavioral health treatment within the county system
- The TCBHS 2018 – 2020 Innovation project will build on our two previous projects, enhancing and defining the role of the trained peer specialist.
- Trinity county believes that both the peer respite concept, and the peer specialist provider will be a critical element in crisis intervention throughout the State in the years to come.

Putting It All Together

- Today, Trinity County is asking that the OAC approve its request to use its annual Innovation allocation of $89,000 to underwrite the total costs of the day time Cedar Home Coordinator for the next 20 months, through June of 2020.
- Our Study question remains similar to our prior two successful Innovation projects: “Will the use of Peer Specialists improve quality of services including better outcomes?”
- Trinity County appreciates the support that the OAC has demonstrated to our County over the past years, and we hope to continue our collaboration with the OAC to improve services for State consumers of the public behavioral health system.

Proposed Motion

- The MHSOAC approves Trinity County's Innovation plan as follows:

- Name: Cedar Home Peer Respite
- Amount: $267,000
- Project Length: Twenty Seven (27) Months

Intensive Case Management/Full Service Partnership (ICM/FSP) to Outpatient (OP)Transition Support

Presenters:

Imo Momoh
Tracey Helton
Jose Orbeta

March 22, 2018

Need & Goal

Fewer than 19% of clients who leave Intensive Case Management (ICM) programs **transition successfully** to Outpatient Care (OP)

Of ICM clients discharged:

- 18% engage successfully at OP within three (3) months
- 9% remain engaged in outpatient for up to a year
- 23% New Crisis/ICM/Inpatient Episodes

<u>Numbers indicate that many clients</u> who have worked hard on their wellness may be <u>at risk for destabilization</u>.

Goal: By Year 3 of project 25% of ICM clients will engage successfully at OP

Peer Linkage Team

- SCOPE -

- Give client the perspective of gaining a team as opposed to losing service(s).

- Connect with clients before discharge and guide/engage with them until successful linkage.

- Serve as a bridge for each client transitioning from ICM to outpatient care (step-down specialist).

- Multicultural team of peers to provide culturally responsive services.

Proposed Peer Model

- Culturally and linguistically diverse/competent.
- Peers will be situated in a cohort to respond to client referrals.
- Ongoing education and training to increase skills, competency, and resourcefulness.

- One clinician on team to provide support on clinical matters/supervision.
- Peers will participate in client case conferences with ICM and OP providers.
- Support and accommodations will be provided to peer staff to ensure their own wellness.

Learning Questions

1. **How effective is a highly skilled peer transition team** in helping clients from intensive wraparound services engage in appointment-based outpatient (OP) care?

2. **What program elements** need to be in place for a peer transition support team to be successful?

3. **What factors create a resilient relationship between the client and peer** transition team member?

4. **Which practices best support the peer transition team member's wellbeing** and professional development?

5. **What programmatic elements facilitate collaboration and communication** between providers at the ICM/FSP and OP programs during a referral and linkage process?

Community Planning Process

- Seventeen (17) community engagement meetings.
- Engagements held in multiple languages including Spanish and Cantonese.
- Diverse groups represented including providers, clients, family members, faith-based organizations and other stakeholders.
- Participation of stakeholders from various cultural backgrounds.
- Community engagements meetings are still ongoing.

Peer Perspective

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Dankie
(Afrikaans)

Salamot Po
(Tagalog)

Merci
(French)

Grazie
(Italian)

Efharisto
(Greek)

Toda
(Hebrew)

Tak
(Danish)

Tack
(Swedish)

THANK YOU

Arigato
(Japanese)

Obrigado
(Portuguese)

Danke
(German)

Kamsa hamnida
(Korean)

Gracias
(Spanish)

Pasibo
(Russian)

Xie Xie
(Mandarin)

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Proposed Motion

- The MHSOAC approves San Francisco County's Innovation plan as follows:

  Name: Intensive Case Management/Full-Service Partnership to Outpatient Transition Support

  Amount: $3,750,000

  Project Length: Five (5) Years

Mental Health Services
Oversight & Accountability Commission

Stakeholder Contracts Update

Tom Orrock, Chief, Commission Operations and Grants
Angela Brand, Stakeholder Contract Lead
March 22, 2018

WELLNESS • RECOVERY • RESILIENCE

Purpose

To provide an overview and update on advocacy work funded by the Commission.

Background

- Transition from sole source to competitive bid
- 2017 new contracts awarded; contracts end August 2020
- Next round of funding in 2020
- Exploring opportunities for additional funding for immigrant/refugee communities and criminal justice involvement

Stakeholder Contracts

All stakeholder contracts have been awarded and are held by the following organizations:

- Consumers: ***Mental Health America of Northern California (NorCalMHA)***
- Diverse Racial and Ethnic Communities: ***NAMI California***
- Families of Clients/Consumers: ***NAMI California***
- LGBTQ: ***Health Access Foundation***
- Parent/Caregivers of Children/Youth: ***United Parents***
- Transition Age Youth: ***California Youth Connection (CYC)***
- Veterans: ***California Association of Veteran Service Agencies (CAVSA)***

Progress of Current Activities

All contracts include various activities specific to the needs of their target population under four main areas:

- Annual State of the Community Report
- Training and Education
- Outreach, Engagement, and Communication
- Advocacy

Progress of Current Activities

Annual State of the Community Report

The Annual State of the Community Report will present a cumulative portrait of the target population including an assessment of key mental health needs and challenges of the target population at the local-level and state-level, summary of resources, and opportunities to improve mental health policy, programs, and outcomes.

First reports will be due in August 2018.

Training and Education

The goals for training include support for mental health needs, understanding of local and state level policy and program development, systems navigation and the rights of consumers and family members, effective methods of engagement, employment, and stigma and discrimination reduction efforts.

The training and education deliverables include training for the target population as well as training for local and state policy makers, providers, the public and those who work with and on behalf of the target population.

Progress of Current Activities

Outreach, Engagement, and Communication

Activities include communication of local services and supports, information on state and community-based events, activities to enhance stakeholder participation in state and local advocacy activities.

These deliverables include activities at both the state and local level.

Advocacy

Activities include support for collaboration among counties, community-based organizations, and stakeholders in mental health service delivery including advocacy for mental health services at county mental health departments, Boards of Supervisors, state and local policy leaders, Legislative staff, and State level agencies and entities.

These deliverables include activities at both the state and local level.

Looking Ahead

State of Community Reports will be completed by August 2018; opportunity to present information and findings within the reports.

Explore opportunities identified in the State of the Community Reports that the Commission may wish to address.

Identify opportunities to provide additional updates on progress of contracts and activities.