CHCFC Center for Healthier Children, Families and Communities

Critical Pathways to School Readiness: Implications for First 5 Ventura County Strategic Planning, Funding and Evaluation

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INTRODUCTION

The UCLA Center for Healthier Children, Families and Communities (CHCFC) has developed the School Readiness Critical Pathways (SRCPs) as an evidence-based conceptual model that links related outcomes and strategies. This helps to organize an array of broad and diffuse evidence regarding the strategies that produce school readiness outcomes for young children, families and communities in order to communicate the First 5 Ventura County "story." It also provides a blueprint for systematically developing a set of recommendations that are designed to help inform the First 5 Ventura County Commission's strategic planning, funding and evaluation efforts.

There are five sections to this report.

- Section I of this report describes how the SRCPs were developed and how to interpret and communicate the basic SRCPs diagram.
- Section II presents a gaps analysis that compares the SRCPs to First 5 Ventura County's s*trategic plan* in order to make recommendations about how future iterations of the plan can be increasingly aligned with the evidence base.
- Section III conducts a second gaps analysis that compares the SRCPs to the *strategies funded* by the Commission in fiscal year 2004-2005 in order to make recommendations about future funding priorities.
- Section IV draws on the outcomes identified in the critical pathways to prioritize a set of countywide indicators and programmatic performance measures that will be used to assess the contribution of First 5 Ventura County in achieving school readiness outcomes for young children, families, and communities.
- Section V summarizes the recommendations that are detailed in sections II – IV.
- Section VI concludes with suggestions on future refinement and uses of the critical pathways.

I. CRITICAL PATHWAYS TO SCHOOL READINESS

Background

The School Readiness Critical Pathways developed by CHCFC (Appendix A) draw on a number of conceptual models such as the Theory of Change framework, Logic Models, and previous work on critical pathways and life-course trajectories.[1-3]

The definition of school readiness that has been adopted for developing the SRCPs is based on that of the National Education Goals Panel (NEGP) because it is a well-established definition that embodies the same comprehensive approach to school readiness as does First 5 Ventura County. [4] The NEGP definition of school readiness describes three interrelated components:

- Children's readiness for school - Five domains are: (1) health and physical development, (2) emotional well-being and social competence, (3) approaches to learning, (4) communicative skills, and (5) cognition and general knowledge
- Schools' readiness for children
- Family and community supports and services that contribute to children's readiness.

Methods

To develop the SRCPs, CHCFC conducted a comprehensive literature review from September 2002 to December 2002 to summarize the evidence base regarding the outcomes and strategies that have been found to be most important in achieving children's readiness for school.[1] A summary of this review is provided in Appendix B - *A Literature Review to inform the development of School Readiness Critical Pathways*. The literature review determined which outcomes and strategies should appear in the SRCPs diagram. Additionally, the review established the relationships between the various outcomes and strategies on the pathways (as depicted by the lines on the diagram that connect outcomes and strategies).

For each outcome and strategy that appears on the SRCPs diagram, Appendix B provides a bibliography of the references and summarizes what has been found in the research regarding how they potentially lead to school readiness. Appendix B consists largely of peer reviewed literature spanning from 1985 to 2001. Although Appendix B is representative of the body of knowledge in the field of early childhood health and development and aims to capture the seminal works within the field, it is not intended to be an exhaustive source of the empirical literature.

For each outcome on the pathway, Appendix B aims to describe:

- The populations that have been found at high risk for adverse outcomes;
- The barriers to achieving the outcome;
- How the outcome relates to other outcomes on the pathway; and
- The strategies that have been found potentially effective in achieving the outcome.

For each strategy on the pathway, Appendix B aims to describe:

- What is known about the strategy's effectiveness;
- The populations for whom the strategy has been found most effective;
- How to implement the strategy to achieve a high quality program; and
- The common barriers to implementing the strategy.

Results

Appendix A visually presents the SRCPs in a detailed diagram. In order to familiarize readers with Appendix A, we will first review Figure 1 which outlines the underlying logic (or conceptual framework) guiding the construction of the SRCP diagram. This will assist readers in understanding the seven potential levels of influence that organize the outcomes and strategies on the SRCPs. Together, the seven levels of influence form a network of interrelated processes that serve as potentially important preconditions of children being ready for school. Figure 1 and the SRCPs in Appendix A should be read from top (level 1) to bottom (level 7). Moving downward, each level consists of items that serve as preconditions to the items in the level above it. For instance, the outcomes in level 2 serve as preconditions to the outcomes in level 1, and so forth.

- Level 1 at the top of the SRCPs lists the ultimate child-related outcomes derived from the NEGP's five dimensions of children's school readiness. (1. health and physical

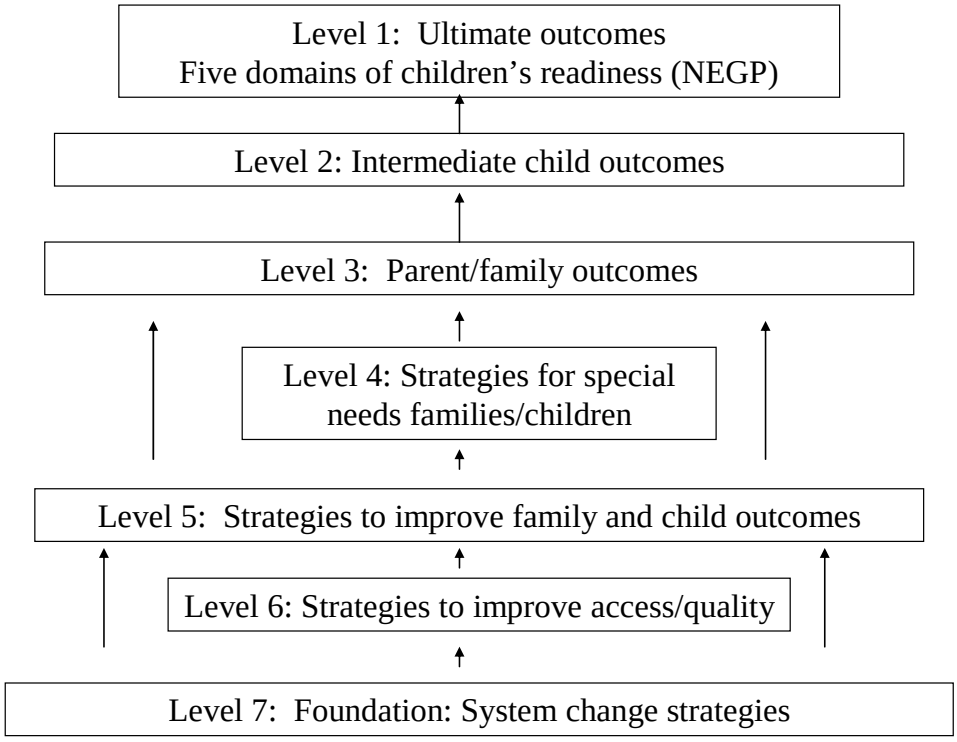
[1] Although some of the studies reviewed for Appendix A were small efficacy trials and therefore have not been tested for broader generalizability, we aired on the side of inclusion versus exclusion.

development, 2. emotional well-being and social competence, 3. approaches to learning, 4. communicative skills, and 5. cognition and general knowledge.) These are the key outcomes for children that have been found in the literature to be important preconditions to achieving school readiness for children.

- Level 2 consists of the key intermediate child outcomes that are preconditions for achieving the five dimensions of school readiness. For example, nutrition and fine and gross motor development are intermediate outcomes in level 2 which serve as preconditions to the ultimate child outcome of physical health.
- Level 3 consists of the key parent and family outcomes that are preconditions for achieving the intermediate child outcomes depicted at level 2. These parent-related outcomes directly support children being ready for school. Several examples on the pathways include parenting knowledge and parent mental health.
- Level 4 reflects strategies for special needs families/children. These strategies are preconditions to the child and family outcomes listed in levels 1-3 for those individuals who have special needs. These strategies include mental health services for children and parents, treatment of developmentally delayed children, and substance abuse treatment programs for adults.
- Level 5 reflects prevention-oriented strategies that have been found to improve child and family outcomes.[2] Several examples of these include home visiting, preschool, and pediatric health care.
- Level 6 reflects strategies that have been found to improve access to and the quality of programs and services for families. These include outreach and referral services and provider education and training programs.
- Level 7 (at the bottom of the pathways), includes those strategies that seek to build infrastructure and improve the functionality of the service delivery system. Examples include efforts to integrate services, sustain programs, and engage the community.

[2] Our objective here was to identify a comprehensive set of evidence-based strategies that fall within the parameters of the First 5 mandate. Important strategies such as direct financial assistance to families were not included because they were seen to be outside of the First 5 purview.

Figure 1: Conceptual Framework for School Readiness Critical Pathways



To understand how to interpret the SRCPs in their entirety, it is first useful to examine one individual pathway on the diagram from the top level of the pathway down to the bottom. For example, one of the pathways in Appendix A summarizes the evidence supporting the benefits of breastfeeding. Mother's breastfeeding is depicted on the critical pathway as an outcome at level 3 and is shown to be one important precondition of children's optimal health and development shown in level 1. The breastfeeding pathway indicates that there are three preconditions (also at level 3) that can enable a mother to breastfeed if she so chooses – mother's optimal physical health, mental health, and the knowledge, skills and supports she needs to breastfeed.

This particular pathway also shows that key strategies found to increase parental knowledge, skills, and supports around breastfeeding include parent education classes, home visiting, breastfeeding education/support services, prenatal care, pediatric care, and family friendly work policies (level 5). For each strategy that aims to increase a mother's ability to breastfeed, there is a corresponding strategy to help ensure that there is both access to those services as well as to help improve the quality of those services (level 6). For example, outreach and referral programs are needed to identify the target population and refer new mothers into breastfeeding support programs, if they so choose. Home visitor education programs help to ensure that home visitors receive the training they need to be effective in supporting a mother's breastfeeding goals. Lastly, at the bottom of the pathway (level 7) are a series of infrastructure building and system improvement strategies that support all the strategies listed above them. At this level, service integration strategies such as inter-agency partnerships, coordinated inter-agency referral

systems, and family resource centers can help to provide coordinated, comprehensive, and easily accessible services to breastfeeding mothers.

Together, the pathways on the diagram cumulatively make up the key outcomes and strategies within the First 5 purview that have been found in the research to potentially contribute to school readiness for young children. Thus, the diagram:

- Helps to depict the relationship between outcomes; between outcomes and strategies; and between individual pathways;
- Can delineate which set of strategies aim to achieve similar outcomes; and
- Shows how all outcomes and strategies contribute to the overall goal of achieving school readiness for children in Ventura County.

The SRCPs can serve as a tool for Commissioners, First 5 Ventura County Staff, funded programs and evaluators to systematically communicate the First 5 Ventura County "story" and to organize and analyze the elements of school readiness for the purposes of planning, evaluation and quality improvement.

Because the SRCPs depict the interrelationships among outcomes and strategies, they can guide the Commission toward strategies that can potentially lead to multiple outcomes on the pathways. Thus, the pathways help to determine which strategies represent the most efficient investments in terms of having an impact on a wide range of outcomes. For example, the pathways confirm that the Commission's significant investment in preschool and provider education for early care and education can have an impact on all three of the ultimate child outcomes.

The pathways can also highlight how certain key outcomes are most likely to be achieved with a diversified set of strategies. In the case of "children achieve optimal social and emotional development," a number of parenting supports as well as high quality preschool programs are shown to be potentially effective strategies.

II. IMPLICATIONS FOR STRATEGIC PLANNING

Background

This section presents a gaps analysis that compares the SRCPs to First 5 Ventura County's strategic plan in order to make recommendations to the Commission about how future iterations of the plan can be increasingly aligned with the evidence base. To develop our recommendations, we considered the following question:

How can the First 5 Ventura County strategic plan be continuously updated to increasingly reflect current research on effective intervention strategies?

Before answering this question, it is useful to underscore that the recommendations in this section focus on what should be *considered* in the strategic planning process – not necessarily what should be *funded*. Critical pathways are but one tool to help guide a strategic planning

process. They help to ground the planners in the outcomes and strategies that research has said are potentially important. Once this foundation is laid, planners should consider a variety of other factors in making funding priorities. For instance, strategic planning typically includes consideration of needs and asset-based assessments, the values and priorities of stakeholders, the level of resources available, and the existing and appropriate roles and responsibilities of providers and organizations outside of the domain of the particular strategic planning effort.

Methods

In order to make recommendations regarding how future iterations of the strategic plan can be increasingly aligned with the evidence base, we conducted a gaps analysis by comparing the outcomes and strategies on the SRCPs to the outcomes and strategies outlined in the April 2000 First 5 Ventura County strategic plan and the 2003 revision of the plan. Only outcomes and strategies that were explicitly discussed in the strategic plan were incorporated into the analysis.

Results

First, we consider those outcomes and strategies in the SRCPs that do not appear in the existing strategic plan in order to assess which outcomes and strategies might be considered in future revisions of the plan. Second, we consider better specifying the relationships between outcomes and strategies in future strategic planning.

Outcomes/Strategies on Critical Pathways that Do Not Appear in Strategic Plan

Overall, the gaps analysis revealed that the Commission's strategic plan is well-aligned with the evidence base depicted in the SRCPs. There were only two outcomes (child nutrition and breastfeeding) and two strategies (child care compensation and pediatric oral health) included in the SRCPs that are not clearly identified in the plan. Although these strategies and outcomes are not described in the strategic plan, all but child care compensation have been funded, to some (or even to a large extent) in Fiscal Years 2003-2005.

The First 5 Ventura County strategic plan discusses the key child outcomes of physical and mental health, cognitive, language development, and social-emotional development and it discusses the importance of improving family, community and system capacity to support child development and promote school readiness. The plan also outlines the strategies that the evidence has found potentially important to achieving these outcomes.

Two outcomes that are included in the SRCPs but are not explicitly mentioned in the strategic plan are: 1) Parents provide nutritious diets to their children; and 2) Mothers breastfeed children. Additionally, only very limited mention is made of parental mental health.

Nutrition: The outcome of "parents provide a nutritious diet" is not explicitly discussed in the 2000 strategic plan or its 2003 revision. It is however implied within (and a component of) the Commission's three goals[3] and could be considered one of many implied outcomes of the Commission's family support/empowerment initiatives. The Commission may wish to mention child nutrition more explicitly in the plan because of its many affects on lifelong health. Only recently have researchers recognized that many children eat too much of the wrong things and

[3] Goal #1- Children will be emotionally, socially, and academically ready for school; Goal #2-Children will be physically and mentally healthy; and Goal #3-Families provide an environment

that childhood obesity and the lack of important micronutrients such as iron are a greater threat to child health than insufficient calorie intake. Childhood obesity has reached epidemic proportions, affecting 10% to 15% of children in the United States, and approximately 9 percent of toddlers and 3 percent of three- to five-year-olds are iron deficient. [5, 6] Poor children from birth to age five are twice as likely as better off children to be obese, and about a third are more likely to be anemic. The highest prevalence for childhood obesity is found in American Indian, Hispanic and African American children. Physical activity, dietary behavior and genetics affect a child's weight across all age groups. Children who are overweight are more apt to be overweight adults and are more likely to suffer chronic health conditions later in life such as Type 2 diabetes and cardiovascular disease.[7] Iron deficiency impairs immune function, cognitive functioning, and energy metabolism. [8]

Although childhood nutrition is not outlined in the strategic plan, it does appear that several programs have been funded to provide nutrition education and/or nutrition subsidies. In addition, many of the programs funded to conduct parent education may be covering nutrition-related topics. Adding this outcome to the strategic plan will provide a rationale for funding nutrition-related initiatives. Additionally, adding this to the plan will encourage programs to incorporate this topic, as appropriate, into their services/curricula.

Breastfeeding: Again, although some funded partners are providing breastfeeding education and support, the outcome of breastfeeding is not mentioned in the strategic plan. Breastfeeding is cited by the strategic planning Ad Hoc Committee as a need but it is not brought forward as a recommendation in the revised plan in 2003.

Breastfeeding exhibits large disparities by race and it has been linked to improved developmental outcomes. Some 70 percent of white infants, but only 40 percent of black infants, have ever been breast fed. At six months, 29 percent of white infants, but only 9 percent of black infants, are still being breast fed.[8] The Commission may wish to mention breastfeeding in the plan because research suggests links between breastfeeding and various health and developmental outcomes. Breastfeeding affects a child's cognitive development through three channels. First, it prevents diseases such as ear infections and may even prevent asthma. Second, breastfeeding provides nutrients that may affect infants' brain development. Third, breast feeding may promote maternal-infant bonding that may, in turn, be beneficial for learning. Many studies link breastfeeding positively with cognitive skills.

By adding this outcome to the plan, more focus can be given to appropriate strategies that support breastfeeding. For instance, the pathways show that strategies that support breastfeeding include anticipatory guidance from prenatal care and pediatric care providers, home visiting programs, breastfeeding education and support programs and family friendly work policies that enable mothers to express their milk during the work-day.

Parental mental health: The original strategic plan of 2000 did not mention parental mental health (even though there is the Mental Health Initiative funded by the Commission). The revised plan of 2003 does list parental mental health as a focus for the 2003-2005 health initiative, however, there is no discussion in the plan regarding why this outcome is important to school readiness. In future iterations of the strategic plan, the Commission may want to describe

the growing body of evidence on the impact that mental health problems, particularly maternal depression, have on developmental outcomes of young children.

Rates of depression for parents with young children are estimated at 12-19%. Maternal depression occurs in a mild form in approximately 40% of all mothers and in a moderate or severe form in approximately 10% of mothers during the immediate postpartum period. Studies of the relationship between maternal depression and child development have found that depressed mothers are less likely to interact with their infants in a positive way. There are also associations between maternal depression and child behavior problems, insecure attachment, and cognitive problems. [8]

The SRCPs delineate the strategies that have been found potentially effective in identifying, preventing and treating parental mental health problems. These strategies include screening, counseling and education from primary care providers and pediatricians, social support through home visiting and parent support groups, and clinical therapy and treatment for substance abusing parents.

Two strategies that are included in the SRCPs but are not explicitly mentioned in the strategic plan are: 1) Child care provider compensation; and 2) Pediatric oral health care

Child care provider compensation: The 2000 strategic plan discuss incentives for child care providers to offer weekend and evening care, however it does not mention child care provider compensation in terms of enhanced salaries to improve the recruitment and retention of high quality providers. The revised plan of 2003 directed the Center for Excellence in Early Childhood Development to assess the feasibility of universal preschool in Ventura. Part of this targeted study was to address an evaluation of the costs of increasing child care staff wages for purposes of retention and quality of care. Whether this strategy is implemented as part of a universal preschool initiative or as a more limited strategy with existing providers, the Commission may want to consider including this strategy in future iterations of the strategic plan.

Pediatric oral health: While pediatric oral health care is not explicitly discussed in the plan, the Commission is already funding a number of pediatric oral health services. The Commission may wish to add a discussion of pediatric oral health to the plan so that it more completely reflects the Commission's funding priorities.

Enhancing the description of relationships between outcomes and strategies

Although the strategic plan is quite comprehensive in identifying the important outcomes and strategies that help to bring about school readiness, it would be helpful to increase its discussion of the relationships between the outcomes it aims to achieve and the strategies that have been found to lead to those outcomes. Making these relationships more explicit in the plan can assist planners and program development staff, particularly those who may be new to the process, in developing funding initiatives that involve strategies that are clearly and consistently aligned with appropriate outcomes.

Additionally, it is helpful for the plan to increasingly describe the relationships between various outcomes on the pathways. For instance, it would be helpful for the plan to clearly state that parental mental health is one important precondition of appropriate parent-child interaction, and parent-child interaction is one important precondition of a child's social-emotional well-being. This can help to ensure that planners and program staff have identified appropriate and measurable outcomes and can articulate the mechanisms by which these outcomes, ultimately contribute to school readiness.

III. IMPLICATIONS FOR FUNDING

Background

In the previous section, we presented a gaps analysis that compared the SRCPs with the outcomes and strategies discussed in the *strategic plan*. In this section, we present a second gaps analysis that compares the SRCPs to the actual strategies that are being *funded* by the Commission in fiscal year 2004-2005. To develop our recommendations for this section, we considered the following question:

How might First 5 Ventura County increasingly align its funding initiatives with strategies that are most likely to produce desired outcomes?

This analysis is designed to help the Commission reflect on the current funding and determine whether or not the distribution of funds is consistent with the evidence base and whether it is consistent with the priorities outlined in the most recent iteration of the strategic plan. Even though the recommendations in this section are directed toward funding priorities, there are other key criteria involved in the prioritization process that may supersede the recommendations made here. For instance, there may be evidence-based strategies depicted in the SRCPs that the Commission is purposefully not funding because it has knowledge that these strategies are already well-funded by another organization.

Methods

To conduct this second gaps analysis, we reviewed the service provisions of the programs funded by First 5 Ventura County in FY 2004-2005 and categorized all of the services by strategy and outcome type relative to the SRCPs. Based on this analysis, we present a frequency distribution of strategies so that the Commission can gain a sense of the most and least frequently funded strategies. This analysis assesses the frequency with which program strategies were funded but cannot assess the total amount allocated to each strategy and/or outcome because funded programs do not make this level of distinction in their program budgets. Therefore, even though a particular strategy may be shown to have only been funded once, the total dollar allocation might be higher than for a strategy that the Commission has funded many times to various providers. For this reason, the relative frequency of funded strategies should be interpreted with caution.

Results

Overall, the gaps analysis revealed that the strategies that are being funded by First 5 Ventura County are closely aligned with what the empirical literature says is potentially effective. Table 1 shows the frequency with which strategies have been funded by First 5 Ventura County in FY 2004-2005. Of the 37 programs funded as of January 2005, Table 1 lists the number and percent of funded programs (from most to least) that employ each strategy.

We present our findings by the level in which they appear on the SRCPs (Refer to page 3 for a description of the SRCP levels).

- *Strategies for special needs populations - treatment (Level 4)):* The gaps analysis found that within strategies for special needs populations, the most frequently funded strategies are parental mental health (6 programs or 16%) and children's mental health treatment (6 programs or 16%). No programs have been funded to provide substance abuse treatment for parents or expectant mothers. In addition, no programs have been funded to provide treatment for children with chronic disease and physical disabilities.

- *Strategies to improve child and family outcomes - prevention (Level 5)):* Parent education and child care/preschool are the most frequently funded strategies (57% and 32% of programs respectively). Maternal oral health treatment is the least frequently funded strategy (1 program or 3%).

- *Strategies to improve access to and the quality of services (Level 6)*: Outreach and referral is the most frequently funded strategy to improve access (38% of programs) and child care provider education training and support is the most frequently funded strategy to improve the quality of services (32% of programs). Although in the initial years First 5, Ventura County funded child care infrastructure and equipment, it has not funded this strategy in FY 2004-2005. As mentioned, the majority of provider education focuses on early care and education providers. Little provider education funding is focused on other provider types such as home visitors, prenatal care providers, or pediatricians.

  Some of the provider education programs, funded by the Commission, focus on specific topics such as tobacco cessation or children's oral health. Although 5 programs (14%) have been funded to conduct developmental screenings, few if any programs have been funded to train and coach providers on how to improve the delivery of developmental services. Identifying and treating problems such as chronic disease and developmental delay in young children is not always provided as part of routine care by pediatric health care providers. Furthermore, other early childhood service providers are often inadequately prepared to recognize and make referrals for these problems. The Commission might consider an initiative that trains providers in the use of standardized protocols to conduct developmental surveillance, screening and assessment, and to provide appropriate referrals, education, case management and care coordination. This initiative might also include the development of a tracking system to collect information on the numbers of children screened, identified, referred and receiving services for special needs.

Table 1: Strategies Funded by First 5 Ventura County FY 2004-2005

Strategies on Critical Pathways	# of Funded Programs	% of Funded Programs Employing Strategy (N=37)
Strategies: For special needs populations		
Parental mental health treatment	6	16
Children's mental health treatment	6	16
Support for foster children/families	3	8
Tx for children w/ dev. delays/ learning disability	2	5
Child abuse treatment	2	5
Tx of chronic disease and physical disabilities for children	0	0
Substance abuse tx for parents/ expectant mothers	0	0
Strategies: Improve child/ family outcomes		
Parent education classes and materials	21	57
Child care and preschool	12	32
Parent support programs	8	22
Parent/family literacy programs	8	22
Pediatric oral health care	8	22
Developmental screening	5	14
Pediatric health care	4	11
Home visiting	4	11
Libraries/ book distribution programs	3	8
Adult Education/citizenship	3	8
Nutrition education subsidies	3	8
Breastfeeding education and support	3	8
Parks and playgrounds	2	5
Preconceptional/ prenatal care	2	5
Immunization services/ strategies	2	5
*Maternal oral health treatment	1	3
Strategies: Improve access and quality		
Outreach and Referal services	14	38
Child care provider education and training	12	32
Case management	12	32
Community strengthening	8	22
Child care subsidies or vouchers	8	22
General provider education and training/support	3	8
Health insurance outreach and enrollment	2	5
Child care provider compensation	1	3
Transportation	1	3
Employer training on family friendly workplace	1	3
Child Care infrastructure/equipment	0	0
Training on Developmental Services	0	0
Home visitor education and training	0	0
Preconceptional/ prenatal care provider ed/ training	0	0
Breastfeeding provider training	0	0
Pediatric provider education and training	0	0
Child care resource and referral services	0	0

IV. IMPLICATIONS FOR EVALUATION

Background

Section I of this report described the SRCPs and sections II and III presented gaps analyses that compared the SRCPs to both the First 5 Ventura County strategic plan and to the strategies that have been funded by the Commission in FY 2004-2005. This section draws on the outcomes identified in the SRCPs to prioritize a set of countywide indicators and programmatic performance measures to help evaluate the effectiveness of First 5 Ventura County in achieving school readiness outcomes for young children, families, and communities. To develop our recommendations, we considered the following two questions:

What are the key indicators that should serve as population-based benchmarks to help First 5 Ventura County determine the degree to which their efforts are contributing to school readiness countywide?

What are the programmatic performance measures that funded programs should collect to assess whether, as a result of their efforts, participants are better off?

First, we define what is meant by the terms "indicator," and "performance measure," and then we describe the methods used to identify and prioritize these measures for First 5 Ventura County. Lastly, this section presents the set of indicators and performance measures developed for the First 5 Ventura County evaluation.

Using the language of results accountability,[4] an indicator (or benchmark) is a population-based measure which helps to quantify the achievement of a result (or outcome). A performance measure is a measure of how well an individual program is working toward its own program-level outcomes. Some measures can serve as both indicators and performance measures. For instance, as an indicator, the "frequency with which families read to children" can be ascertained from a population-based survey such as the California Health Interview Survey (CHIS) in order to help a community quantify the degree to which they are preparing children to be ready for school. As a performance measure, a family literacy program can collect pre-test and post-test information from their participants on the "frequency with which families read to children" to gauge the effectiveness of their program on improved family literacy for their client population.

For both indicators and performance measures, it takes multiple measures to adequately gauge progress towards a specified outcome. Additionally, to be effective, these measures should be determined valid and reliable, data should be consistently available, and they should be easily understood and compelling to key stakeholders. In the context of the First 5 Ventura County evaluation, data to track indicators are primarily drawn from CHIS, the National Survey on Early Childhood Health (NSECH) and the proposed fall 2005 school readiness assessment conducted by kindergarten teachers in Ventura at school entry. Performance measures are collected from First 5 funded programs and housed in the GEMS data system for analysis.

[4] The Fiscal Policy Studies Institute, http://www.resultsaccountability.com/language.htm

Methods/Results

This section outlines the methods used to identify key indicators for First 5 Ventura County and the methods used to develop a range of performance measures that reflect the diverse efforts of First 5 funded programs.

Key Indicators for First 5 Ventura County

The process of developing indicators for First 5 Ventura County took place between January and April of 2003 and involved the following two-stages. The first stage involved a research component conducted by CHCFC. Potential indicators were selected for all outcomes on the SRCPs and the indicators were organized by the following three outcome categories: 1) Child/family; 2) Access and quality; and 3) Infrastructure building and system change. Initially, over 100 potential indicators were identified from existing indicator sources such the First 5 California Indicator book developed by Child Trends and SRI International, and a variety of national sources such as the NSECH. Four members of CHCFC's research team independently scored the indicators using the criteria listed below. Indicators were scored higher if they:

- Were valid and reliable measures for evaluation purposes;
- Had strong data power (e.g., data could be collected consistently from population-based data sources)
- Had strong communication power;
- Corresponded with First 5 Ventura County funding priorities as of FY 2002-2003 (as articulated in the strategic plan);

Based on these criteria, the 50 highest scoring indicators were identified and considered to be "core" indicators The second stage asked Commissioners and members of Commission committees representing funded programs and parents to weigh-in on the core indicators by further prioritizing the list down to a set of key indicators. To accomplish this, CHCFC presented the core indicators at various First 5 Ventura County meetings (Commission meeting, Oversight Committee, Program Development Committee and Parent Advisory Committee). Members were asked to individually select the 15 indicators they regarded as the most worthy of serving as key indicators. All members were asked to vote based on the following two criteria:

- Is the indicator easily understandable and compelling to First 5 Ventura County stakeholders?
- Is the outcome associated with this indicator something that First 5 Ventura County can improve in the population as a whole over the next five years?

This participatory process resulted in the establishment of 14 key indicators for First 5 Ventura County (See next page)

FIRST 5 VENTURA COUNTY KEY INDICATORS

OUTCOME/STRATEGY ON CRITICAL PATHWAYS	INDICATOR
Child/Family Outcomes	
Optimal learning comprehension skills and cognitive development	#/ and % of children entering kindergarten with optimal learning/comprehension skills and cognitive development as measured by teacher assessment
Optimal social-emotional development and mental health	#/ and % of children entering kindergarten with optimal social-emotional development and mental health as measured by teacher assessment
Free of illness / disease	#/ and % of children aged 19-35 months who receive the recommended vaccines
Children are born healthy	#/ and % of women who did not smoke during pregnancy
Optimal nutrition	#/ and % of children 0 to 5 years of age who are in the expected range of weight for height and age
Appropriate parent-child interaction	#/ and % of families who report reading or telling stories regularly to their children, 3 to 5 years of age
Parent knowledge/skills	#/ and % of families rated by self-response as having adequate parenting skills
Parental mental health	# and % mothers with depression
Access and Quality Outcomes	
Early Care and Education	# and % of children who have attended a preschool, nursery school, pre-kindergarten by the time of kindergarten entry.
Developmental Services	# and % of children screened, diagnosed, referred, and receiving services for their special needs by the time of kindergarten entry (parent self-report) CONTIGENT UPON INCREASED EMPHASIS IN REVISED STRATEGIC PLAN
Developmental Services	# and % of First 5 funded programs who screen and refer children for special needs (provider survey) CONTIGENT UPON INCREASED EMPHASIS IN REVISED STRATEGIC PLAN
Pediatric Oral Health	#/ and % of children ages 3 and older who receive annual dental exams
General satisfaction	#/ and % of parents satisfied with content and quality of First 5 services
General access	#/ and % of parents who feel they have a regular place to take their child or get advice (other than an emergency room) when their child is sick

Performance Measures for First 5 Ventura County

The goal of developing performance measures for First 5 Ventura County funded programs is to establish appropriate and uniform outcome measures of accountability between programs employing "like" strategies so that data from funded programs can be aggregated and analyzed by strategy type and for the initiative as a whole.

The process of developing performance measures for First 5 Ventura County took place between May 2003 and June 2004. As with indicators, developing the performance measures involved a research component conducted by CHCFC to ensure that the measures derived from the outcomes on the SRCPs were valid measures of how well a program is doing and could be reliably collected by funded programs. Where ever possible, performance measures were developed from existing survey items, scales and a variety of other diagnostic instruments and data collection tools. Where no existing data collection instruments addressed local needs, CHCFC developed new measures.

For each First 5 funded strategy type, at least one performance measure was developed. For instance, on the critical pathway, there is the strategy type "family literacy program" which aims to improve "family literacy" as its outcome. The performance measure associated with this outcome is "the number and the percent of participants demonstrating improved child literacy-promoting behaviors."

Once performance measure were established for each outcome, CHCFC developed pre and post-test questionnaires (generally completed by parents) to collect the program data needed to assess the performance measure. Again, the family literacy strategy provides an example of how pre and post test questionnaires were developed for each strategy type. In the case of family literacy, a questionnaire was developed using questions from the National Survey on Early Childhood Health. This particular questionnaire is designed to ask the same set of four questions to parents before a program service begins and after the services are completed: The four questions on the family literacy questionnaire are listed in Figure 2.

Figure 2: Example Pre And Post-Test Questionnaire

Strategy Type: Family literacy program

Performance Measure: The # and % of participants demonstrating improved child literacy-promoting behaviors.

1. In a typical week, how often do you or any other family member sing songs with your young children?	_____Number of days per week
2. In a typical week, how often do you or any other family member tell stories to your young children?	_____Number of days per week
3. In a typical week, how often do you or any other family member read or show pictures books to your young children?	_____Number of days per week

4. The best time to start reading to your child is:

☐ During the first year	☐ When they are ages 2-4	☐ When they are in kindergarten (5-6 yrs)	☐ Not sure

Appendix C lists the performance measures and the corresponding pre and post test questionnaires developed for First 5 Ventura County funded programs. For each performance measure in Appendix C, we list the:

- Strategy category which corresponds to the SRCPs
- Outcome on the critical pathway
- Performance measure
- Pre and post test questions for each questionnaire
- Recommended mode of data collection (e.g. self-administered, etc)
- Person who is to complete the questionnaire (e.g. parent, teacher, etc.)
- Timing of when the data is to be collected (e.g. pre test, post test etc.)
- Source of the measure (e.g. NSECH, CHIS, developed in-house, etc)

In August 2004, CHCFC distributed the questionnaires to funded programs and trained program staff on how to administer the questionnaires and collect the data. In January 2005, Mosaic Inc, trained program staff on how to enter data from the performance measure questionnaires and a variety of other required forms into the GEMS data system.

Data Analysis

Programs can generate program level GEMS reports to assess their performance measure data. This will help programs conduct program level evaluation, strategic planning and quality improvement efforts. Additionally, CHCFC will export the data from GEMS to aggregate these data for initiative-wide evaluation. Where available, CHCFC will compare GEMS performance measure data over time to the key indicators discussed earlier in order to assess the extent to which First 5 is contributing to shifts in overall population-based indicators.

V. LIMITATIONS

There are several limitations associated with the efforts described in this report. First, the literature review that guided the pathways was conducted up to 2001 and therefore empirical knowledge that has emerged since that time, may not be reflected in the pathways. The evidence base for early childhood wellbeing and school readiness is changing rapidly and therefore there is a need to continually update pathways to reflect most current research. Second, the literature review was not as systematic as it might have been given additional time and resources. Additional review of the literature could involve a more defined set of criteria. Lastly, in order to depict the primary relationships on the pathways, some of the connections and interrelationships between outcomes and strategies may be oversimplified.

VI. SUMMARY OF RECOMMENDATIONS

Strategic Planning: Overall, the gaps analysis revealed that the Commission's strategic plan is generally well-aligned with the evidence base depicted in the SRCPs. There were only a few instances where outcomes and strategies that evidence has found important to school readiness were not identified in the strategic plan. We also note opportunities for enhancing the description in the plan regarding the relationships between outcomes and strategies.

As a result of our analysis, we suggest that the next iteration of the First 5 Ventura County strategic plan consider a discussion of:

- Two outcomes that are included in the SRCPs but are currently not mentioned in the strategic plan: 1) Parents provide nutritious diets to their children; and 2) Mothers breastfeed children. Additionally, the Commission should consider enhancing its discussion of parental mental health.

- Two strategies that are included in the SRCPs but are not explicitly mentioned in the strategic plan: 1) Child care provider compensation; and 2) Pediatric oral health care.

- The relationships between outcomes. For instance, it would be helpful for the plan to clearly identify that parental mental health is an important outcome (or precondition) of appropriate parent-child interaction, and parent-child interaction is one important outcome (or precondition) of a child's social-emotional well-being. This can help to ensure that planners and program staff have identified appropriate and measurable outcomes and can articulate the mechanisms by which these outcomes, ultimately contribute to school readiness.

Funding Priorities: Overall, the gaps analysis revealed that the strategies that are being funded by First 5 Ventura County are closely aligned with what the empirical literature indicates is potentially effective. There were however, a number of strategies on the SRCPs that have not been funded (or have been funded infrequently) by First 5 Ventura County in FY 2004-2005. These strategies include:

- Substance abuse treatment for parents
- Maternal oral health treatment
- Provider education programs specifically designed for home visitors, prenatal care providers, and pediatricians
- Provider education programs focused on developmental services

As noted earlier, CHCFC is recommending what should be *considered* for funding – not necessarily what should *be* funded. The Commission should also consider a variety of other important factors in making funding priorities. For instance, the Commission should consider whether the strategy with the greatest and most efficient impact is one that attempts to address outcomes through many different service delivery pathways or whether it is one that achieves its defined goals by targeting a specific pathway. The Commission should also consider how to target its efforts within any given pathway in order to both intensify the provision of services and to improve the functionality of the service delivery system within that pathway. Identifying the

most potentially effective and efficient pathways should involve an analysis of the evidence supporting effective strategies, needs of the community, and leveraging opportunities including consideration of the pathways where First 5 Ventura County has already invested significant resources and has shown a measurable impact. In addition, consideration should be given to the level of resources, relationships and coordination that are needed for the pathway to optimally perform. Without such an approach, investment in any given pathway may be insufficient to accomplish defined goals.

Directions for Evaluation: CHCFC drew on the outcomes identified in the SRCPs to prioritize a set of countywide indicators and programmatic performance measures to help evaluate the effectiveness of First 5 Ventura County in achieving school readiness outcomes for young children, families, and communities. The results section of this report described these measures. This section recommends activities for refining these measures in future years. We recommend that the Commission:

- Refine the key indicators to increasingly reflect the current priorities and funding patterns of First 5 Ventura County and to also reflect data that is most consistently available and relevant from existing population-based data sources. The two best sources of local population-based data that are relevant to First 5 Ventura County are the California Health Interview Survey (CHIS 2003) and the proposed fall 2005 expansion of the School Readiness Assessment Profiles pilot study in Ventura.

- Refine the performance measures. Developing and collecting performance measure data that is standardized across "like" programs for the entire First 5 Ventura County initiative is an ambitious endeavor and is unique amongst the local county commissions. Many of the measures and questionnaires developed for this effort, were new or adapted from existing instruments. As such, the first year of using the performance measures can yield important lessons learned from the perspectives of the evaluators, policy makers and funded programs. We recommend convening workgroups toward the end of the fiscal year to discuss the successes and challenges of using the performance measures and associated parent questionnaires in order to gain input into how to refine these measures in the future.

VII. CONCLUSION

First 5 was designed to encourage counties to more effectively, efficiently and equitably use resources to develop systems that optimize the healthy development and school readiness of all young children. Funds were allocated to help improve the quality of services and service delivery pathways within the health, family support and early care education sectors. In addition, because of its holistic and integrated approach, First 5 aims to overcome some of the more traditional barriers that come with sector-specific strategies operating within service silos by developing more comprehensive, integrated, family-centered, and community-based service delivery systems.

First 5 Ventura County, as with many commissions throughout the state, is completing the first phase of its work with initial planning, implementation and evaluation occurring in a relatively

short amount of time. The knowledge that the Commission has gained by focusing its initial years on a broad array of service delivery pathways has provided essential information on potential impacts and returns on its investments. As is the case with a child's brain development where there is an early overabundance of synapses that are selectively eliminated to form a more highly organized and efficient brain, the Commission is experiencing a developmental process where there are appropriate phases of initially spreading out and then "pruning-back." The SRCPs represent the potential connections that could be further developed by the Commission to achieve its desired outcomes. As the Commission considers a transition from a funding strategy that is relatively broad to one that is more targeted and intensive, however, it needs to guard against losing the value added of First 5 and falling back into what were pre-existing silos.

As the Commission begins to consider how it will focus its investments, it will need to use a set of performance criteria to evaluate the services and service delivery systems on its pathways. These criteria should include consideration of the effectiveness, efficiency, availability, appropriateness, capability, safety, continuity, acceptability, coordination, and equity of services and service systems.[9] Conducting such an analysis represents the next phase of the Commission's work as it evaluates how to continue to leverage its investments to achieve desired results.

Although the analysis conducted for this report has not provided recommendations on where to narrow the Commission's focus, it has provided recommendations on the criteria that should be used to target certain pathways more intensively. This report has also served to ground First 5 stakeholders in the evidence base that supports school readiness and to provide a framework to organize, analyze and communicate on-going strategic planning, funding and evaluation efforts. We have provided recommendations to ensure that the strategic plan is as closely aligned with the evidence base as possible and to help the Commission determine whether or not they have made funding allocations that are aligned with the evidence-base. The pathways have also been used to develop key indicators that can help to assess the contribution of First 5 to children and families in Ventura County over time and to develop programmatic performance measures to assess program accountability and effectiveness for the populations they serve.

Lastly, this report also serves as the starting point for future refinement of the SRCPs that would provide recommendations on where to intensify the Commission's efforts. Future refinement of the SRCPs pathways might include a process of ranking the strength of the evidence on the strategies listed on the pathways. It might also involve an analysis of leveraging opportunities and mapping current First 5 Ventura County investments to outcomes and strategies.

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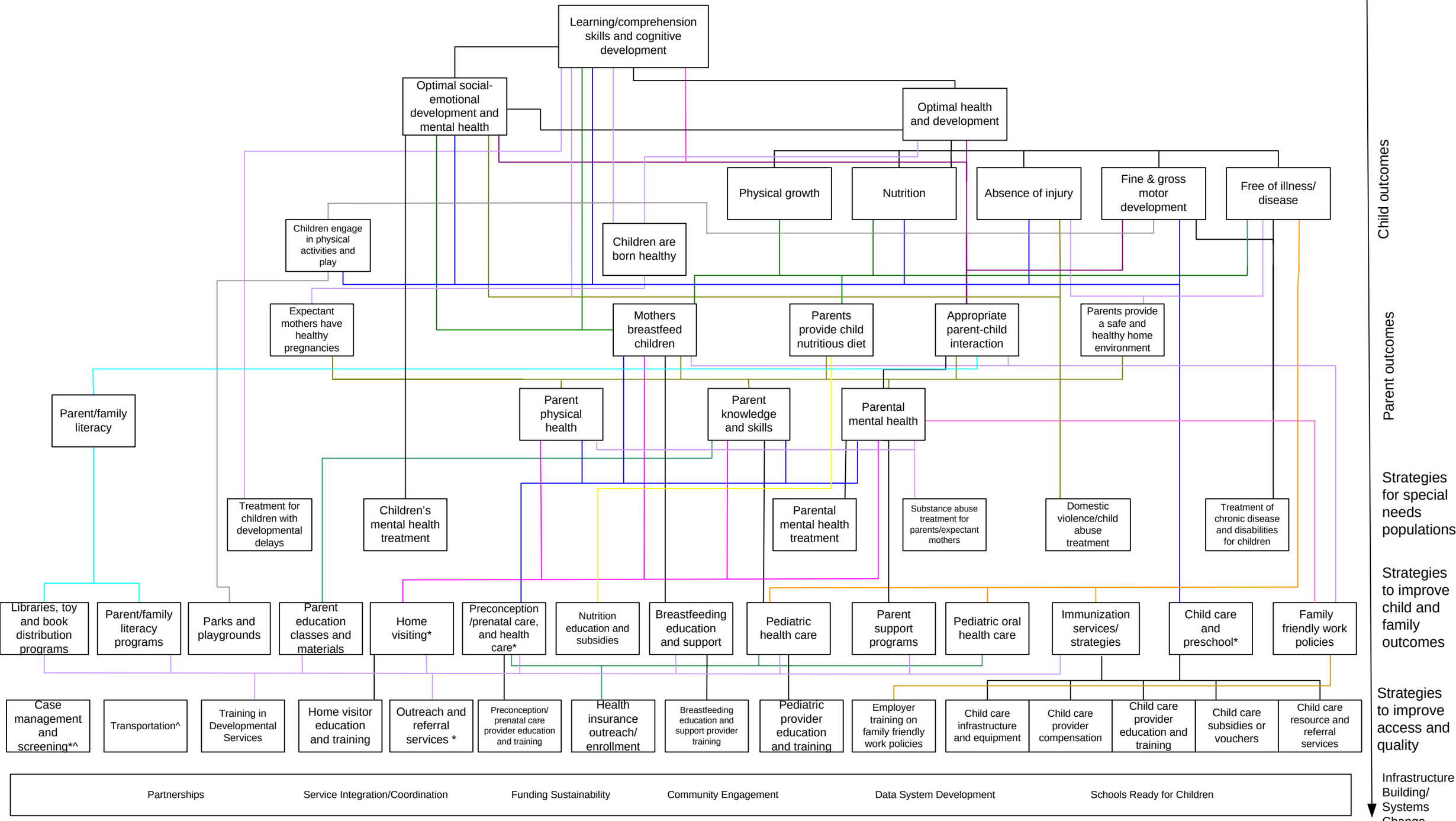
APPENDICES

Appendix A: School Readiness Critical Pathways



* These strategies refer parents and children to specialty care ^ These strategies increase access to all strategies that improve child and family outcomes and special needs populations

UCLA Center for Healthier Children, Families and Communities

Appendix B
A Literature Review to inform the development of School Readiness Critical Pathways

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Center for Excellence In Early Childhood Development
FIRST 5 VENTURA COUNTY

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Appropriate parent-child interaction

Definition: Parents respond to child's expressions of emotion and need in a timely and appropriate way that forms a healthy parent-child attachment and encourages the child's development of feelings of security and confidence. Parents interact daily with their children by participating in activities that encourage cognitive and socio-emotional development.

Summary of findings:

Through daily interactions with their children involving looking at books, encouraging communication, and exposing children to a range of auditory and visual stimuli, parents provide their children with experiences that foster cognitive and linguistic development. Through regularity and consistency in these daily routines, parents provide continuity and stability, conditions thought to be important to children's development. It is not just the quantity and frequency but the quality of these interactions that has been linked to children's cognitive and social-emotional outcomes. For example, children's creativity has been shown to be related to the quality of parent-child reading interactions, and children's perceived competence was related to both the quantity and quality of parent-child reading.

The nature of a child's attachment relationship to his or her parent or primary caregiver indicates the quality of their relationship and affects the child's social-emotional development and cognitive development.

Children with secure, healthy attachments have a more balanced self-concept, a more advanced memory process, a more sophisticated grasp of emotion, a more positive understanding of friendship, and greater conscience development. About 30% of children have been found to have insecure attachment with their parent(s). Insecure attachment may be defined as avoidant, distant, or anxious clinging in the presence of a parent. A child who is not securely attached to his or her parent is more likely to be depressed, anxious, react more negatively in stressful situations, and have poor relationships with others.

Children at risk for insecure attachments include children whose mothers suffer from mental illness such as depression, and children whose parents employ consistently inappropriate, inconsistent or ineffective parenting practices. Thus, parental mental health services and parent education and support programs that improve parent skills, knowledge and capacity can help to ensure optimal child attachment.

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Breastfeeding education and support

Definition: Education - activities or materials that promote an understanding of the importance of breastfeeding for child health and development. Support – programs and services offer both working and non-working breastfeeding mothers the support they need to continue breastfeeding their children for as long as they choose.

Summary of findings:

For breastfeeding to be initiated and to continue over a significant period of time, women who choose to breastfeed need education and support from a variety of sources, includes clinical and counseling services from health care providers and hospitals, basic education about the importance and benefits of breastfeeding for parents and communities, and community-based support services including breast pumps. However, studies indicate a number of barriers to the widespread availability and provision of breastfeeding education and support.

Studies have found that physicians are generally poorly prepared to provide adequate breastfeeding support and advice. As of 1992, 55 percent of medical schools and 30 percent of obstetric and pediatric residencies offered no didactic lectures on lactation or breastfeeding to their students. Additionally, there is currently no organized movement within the California hospital system to support breastfeeding. In addition, there are few lactation services connected to child care settings except for employer-based lactation programs with on-site child care services such as the ones at Patagonia, Inc., in Ventura County, though lactation programs are offered by only 15 percent of large employers.

A number of strategies for breastfeeding education and support have been found to be effective, including Medi-Cal's Comprehensive Perinatal Services Program (CPSP), the Women, Infants and Children (WIC) program, and the Baby-Friendly hospital designation.

CPSP provides women with prenatal care, nutritional counseling and lactation support from licensed health care professionals, as well as rental or purchase of breast pumps and banked human milk for infants who require it — during pregnancy and up to 60 days postpartum - not long enough given that public health goals and professional health care organizations recommend much longer breastfeeding as optimal for mothers and babies, though the program has been effective at increasing breastfeeding rates.

The Baby-Friendly hospital designation is an international hospital initiative developed to address barriers in hospital policies to breastfeeding. As of 2001, just 31 birth centers and hospitals in the U.S., six of them in California, had been evaluated and deemed Baby-Friendly, largely because the process takes a long time to complete and is expensive. The Ventura County Medical Center has indicated an interest in receiving the Baby-Friendly designation.

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Breastfeeding education and support provider training

Definition: Varying levels of training are available for health care professionals, members of the health care team, and qualified volunteers to gain knowledge and skills to become better qualified to help educate new mothers about breastfeeding their children.

Summary of findings:

In 1956, La Leche League and other breastfeeding training programs began in the U.S. Many early programs focused on mother to mother education and included many women who wanted to teach other new mothers about breastfeeding and help answer any of their concerns. Although many states do not require certification of breastfeeding educators, various certification programs provide education to health care professionals and others working with new mothers.

In 1985, La Leche League established a nonprofit corporation, the International Board of Lactation Examiners (IBCLE), to develop an international exam for certification of lactation professionals. The International Board Certified Lactation Consultant (IBCLC) is usually a health care provider who has passed this examination testing special skills and knowledge on breastfeeding education. In order to be accepted to take the IBCLE certification exam, the applicant must apply and meet eligibility requirements including minimum hours of clinical practice as a lactation consultant and continuing education on breastfeeding. The exam sets standards at the university level and tests knowledge on lactation, the sciences, psychology, public health, and other related subjects. The exam is offered annually worldwide, and IBCLCs are required to complete continuing education and take a recertification exam after five years. There are currently thousands of IBCLCs worldwide from a variety of backgrounds including nurses, physicians, dieticians, educators, developmental therapists, and social workers.

Other types of training and public health education programs provide skills and knowledge to health educators working with new mothers on initiation and maintenance of lactation. A Lactation Consultant (LC) is typically a member of the health care team who educates women on breastfeeding skills and provides support to address any problems or concerns the new mothers has regarding breastfeeding her infant. Many LCs have received training from breastfeeding training programs, but they are not required to be enrolled in continuing education or complete recertification. A Certified Lactation Educator (CLE) and Certified Breastfeeding Educator (CBE) are also titles for those who have completed a breastfeeding training program to provide basic breastfeeding education and support. La Leche League Leaders are volunteers who may be of a health profession or the general public, who are trained in breastfeeding education to help provide information and support to new mothers. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have created a program, The Baby Friendly Hospital Initiative (BFHI), to recognize hospitals and birthing centers that provide new mothers with breastfeeding education and encouragement.

The American Academy of Pediatrician (AAP) has also created a program for pediatricians, the Breastfeeding Promotion in Pediatric Office Practices (BPPOP), that distributes information to new parents and provide guidelines on anticipatory guidance of breastfeeding.

Several pathways exist to become a breastfeeding educator and support provider to mothers. A combination of experience and an educational background in the health sciences, lends one with skills and knowledge necessary to have the expertise to be a lactation consultant.

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Case Management/Developmental Screening

Definition: Case managers assess a child's development and the needs of the family to coordinate services to help provide delivery of an integrated, continuum of care.

Summary of findings:

Case managers usually have backgrounds in nursing, social work or related fields and according to the Case Management Society of America (CMSA), individuals can achieve certification as case manager professionals. By coordinating different services ranging from health care, child care, and social services, case managers can help provide families with a more integrated, cost-effective, continuum of care. A case management and preventive health services program for infants of low-income families showed that infants in the intervention group were more likely to receive child health services. Moreover, the cost-effectiveness of providing continuous care was one-fifth ($523) of that of fragmented care ($2,900). Another study shows that developmental screening and early intervention leads to both treatment and prevention of problems that can interfere with normal development. Children that were placed in a prevention group to receive outreach and developmental screening appeared to have superior cognitive functioning, behavioral development, and physical health compared to those who received treatment in response to need. These examples demonstrate that case management promotes a holistic approach to a child's development by coordinating services to ensure prevention and early intervention.

Many families that require a variety of services benefit from a case manager's guidance in identification of service providers that best meet their needs. By coordinating services and referring a family to service providers, the case manager saves the family time and energy in receiving services. Sometimes the case manager is aware of service providers that are sharing resources to offer integrated services such as a pediatric health care center that has prenatal care services at the same office. Another instance that a case manager can help families is by determining which services a family needs. For example, developmental screenings can provide opportunities for preventive care or referral for early intervention. Early diagnosis and treatment of health and learning problems can increase a child's opportunities for healthy development and growth. Often a child with special needs can also benefit from integration and coordination of services. For example, a case manager may determine that a child is showing signs of slow growth through a developmental screening. The case manager would then suggest that the child visits a pediatrician for a check-up. If the child requires continual treatment following a pediatrician's diagnosis, the case manager can monitor treatment and coordinate required services. A physically disabled child may need to coordinate physical therapy care with health care and his or her child care. The case manager can provide guidance to the child's parents and teachers and connect various service providers so that the child receives a continuum of care.

Thus, coordinating services to provide services to a family with multiple needs, promotes a more cost-effective and efficient system. Receiving coordinated services from multiple providers helps a child with special needs receive a continuum of care. This enhances the quality of the child's care and ultimately improves the child's development. A case manger may also recommend a home visitor if the child requires long-term care and the family would benefit from more intensive parent education and support. By coordinating services, a case manager provides information and identifies resources that will most help a family receive services to create better developmental outcomes for children.

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Child abuse/Domestic violence prevention and treatment

Definition: Child abuse involves physical, sexual, or psychological abuse and/or child neglect. Child abuse treatment can be conceptualized as a continuum with promotion of wellness at one extreme and intervention for established problems at the other. The three levels of prevention within this continuum are universal, selective, and indicated interventions for the entire population, for high-risk families, and for cases in which maltreatment has already occurred respectively.

Summary of findings:

There are a variety of different types of child abuse and domestic violence programs. Proactive programs include home visiting, multi-component, social support/mutual aid, and media interventions. Reactive programs include intensive family preservation services, multi-component, social support/mutual aid, and parent training. Reactive programs often provide counseling, advocacy, training, and/or concrete support and address a broad range of issues such as stress reduction, parent-child training, problems solving, self-control, assertiveness training, home safety and cleanliness, job placement, alcoholism referral, money management and marital counseling.

In MacLeod et al.'s meta-analysis, which reviewed 56 programs designed to promote family wellness and prevent child maltreatment, they found that most interventions which aim to prevent child maltreatment are successful. They found that while gains made through proactive interventions are sustained, and even increased, over time, those made through reactive interventions tend to fade more quickly. The least effective proactive home visiting programs were those with 12 or fewer visits and less than a 6-month duration. Intensive family preservation programs with high levels of participant involvement, and empowerment/strength-based approach, and a component of social support had more success than programs without those elements. Both home visiting and family preservation were more effective with participants of mixed socioeconomic status (SES) than programs comprised exclusively of participants with low SES.

There is little clinical consensus in the literature regarding the effectiveness of many modalities used to treat children who have been victims of abuse. A survey of clinicians found that a wide variety of modalities are used including pharmacotherapy, psychodynamic and cognitive-behavioral therapy. The most common modalities among non-medical providers were cognitive-behavioral, family, and nondirectve play therapy.

Barriers to obtaining treatment for children who have suffered from abuse is that many of them are abused by the adults they depend on including parents, caregivers, and other adults they are supposed to trust. Often, these children have poor family functioning and a lack of social support. It is also sometimes difficult for a young child to understand and communicate abuse. Health care workers, teachers and other professionals who work with children should

receive training to recognize signs of child abuse and neglect so that these children can live in a safe environment and receive the services they need to heal.

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Child care and preschool

Definition: High quality center- or home-based child care and early education programs that offer a variety of developmentally-appropriate educational activities and opportunities for socialization. High quality programs are characterized by licensure or accreditation, well-trained, well-compensated providers, adequate staff-child ratios, and quality interactions between providers and children. Center-based care has generally been found to be of higher quality than home-based care.

Summary of findings:

The 59% of children under age 6 in Los Angeles, Orange, and Ventura counties who participate in some type of non-parental child care are cared for in a variety of settings, suggesting that not all children in child care are receiving care of equally high quality. Thirty-five percent have a home-based provider as their primary arrangement, with only 17% of these being licensed. Twenty-five percent have a center-based provider as their primary arrangement, presumably with 100% of these being licensed. Twenty-one percent have a relative as their primary arrangement, with few of these being licensed. Availability and affordability of high-quality child care remains a major challenge as evidenced by long waiting lists for subsidized and high-quality child care.

The effects of participation in high-quality child care on children's development are only about half as large as those associated with family environments, but emerge repeatedly in study after study and are consistent for children of every ethnicity and every language group.

Enrollment in high-quality child care is associated with positive early learning skills, vocabulary, prereading skills, and pre-math skills, and the positive influences of high quality child care on cognitive development continue well into the elementary school years. High quality child care also has a positive influence on children's social-emotional development, with children enrolled in high-quality child care more likely than children enrolled in low-quality care to cooperate and comply with their mothers and child care providers. Child care that provides opportunities for physical play and activities that build manual dexterity enhance development of fine and gross motor skills. Additionally, children who were enrolled in high-quality child care as infants and toddlers are more likely than children enrolled in low-quality care to cooperate with teachers after entering school and, in the eyes of teachers and parents, to have fewer behavior problems. In the longest studied children, these differences persist into adolescence. Similarly, children enrolled in high-quality child care are more socially competent with peers and less likely to be aggressive or withdrawn from peers as young children when compared to children enrolled in low quality care.

Research indicates that benefits associated with participation in early childhood education programs such as preschool include higher IQ, improved academic achievement, lower grade-retention rates, lower rates of placement into special education, higher graduation rates, and lower delinquency rates. Numerous studies have demonstrated that warm and stable

relationships between providers and children are associated with a range of positive child outcomes. Children whose child care providers give them ample verbal and cognitive stimulation and generous amounts of individualized attention perform better on a wide range of assessments of cognitive, language, and social development. At the same time, children who do not have stability and consistency in regard to their relationships with child care providers are more aggressive, less skilled with peers, and have smaller vocabularies.

Data on the quality of interactions between child care providers and children in Southern California comes from two large nationally representative observational studies – the Family and Relative Care Study and the Cost, Quality and Outcome Study. Three categories of quality were used in these studies: (1) care that was good to excellent where children are safe and provider-child interactions are warm, positive, and stimulating; (2) care that was safe but mediocre, where provider-child interactions were routine and not conducive to learning; and (3) care that was poor and unsafe and provider-child interactions were harsh and restrictive. Only 14% of child care centers, 12% of regulated family child care homes, 3% of unregulated family child care homes, and 1% of relative care were rated as good to excellent, while 13% of center care, 13% of regulated family child care, 50% of unregulated family child care, and 69% of relative care were rated as unsafe – indicating a scarcity of quality interactions between children and providers in all types of care and particularly in home based care.

There are a number of strategies that improve access to and quality of child care and preschool. Child care subsidies and vouchers make higher-cost, higher-quality child care more affordable for low-income families. Provider education and training programs improve child care providers' knowledge and skills. Research shows that providers who are better compensated, who receive more education and specialized training, and who care for fewer children at a time are more likely to engage in warm, sensitive, and stimulating interactions with the children in their care. Thus, efforts to promote better compensation, education and training, child-provider ratios and group size will lead to improved child-provider interactions and, in turn, child outcomes. Child care resource and referral services help families locate high-quality child care providers in their communities. Accreditation programs help child care centers improve the quality of their program. Increased provider compensation increases provider quality and reduces turnover. Finally, child care centers in states with more stringent regulations generally have higher-quality care.

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Child care infrastructure and equipment

Definition: High quality child care and early education programs should be in a facility that offers a comfortable and safe environment with the necessary educational materials to create a developmentally-appropriate learning environment.

Summary of findings:

The Early Childhood Environmental Rating Scale (ECERS) is a widely used instrument to measure process quality. According to the ECERS, process quality consists of the experiences that take place in a child care or preschool and includes the building space and environment, curriculum, equipment, and learning materials. The surroundings in which a child spends time participating in daily activities and interacting with others should support all aspects of learning and development. Safety and environmental guidelines should be followed so that each child feels comfortable and secure to make the most of learning.

A high-quality classroom not only has adequate materials such as books and toys for all enrolled children, but the teacher also uses a curriculum that is set to encourage learning and reach specific outcomes. Activities that are developmentally appropriate and challenge each child to grow socio-emotionally and cognitively are integrated in high-quality programs. Physical health is also set in the daily routine to ensure that children eat nutritious foods and have playground space and equipment to exercise. The National Association for the Education of Young Children (NAEYC) states that the use of technology and computers may be used in the classroom to assist early learning and socialization if only developmentally appropriate and useful. Developmentally appropriate computer programs help children to use creativity, build problem-solving skills, and maintain interaction with other children. Similar to other teaching materials, technology should incorporate differences in language and culture and not teach children to stereotype groups. Generally, equipment used in early learning activities should be an accessible tool that promotes imaginative play and cognitive learning with other children.

Child care and preschool is a place where many young children spend several hours each week. Interacting and building relationships with adults and other children is a key component for early childhood learning and development. Books, toys, and games are tools for children to socialize with others and join in imaginative play. Play materials that are educational and supportive of peer interaction in a safe, clean environment with adequate space are elements of a quality learning program. An early learning classroom cultivates young minds by supplying an environment with materials to promote optimal learning.

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Child care provider compensation

Definition: The salary or wage and benefits package including health care and retirement options offered to a child care provider.

Summary of findings:

The compelling evidence for the positive influences of high-quality child care, the scarcity of high-quality care, and the alarming turnover rates have led researchers to examine what factors motivate highly educated and skilled providers to enter and remain in the child care field. Every study in which this question has been examined suggests that child care provider wages are linked to the provision of high-quality care, even when training and ratios are simultaneously considered. Moreover, wages are the primary determinant of provider turnover – a feature of care quality that is associated with poorer outcomes for children.

San Francisco is the first county in the state and one of a few in the United States to implement a child care provider compensation and retention program. Beginning in April 2000, the San Francisco Compensation and Retention Encourages Stability (CARES) Initiative encourages child care providers to continue to build their careers through further education. In its first year (1999-2000), 1239 child care providers applied and 414 received stipends ranging from $500 to $5,000. To further the goal of increasing child care provider compensation, San Francisco allocated $4.1 million in FY 2000-01 to the Department of Human Services to offer a wage compensation package to child care centers that increased the lowest wage to $9 per hour. The San Francisco Department of Children, Youth, and their Families also improved the compensation package of child care providers with the Child Care Provider Health Benefits Project. This initiative is a $250,000 pilot project that increases access to health insurance for child care providers by covering two-thirds of the cost of the health care premium. Innovative strategies such as the San Francisco CARES project not only provides additional compensation to qualified child care providers, but also assists them in receiving further training and education. By meeting the needs of child care providers, they will more likely remain in the child care field and receive additional training to enhance the quality of child care.

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Child care provider education and training

Definition: Classes or programs that offer current child care providers additional education and skill-building opportunities to enable them to continually improve the quality of the services they provide and better meet the needs of the young children they serve. Individuals who participate in these programs should be well-informed about child development, know how to create a safe and stimulating environment where children can learn and play, and have the skills needed to create a developmentally-appropriate curriculum that facilitates cognitive and language development, social-emotional development, and physical health and motor development.

Summary of findings:

Large representative national child care studies have examined barriers to child care provider education training among providers already working in the field. Providers of both center- and home-based child care overwhelmingly report that they cannot take advantage of existing training opportunities because they are too costly, they are unable to take off work for daytime training, or they must care for their own families during their off-work hours. Although the majority of center-based providers report that they would like more training, family child care providers and license-exempt providers do not report similar eagerness to engage in training due to different beliefs about the nature of their work.

Specialized and formal child care provider education and training can predict more sensitive, warm, and learning-enhancing provider-child interactions, which are in turn associated with positive developmental outcomes for children in the areas of cognitive/language and social-emotional development. However, the benefits of provider education and training have been found to be larger for community college-based courses targeted to center-based providers than for a less intensive non-college-based program. In a non-college-based program that was studied, only 20% of the providers showed observable improvement and 8% got observably worse after training.

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Child care resource and referral services

Definition: Services that offer parents information about and linkages to high-quality child care providers in their area. These services are designed to help parents locate child care that is developmentally appropriate and safe, and that meets their specific needs regarding cost, age group served, hours of operation, and other service characteristics. In addition to helping parents locate appropriate child care, some child care resource and referral agencies also engage in other activities to improve the availability, quality and affordability of child care such as offering provider training, working to create additional high-quality slots, and assisting eligible families with applications for child care subsidies.

Summary of findings:

There are over 765 local child care resource and referral agencies distributed throughout the country, and this number continues to grow. In 2001, local CCR&R programs provided over 1.65 million referrals to those seeking early care and education and out of school time options for children. Of these referrals, 45% were to low-income families and 35% were to families receiving support through TANF (Temporary Assistance for Needy Families).

There is no data regarding the relationship between the use of child care resource and referral agencies and child developmental outcomes. However, a survey by the National Association of Child Care Resource and Referral Agencies of its members suggests that these agencies have been effective at improving parental awareness of what constitutes high-quality child care, at linking parents to child care providers that meet their needs, and at helping eligible parents get financial assistance in paying for child care.

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Child care subsidies

Definition: Government financial support provided either directly to parents or to eligible child care providers to enable low-income parents to select high-quality child care for their children regardless of cost.

Summary of findings:

Many low-income families cannot afford high-quality child care, and must place their children in less costly informal child care arrangements such as care by a relative or friend that may not provide a safe and stimulating environment. To increase the likelihood that families with financial constraints will enroll their children in high-quality child care that fosters child cognitive/language, social-emotional, and physical and motor development, states can use funds from the Child Care and Development Fund (CCDF) or Temporary Assistance for Needy Families (TANF) block grant to offer child care subsidies to low-income families. Studies attest to the effectiveness of child care subsidies: child care programs that have access to public funds are higher in quality than non-subsidized community-based child care programs.

Unfortunately, studies also suggest that as many as 75% of families in some communities who are eligible for subsidies fail to sign up. Barriers to the use of subsidies include the fact that many families may not be aware that subsidies are available, may mistakenly believe that the same time limits that apply to TANF apply to child care subsidies funded by TANF, or may not realize that the type of care they use is eligible for subsidies. There are few federal legal barriers that prevent states from promoting accessible and affordable quality child care under CCDF and TANF, and states may offer subsidies to families using both home- and center-based child care so long as that care meets state licensing requirements. However, a scarcity of federal and state funds relative to need has resulted in long waiting lists for subsidized child care in California and elsewhere.

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Children are born healthy

Definition: Children are born healthy and free of birth defects, low-birthweight, exposure to teratogens, and other problems that might arise from factors including poor maternal health behaviors prior to and during pregnancy.

Summary of findings:

The national rate of preterm and low birthweight births is 11% and just under 8% respectively. One study found that 8.8% of women in California smoked cigarettes during pregnancy, 6.7% used alcohol, and 5.2% used illicit drugs, with substantially greater prevalence of these behaviors among African-American women. Birth defects affect 3.6% of all newborns - nearly 150,000 babies in the United States and 18,000 babies in California are born with birth defects each year.

Barriers to healthy births include risky maternal behaviors during pregnancy such as poor diet and use of alcohol, tobacco and other drugs, as well as late or no prenatal care. Genetic factors may also play a role.

Healthy births are associated with improved health and developmental outcomes during childhood and throughout life. Low-birthweight infants are at increased risk for chronic pulmonary disease, visual and hearing impairment, neurodevelopmental handicaps, learning difficulties resulting in school failures, child abuse and neglect, and recurring illness, as well as infant mortality. Birth defects are the leading cause of infant mortality in the U.S. and California, and children born with birth defects are far more likely than other children to die as infants.

Family planning, preconception care and prenatal care, when integrated with effective psychosocial, nutrition and education efforts at the family, community and state policy levels, plays a significant role in promoting healthy births by averting many of these risk factors, though the extent to which prenatal care reduces the risk of low birthweight and prematurity in particular is still being debated.

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Children play and engage in physical activities

Definition: Children are provided with toys that promote fine and gross motor development though the manipulation of objects, and participate in age-appropriate, health-promoting physical activities on a regular basis.

Summary of findings:

Play is a major part of a young child's education. Children deprived of play experiences can develop learning and other problems from which they may take years to recover. Imaginative play and physical activities are important opportunities for young children to interact with other children and their parents. Starting as young as at age one, children take interest in each other and notice each other's actions. Observational studies have shown that as two toddlers meet on a regular basis they become familiar with each other, and through play they develop emotional and cognitive skills. By developing friendships, young children build relationships and learn how to resolve conflicts through guidance received from adults. Peer relationships also present opportunities for young children to practice their language and cognitive skills. As children grow, the complexity of play increases and a child interacts with several children in a group to coordinate play activities.

Toys and games can be enjoyable activities for young children as they learn new skills and play with others. Parents should be encouraged to buy developmentally appropriate toys. "Educational toys" can be useful in stimulating particular aspects of development, e.g., hand-eye co-ordination, manual dexterity, association of cause and effect. A good variety of toys is important. Children become more quickly bored than adults because their attention span is shorter. A good principle is to buy toys that are challenging without being too difficult. However, children also need time to relax with older, more familiar toys and easily completed activities. Physical play is also important, and is linked to cognitive development because it provides breaks from demanding intellectual tasks.

Although there is no data available regarding the frequency of exercise among children, childhood obesity is a reasonable proxy measure for the extent to which young children engage in healthy behaviors including exercise. Between 5-25 percent of children and teenagers in the United States are obese, and the prevalence of obesity in the young varies by ethnic group, with 5-7 percent of White and Black children, 12 percent of Hispanic boys and 19 percent of Hispanic girls being obese. Some data indicate that obesity among children is on the rise.

Sedentary activities during childhood encourage unhealthy behaviors including overeating, and studies show these activities are on the rise among children. For example, children aged 2-4 have been found to spend an average of more than 4 hours per day every day with media such as television, VCRs, game systems and computers.

Physical inactivity is recognized as an important determinant for chronic disease, and childhood obesity resulting from lack of exercise and poor diet has been linked to a number of

health problems later in life including diabetes, adolescent obesity, hypertension, coronary heart disease, cardiovascular problems, compromised bone mass and osteoporosis. This is in part because lifestyle patterns relating to exercise and diet are established during childhood. Interventions designed to increase physical activity among children has been found to improve children's physical development and health.

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Children's mental health treatment

Definition: High-quality mental health services for children that identify and treat mild-to-severe mental health conditions in a timely and appropriate manner.

Summary of findings:

If left untreated, the physical, social-emotional, and cognitive development of children with mental illness will be severely stunted. Mentally ill children are at a heightened risk for school failure and dropout, drug abuse, and many other difficulties, all of which can be prevented by timely evaluation and appropriate treatment.

According to Jane Knitzer of the National Center for Children in Poverty, Columbia School of Public Health, "Emotional growth, patterns of attachment and increasing competency in the ability to form relationships, and the emergence of self-confidence are as crucial to overall development as are physical growth, cognitive or motor skills. The physical, mental and emotional health of the very young child provides the foundation for all further development". An emotionally and mentally healthy young child forms secure attachments, enjoyable social relationships, and effective coping skills. A young child who does not form secure attachments and has a low self-concept may be predisposed to depression or anxiety disorders. An anxious child may find it difficult to pay attention to a teacher at preschool and interact with other children during play time. As a result, the mental health disorder may harm the child's cognitive and emotional development by interrupting normal learning and socialization. The child who presents a negative affect may also withdraw from and fail to attract other children during play time. By changing cognitive processes, mental health treatment helps children with mental health problems. Positive cognitive characteristics including a positive self concept, positive thinking, and effective coping and problem solving skills have been associated with good child outcomes.

Children's mental health services promote mental health in young children by helping families gain information, support, early intervention, and treatment. Studies have shown that these services are highly effective in averting the negative effects of mental illness on child development. For example, the literature on early intervention for anxiety disorders indicates that preventive interventions for very young children can diminish the severity and course of these disorders. However, most children with mental health problems do not get the help they need, in part because the seriousness of childhood mental problems is not widely known or acknowledged. In addition, most early childhood service providers are not equipped or qualified to identify children's mental health problems before they become intractable, particularly those problems that arise during infancy. Access to and receipt of children's mental health services varies by family characteristics, with one study indicating that children who were older, white, more impaired, experiencing more family conflict, and referred by a pediatrician receiving more services.

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Developmental Services

Definition: Developmental surveillance refers to a "flexible, longitudinal, continuous process of activities that include eliciting and attending to parents' concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals, such as child care providers, visiting nurses, and preschool teachers." Rather than viewing development in isolation during a screening session, emphasis is placed on monitoring development within the context of the child's overall well-being (Dworkin, 1992).

Summary of findings:

Without appropriate content and quality of health care, many cognitive, speech, language, and other developmental problems and issues will go unidentified, parents will not receive important counseling to help them stimulate their children's learning capacities, and children's school readiness will be in jeopardy.

Evidence suggests that services promoting the optimal development of children have the potential to be effective in changing developmental trajectories. The incorporation of services to address concerns related to children's development has grown over the past several decades with a paradigm shift in primary care to incorporate what have been termed the "new morbidities" as key health supervision priorities. "New morbidities" refers to the increasing prevalence of developmental, behavioral, and learning concerns and problems faced by children and their families over the last several decades that pose real threats to a child's or adolescent's healthy development (Haggerty, 1975). Health supervision guidelines over the years have consistently included a growing list of developmental services to be delivered in routine care in response to the new morbidities (AAP, 1997; Green and Palfrey, 2000). These additional developmental services include eliciting and addressing parents' concerns about child development and behavior as well as the psychosocial concerns of the family and problems in family relationships, and providing problem specific developmental interventions beyond the traditional developmental screening exam.

Developmental surveillance activities have been elaborated in detail for each health visit in *Health Supervision Guidelines* published by the American Academy of Pediatrics (AAP, 1997) and the Maternal and Child Health *Bright Futures* project (Green and Palfrey, 2000). We conceptualized these activities as developmental services defined by a typology with four major categories (see Table 2 in Appendix A) (Regalado and Halfon, 2002). *Assessment* services include evaluation of information from parents, developmental monitoring (including screening for developmental problems *when indicate*d), psychosocial assessment, parent-child observation, and assessments of child behavior. *Education* services include anticipatory guidance addressing the parent-infant relationship, child behavior, and various developmental challenges (e.g., promoting healthy sleep habits, discipline practices), and parenting education in different formats. *Intervention* services include various types of problem-focused

counseling in the office setting, such as a telephone service or through home visitation. *Care coordination* refers to the management of service needs, e.g., referrals for diagnostic assessments or other specialists for care. These developmental services define the *content* of "developmental" health supervision for children.

Although effective assessment tools exist to aid the health practitioner in providing developmental surveillance, a recent survey of pediatricians conducted by the AAP and UCLA (Halfon et al., 2000) determined that most (80% of pediatricians) reported lacking confidence in advising parents who have developmental concerns, and a third reported inadequate training in this area. Moreover, only one-third reported having sufficient time for developmental assessment during a routine health visit (AAP Fellows Survey, 2000). Finally, a 1996 national survey of parents of young children revealed that 50-75% had not received anticipatory guidance about common developmental topics such as newborn care, soothing fussy babies, helping infants sleep, toilet training, discipline, and helping children learn (Schuster et al., 2000).

Barriers to effective delivery of developmental services include time limitations, inadequate financial support and reimbursement, inadequate training of physicians, and lack of a linkage between the health office and other community providers.

To overcome some of these barriers, there is a need to address physician training, financial support, and coordination of community wide services. First, there is an important need to improve physician training, particularly in doctor-patient communication and clinical child development, to engender a proactive attitude toward child development concerns, to enhance communication with parents around child development concerns, and to develop effective surveillance skills. Second, for medical plans serving children birth to age 5 (e.g., Medi-Cal, Healthy Families, insurance plans) to provide child development services, contracting managed care organizations (MCOs) must include language in their contracts that specify the desired services. Third, mechanisms should be identified for organizing and integrating the service system using the entire spectrum of community providers in collaboration with the health care provider's office as the health care home. The health care home model identifies the health care office as an ongoing, regular place for comprehensive health care that includes developmental, behavioral and psychosocial issues, where the child has an ongoing relationship with a primary provider and where all the child's health and developmental needs can be assessed and appropriate referrals made for additional care. The health care home also serves as a hub to connect the child and family to other necessary services in their community.

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Employer Training of Family Friendly Work Policies

Definition: Employers learn how to incorporate strategies that help families attain a work/life balance. Providing employers with information on family friendly work policies can teach them about strategies that create more opportunities for parents to interact with their children.

Summary of findings:

Parents are the primary caregivers of their children and should participate in quality activities with them each day to build a relationship that leads to positive child outcomes. Work policies can help parents better manage their schedules to allow them to spend more time with their families. Research on work-family issues have observed four components of a family-friendly workplace: 1) benefits including policies and programs that promote a work/life balance, 2) workplace cultures value the importance of family, 3) workplace relationships support family responsibilities, and 4) work processes/systems ensure that outcomes benefit both employees and the organization. A study showed that when employers understand that a work/life balance leads to a more productive output, then organizations are more likely to be more supportive of family friendly policies.

A recent national survey of 1,057 employers each with over 100 employees stated that 43% train their supervisors in responding to work-family needs of employees. For maternal and child policies, 81% allow a gradual return to work after birth of a child, and about half of employers provide some income replacement during maternity leave. Thirty-six percent have information available to help find child care services, and only 9% offer child care at or near work. The Corporate Reference Guide to Work-Family Programs by the Families and Work Institute presents measurable indicators of a family-friendly workplace. The Institute identifies three basic stages of integrating family-friendly policies: 1) developing a programmatic response, 2) developing an integrated approach, and 3) changing the culture. In addition, the Corporate Reference Guide contains information on The Family-Friendly Index which is a tool to measure a company's family-friendliness. The Index measures attributes of family-friendly programs such as flexibility of work schedule, benefits, and time-off policies. Overall, the workplace should support a work/life balance to increase productivity at the workplace as well as an employee's ability to manage family priorities.

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Expectant mothers have healthy pregnancies

Definition: Expectant mothers receive early and high quality prenatal care, eat healthy, nutritious foods that promote optimal fetal growth and development, engage regularly in health-promoting exercise appropriate for each stage of pregnancy, and avoid alcohol, tobacco, illicit drugs, and other substances that have been found to negatively impact fetal development.

Summary of findings:

One survey found that only one in three women age 18- 45 reported taking daily multivitamins containing folic acid, and only one in five women under 25 reported doing so. About two-thirds of women had heard or read something about folic acid, but of those who knew about it, only 16% knew that folic acid helps prevent birth defects.

Eating foods and taking dietary supplements that provide a variety of essential vitamins and minerals, exercising, avoiding alcohol, drugs, and tobacco, and staying relaxed are important for the health of pregnant women and their developing babies.

If a woman fails to gain an appropriate amount of weight (between 25 to 35 pounds), her baby is at risk for developing birth defects, having low birthweight, or being born prematurely. Nutrients such as folate, calcium, and iron have been found to provide specific benefit to mother or child. For example, folic acid (vitamin B9) is important for proper development of the brain and spinal cord.

Very high levels of stress may contribute to preterm birth or low birthweight in full-term babies. Research has shown that mothers with psychological stress contribute to complications in pregnancy and may lead to unfavorable child development. In addition, expectant mothers with medical conditions that require special attention and treatment such as the management of diabetes, proper prenatal medical care and treatment should be received in a timely manner to ensure a healthy birth.

Exercise reduces stress levels and promotes health. Results show that infants of women who exercised during pregnancy were significantly heavier and longer at birth. In addition, during the middle of pregnancy, women who exercised showed greater placental growth rate and size than mother who did not exercise.

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Family friendly work policies

Definition: Employers are "family-friendly," assisting employees in balancing the competing demands of work and family. This may include providing parents with the opportunity to have flexible work schedules to care for sick children, offering generous paid family leave policies to ensure parents can spend an adequate amount of time bonding with a new baby, providing on-site child care or child care resource and referral services, and offering parent education classes or materials.

Summary of findings:

An increasing number of employers – particularly large employers - are offering family friendly policies, but low-income workers and others who are the most likely to need this type of support are the least likely to receive it.

Research indicates that family-friendly workplace policies and programs improve staff recruitment and retention, reduce absenteeism, and increase job satisfaction and company loyalty. More importantly, however, studies show that parental employment can affect young children positively or negatively depending upon the flexibility of work hours, nature/structure of job, income, and timing of employment – the very factors that family-friendly employer policies are designed to address. For instance, employee-based lactation programs with on-site child care services are an example of promoting a family-friendly workplace, however, only 15 percent of large employers offer lactation programs. According to La Leche League International, a recent study of one company estimates increased production and an annual cost saving of $240,000 in health care expenses for mothers and children as well as lower employee absenteeism (annual $60,000) with a corporate lactation program.

In addition, key features of work, such as intellectual flexibility and self-direction among employees, have been linked to children's cognitive achievement and social behavior. This relationship between work environment and child outcomes most likely results from the fact that parents whose work environments are less stressful and more flexible and satisfying are better equipped to meet the needs of their young children both in terms of the amount of time spent together and the quality of that time. This is particularly important during infancy when optimal child attachment depends on the formation of a deep bond between parents and children.

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Health insurance outreach and enrollment

Definition: Enrollment in a public (such as Medi-Cal or Healthy Families) or private health insurance program that covers part or all of the cost of a range of health services. Some health insurance programs cover children alone, while others provide family coverage.

Summary of findings:

Data indicates that approximately one in five children in California has no health coverage. These children (1.85 million) are more likely than insured children to go without needed health care services, even when they have serious health conditions, with one in four uninsured children having no regular source of health care. Barriers to public health insurance coverage include fear of being branded a public charge, which discourages immigrant parents from enrolling in publicly-funded programs for which they are eligible, as well as lack of awareness about these programs and difficulty navigating the complex application and enrollment process. Barriers to private health insurance coverage include unemployment, lack of employer-sponsored health plans, particularly among small employers and for part-time and low-wage workers.

Health insurance coverage has been found to improve access to and utilization of a range of children's health services that are associated with improved physical health. Furthermore, services are provided to screen and refer for social-emotional problems and cognitive and language delays. Health insurance coverage is also associated with improved access to and utilization of prenatal care, which has been found to result in healthier births, as well as improved access to and utilization of specialized services such as mental health programs for parents and/or children – all of which lead to improved child developmental outcomes. (However, private health insurance has been found to be preferable to public health insurance in terms of increased access to high quality health care and having a medical home or regular source of health care.) Children without a routine provider – many of whom lack health insurance - get sick more often as babies, are less likely to be immunized as toddlers, and are less likely to get treated for routine illnesses that can turn into serious health problems such as hearing loss and acute asthma.

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Home visiting

Definition: A strategy for service delivery from which to launch any number of interventions designed to achieve a wide variety of outcomes. First 5-funded home visiting programs typically consist of preventive services that begin prenatally or during the early months of a child's life, and are sustained over an extended period during the child's first 5 years. Services may include assessments and problem identification, early childhood education, parent education and instruction, counseling and mental health services, health care, advocacy, case management, treatment services, care coordination and referral assistance. Home visiting programs may be universal (provided to all families regardless of socioeconomic or risk status), or they may be targeted to specific or high-risk populations such as first time mothers, teenage mothers, or children at-risk for abuse and neglect.

Summary of findings:

A number of home visiting programs currently operate in Ventura County including Public Health, PHNs (Public Health Nurses), Every Family County, Early Head Start, AFLP (Adolescents Family Life), and Rx for Kids. A barrier to use of these and other home visiting services include the fact that many programs are targeted to high-risk or special needs populations, so that "regular" families who would benefit from these services are unable to access and use them.

A review of evaluations of home visiting programs reveals that these programs can provide parents with information that helps them better understand their child's needs, and offer parental support that promotes parental well-being and helps parents build stronger relationships with their children. These evaluations also suggest that through improved family functioning, home visiting programs can ultimately lead to improved child developmental outcomes.

Mothers who participated in home visiting programs have been found to have an increase in total knowledge about child development. Women who participated in a well-evaluated nurse home visiting program were found to be less likely to abuse or neglect their children, and less likely to have rapid successive pregnancies that would prevent them from finding work and becoming economically self-sufficient and that would put them at risk for substance abuse and criminal behavior. Long term positive child outcomes associated with this particular home visiting program included fewer arrests and convictions, less substance abuse, and fewer sexual partners at age 15. However, a longitudinal evaluation of this program indicated that the program benefited only the neediest families (low-income unmarried women), providing little benefit for the broader population.

A review of the benefits of other home visitation programs that targeted low SES families, families with low birthweight/premature children, and families with other

problems including child abuse and postnatal depression shows positive effects on a range of child and family outcomes, including health behavior, child safety and stimulation. Home visitation was also shown to positively influence cognitive development for premature children.

Research indicates that the quality of home visiting programs and the extent to which they produce positive outcomes for children and families may vary according to the education and training level of the home visitor, and that education and training programs targeted to these providers may help to improve the quality of home visiting programs.

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Home visitor education and training

Definition: The formal education and training professional or paraprofessional home visitors receive prior to working in the field, as well as education and training opportunities offered to home visitors already working in the field to help them improve the quality of services they provide to young children and their families.

Summary of findings:

Although research has not yet determined what should be the minimum qualifications for home visitors, experts have recommended that home visitors be extremely well trained and have at least a high school diploma. However, individual home visiting programs set their own standards regarding how much education and training is required of the providers who work for them, and there is a good deal of variation in these standards from one home visiting program to the next.

A key consideration home visiting programs is whether to employ professional or paraprofessional home visitors. Typically, professional home visitors are defined as those who have earned credentials in a relevant field, such as education, nursing, or social work. It is also possible for paraprofessional home visitors to hold advanced educational credentials; however, their degrees would most likely be in fields other than those that relate directly to home visiting. Paraprofessional home visitors are usually from the same community where a home visiting program is delivered and often share the same racial or cultural background of the program's target population.

There is significant literature on the potential strengths and weaknesses of both professional and paraprofessional home visitor staff. Professionals with clinical expertise can address the specific health, developmental, and counseling needs of families with knowledge and objectivity. Paraprofessionals, who are often hired from the community where home visiting services are provided, may share similar experiences and cultural beliefs with clients, and often have knowledge of and involvement in community networks that can help to quickly gain families' trust.

In terms of outcomes for children and families, one study suggested that paraprofessional staff produce positive effects that fall (in magnitude) between those of professional nurses and a control group.

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Immunization services/strategies

Definition: Specialized services that provide children with appropriate and timely immunizations. These services are intended to supplement pediatricians and other pediatric health care providers who provide immunizations, thereby enabling children who do not have regular health care providers to receive their immunizations on time. Immunizations prevent the development and spread of communicable diseases, lead to better physical health for both children receiving the vaccines and the children they come in contact with, and are required for school entry, so it is important that all children receive the recommended vaccinations whether or not they have a regular source of health care.

Summary of findings:

Prior to childhood immunizations, diseases that are now preventable by vaccinations infected hundreds of thousands of children each year and caused severe complications, disability and death. Vaccines have been shown to be 85-100% effective in preventing diseases, and cost-effectiveness estimates show that for each dollar spent on immunizations, an average of twelve dollars are saved by preventing disease. Childhood immunizations are provided against ten diseases: diphtheria, tetanus, pertussis (whooping cough), measles, mumps, rubella (German measles), polio, *Haemophilus influenza* b (a cause of spinal meningitis), hepatitis B, and varicella (chicken pox). Although immunizations have significantly decreased the incidence of vaccine-preventable diseases, in 1995 only 72% of 19-35 month-old children had up-to-date immunizations.

Due to school requirements, 95% of children receive immunizations by the time they enter kindergarten, however, about one million preschool children do not received complete vaccinations for infectious diseases. As more children are placed into daycare and child care centers before preschool, the Centers for Disease Control (CDC) advises that all children should receive up-to-date immunizations by age two. A child that does not have protection from infectious diseases that can be preventable from immunizations faces increased risk for contracting illnesses during a possible outbreak. For instance, from 1989-1991, a measles outbreak resulted in more than 55,000 cases and more than 120 deaths, of which half were children under 5 years of age. With the goal of having nearly all children receive up-to-date, recommended vaccinations by the age of two, the CDC began to work on the National Childhood Immunization Initiative in 1993 to build a comprehensive vaccination delivery system. Through public outreach and increasing partnerships, the CDC and several state initiatives have started programs that provide immunization services and improve monitoring systems of service delivery.

Economic and cultural risk factors, provider practices, and family knowledge about the importance of timely immunization are three areas that act as barriers for child immunization. Thus, children living below the poverty level, Black and Hispanic, children of teenage mothers, children in large families, and children whose mothers lack social support systems are less

likely to be up to date on their immunizations. Certain policies and procedures in medical offices, such as the inability of parents to obtain appointments when requested, can also serve as a barrier to timely childhood immunization. The American College of Preventive Medicine (ACPM) recommends that health care professionals pay close attention to opportunities where parents of young children can be reminded of the benefits of childhood immunizations as well as eliminate barriers that impede delivery of vaccinations to young children. Offering convenient office hours, reminding parents, and changing mandatory well-child check up policies can help increase vaccination rates. Other opportunities to make childhood vaccination delivery systems more efficient would include exploring delivery opportunities through managed care, local and national immunization registries, and schools. Providing accessible immunization services help more young children receive vaccinations to protect them from preventable, infectious diseases.

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Libraries and toy/book distribution programs

Definition: Libraries and other programs and services that offer parents children's books and toys to take home. These programs are designed to facilitate parent-child interaction and a child's cognitive/language and socio-emotional development by ensuring that all families know about the importance of reading to their children and have access to books and toys they can read and play with their children on a regular basis regardless of their ability to purchase materials.

Summary of findings:

Books, games, and toys are important tools for learning and facilitate parent-child interaction. Play materials should support the attention and activities a parent shares with his or her child rather than substitute for the time they spend with each other. Interactive reading and play help form healthy relationships between caregivers and a child, which leads to early socio-emotional growth and cognitive development. Moreover, this interaction nurtures a child's self-esteem as he or she learns to accomplish new tasks and receives reinforcement from caregivers. Storytelling and toys that encourage imagination foster creativity and problem-solving skills. Parents should be encouraged to buy a variety of toys and books that are right for their child's stages of development. "Educational toys" can be useful in stimulating particular aspects of development, e.g., hand-eye co-ordination, manual dexterity, association of cause and effect. Parents should also choose toys that do not promote negative messages and violence. For young children, caregivers should participate in play activities for interaction as well as for safety. The American Academy of Pediatricians (AAP) recommends that small toys, toys with sharp edges or loose strings should not be provided to toddlers. Storage of toys and making sure toys are clean are also important considerations for playtime activities.

There are currently 20 libraries or library branches available throughout Ventura County, serving a range of communities, and these libraries offer all families an opportunity to have an ever-changing assortment of free children's books in their home at all times.

Having an array of children's books available and in use in a child's home has been linked to the development of early literacy skills among pre-school-age children, and programs designed to provide parents of young children with children's books and reading-related resources and support have been shown to increase the frequency with which parents read to their children. A study of families participating in the Beginning with Books Gift Book Program found that parents who received books visited the library more often and had more reading materials in their homes, and their children were perceived by their teachers to have better literacy and language skills. Another program, Reach Out and Read, is a book distribution and family literacy program being implemented in pediatric offices. The program consists of three components: 1) placing volunteer readers in the waiting room, 2) offering counseling about literacy development by pediatricians, and 3) providing books to families of young children. Several evaluations of this program have demonstrated that the intervention increases book-sharing activities in the family, particularly for low-income and Hispanic families.

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Mothers breastfeed children

Definition: Mothers provide their children with breastmilk as their primary or sole source of nutrition.

Summary of findings:

Available data suggests that 80% of women in California initiative breastfeeding immediately after the birth of their child while they are still in the hospital. However, fewer than 50% of these mothers are still breastfeeding exclusively when they leave the hospital, and by the time infants are 6 months of age, the proportion of mothers breastfeeding is reduced by half, with the decline starting as early as the first or second month after birth.

While white (80 percent), Hispanic and Asian women (both 74 percent) in California are most likely to initiate breastfeeding, lower breastfeeding initiation rates are found among Native American (66 percent), and African-American (56 percent), and Southeast Asian women (38 percent). The lowest initiation rates are traditionally found in the Central Valley, Los Angeles and southeastern counties - areas that are more densely populated and have high numbers of nonwhites compared to the coastal and mountain regions. Furthermore, Hispanic mothers have a relatively high rate of supplementing breastfeeding with formula, while exclusive breastfeeding is greater among white, Native American, and Asian mothers.

Studies have identified various barriers that make it difficult for many mothers to start and continue breastfeeding. The barriers to breastfeeding initiation include negative social attitudes toward breastfeeding, insufficient professional support and encouragement for breastfeeding, and maternity hospital policies and procedures that obstruct breastfeeding soon after birth. The barriers to breastfeeding duration include a lack of education and knowledge among women, a lack of support from traditional support networks, a lack of postpartum support services available in the community, and a lack of support for breastfeeding families in schools, the workplace and in child care settings. These studies indicate that reducing barriers through increased education and support for new mothers would result in significantly higher rates of breastfeeding in initiation and duration. For example, women who are encouraged to breastfeed in the hospital after the birth of their children are more likely to start breastfeeding (74 vs. 43 percent).

A number of studies show that breastfeeding is associated with multiple health and developmental benefits for children in both the short and long term. Breastfeeding, which provides complete nutrition and hydration for infants up to 6 months of age, and an average of 30% of calories needed between ages 1 and 2, has been found to result in improved child outcomes in the areas of cognitive and language development. Children who are breastfed show improved IQ and improved performance on developmental assessments. Several studies suggest that breastfeeding may have small long-term benefits for child cognitive development

among children born with very low birthweight. One such study of 413 very low-birthweight infants found that increased duration of breastfeeding is associated with increases in verbal IQ and performance IQ.

Breastfeeding is also associated with positive child outcomes in the area of physical health and motor development. Children who are breastfed have a reduced risk of infectious disease, chronic disease, Sudden Infant Death Syndrome (SIDS), retinopathy of prematurity, and baby bottle tooth decay/caries relative to other children.

Other studies indicate that there may be social-emotional benefits for children that result from breastfeeding's positive impact on maternal self-esteem, maternal-child bonding, and the risk of maternal depression.

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Nutrition education and subsidies

Definition: Nutrition programs and subsidies provide people with nutritious foods and support healthy eating habits. Nutrition education teaches families about the components of a well-balanced diet and how to choose nutritious foods. America's Second Harvest defines hunger as the inability to purchase enough food to meet basic nutritional needs. Nutrition programs and subsidies help end hunger so that low-income families are able to buy food items and attain proper nourishment.

Summary of findings:

Nutrition education programs enable families and their young children to learn about making healthy choices about eating a well-balanced diet with sufficient protein, iron, and essential vitamins. By learning about daily caloric requirements and recommended portions from each basic food group, families will prepare healthier meals. Eating healthier helps children to physically grow and has a positive effect on cognitive development. Children who eat well are better able to learn because getting the proper nutrients on a daily basis helps create a healthy body and mind. Food counseling about dietary needs assists families in making more informed decisions about eating certain types and amounts of foods at particular times.

Educating families about the benefits of eating a well-balanced diet is sometimes not enough for those who cannot afford to buy enough food to meet basic nutritional needs. Some programs including the federally-funded WIC (Women, Infants, and Children) program offers food vouchers to pregnant mothers, mothers and their infants and children up to age 5. WIC is a program of the Food and Nutrition Services of the U.S. Department of Agriculture. The WIC program officially began in 1974 by providing federal grants to States for nutrition education and food subsidies. In addition, the WIC program started the Farmer's Market Nutrition Program (FMNP) in 1992 to provide coupons so that WIC mothers can buy foods at local farmer's markets. The program became Healthy Meals for Healthy Families in 1994 and provides mostly vouchers through authorized food stores. Over 46,000 food stores nationwide accept the food vouchers and WIC provides services to more than 7.5 million women and children. It is estimated that WIC provides services to 47% of all babies born in the U.S and has attained full coverage of eligible infants.

Moreover, WIC has been shown to be effective in improving birth outcomes and savings in health care costs. Research has shown that the WIC Program reduces fetal deaths and infant mortality, reduces low birthweight rates, and increases the duration of pregnancy. The growth of at-risk infants of children improves and the incidence of iron deficiency anemia is decreased. Pregnant and postpartum women enrolled in WIC have better diets, gain more weight, and receive prenatal care earlier. The diet of children who received WIC benefits also improves. More indirect outcomes of the WIC program are that these children are more likely to have a medical home and to have received immunizations on schedule. Moreover, children enrolled in WIC show enhanced cognitive development by improved vocabulary scores and

memory for numbers. Overall, the benefits of WIC reach millions of women and their young children by helping them meet their nutritional requirements to lead healthier lives.

Other types of food programs that provide food for proper nutrition of families and their young children include food stamp programs, food distribution networks, and food pantries. The Food Stamp Program of the U.S. Department of Agriculture provides coupons to about 19 million people each year. America's Second Harvest is an example of a food bank network and distributes food to over 50,000 local hunger-relief agencies and partners with over 500+ national grocery stores to provide food services to 28 million people. Of all their client households, 9.1% of all people that receive food at a food pantry are children 0-5.

Food programs reach millions of families with young children to help them receive nutritious, healthy meals. Growing children and their families benefit from these services by helping them acquire proper nutrition. Meeting nutritional needs are important for all people, and especially crucial for a young child's developmental growth.

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Outreach and referral services

Definition: Outreach and referral is a very broad term but is fundamentally comprised of efforts to reach families in their own communities to increase awareness of and enrollment and participation in desired programs and services.

Summary of findings:

Outreach programs employ a variety of strategies with the aim to identify the target population, increase public awareness and educate individuals about the benefits and availability of programs. They also serve to motivate individuals to participate in programs, facilitate actions and address barriers to participation, and follow-up on use of services. A wide variety of approaches have been used including television commercials, radio spots, bus advertisements, and placement of brochures at convenient locations. Strategies also include co-locating outreach workers in sites such as community health centers, hospitals, schools, and other community settings.

Common barriers to successful outreach that are identified in the literature are: A lack of culturally and linguistically appropriate outreach materials, confusion about eligibility for particular programs, beliefs that programs are not important or useful or that there is a stigma attached to them. Much of the outreach literature focuses on enrolling families into health insurance programs and other public benefits. Barriers specific to this area have to do with parents' concerns about losing public or private benefits or losing immigration status. These barriers also involve cumbersome application processes and long delays from time of application t receipt of benefits. Even when families are successfully identified and public awareness is increased, families often do not use the services because there is an inadequate supply of providers and facilities or a lack of transportation or child care services.

One literature review on the effectiveness of outreach programs found that because of the lack of rigorous evaluation, programs are most often developed based on "best practices" and professional expertise. This report recommended the following best practices: Simplify the application and enrollment process, develop consumer-driven marketing strategies, focus outreach efforts at the local level, forge public and private partnerships, and develop multi-faceted campaigns. Person-to person outreach strategies for low-income families have been found effective at improving childhood immunization coverage rates.

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Parent education classes and materials

Definition: Classes, materials and information that help expectant and/or new parents build the knowledge and skills they need to promote optimal development in their young children. Specific topics covered may include appropriate parenting behaviors, child physical growth and motor development, child social-emotional development and mental health, child cognitive and language development, high quality child care and preschool and how to recognize it, breastfeeding and proper nutrition, and the importance of timely immunizations and regular high quality pediatric care.

Summary of findings:

Although all parents regardless of socio-economic status need and want to be adequately prepared for childrearing, there is a common misconception that parent education as a formal process (i.e. classes, books, etc.) should be targeted to populations of greatest need. On the other hand, recent national surveys suggest that while all parents report a desire to learn more about parenthood and most participate in childbirth classes that may have included a parent education component, relatively few parents participate in formal parent education classes, and parents from lower SES backgrounds are the least likely to participate in such classes. This data suggests a universal demand for parenting education but a large measure of unmet need. Parent education classes that inform parents about child development are important strategies to help parents promote their children's learning and growth. Parent education classes that focus on the connection between home environment and children's success in school have been found to positively affect school readiness. Research shows that the benefit of parenting classes is greater for parents who participate in more classes.

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Parent/family literacy

Definition: Parents of young children possess basic literacy skills in at least one language (not necessarily English – in terms of the effect on child literacy, parent literacy in any language is of great benefit; for other purposes such as job training however, English literacy may be important).

Summary of findings:

Several studies show that parental literacy positively affects children's experiences, attitudes and abilities regarding reading and writing. For example, children aged 4-6 with parents who could read and write at more complex levels and who regularly engaged in these activities with their children were found to begin formal literacy instruction knowing more about critical written language concepts.

By discovering books, reading, and storytelling with their children, parents encourage communication and exposure to a range of auditory and visual stimuli. Parents who participate in reading activities with their children share experiences that foster cognitive and linguistic development.

National survey data reveals that only 52% of children have parents who report reading to them daily. Twenty-seven percent of children have parents who report reading to them 3-6 times a week, 15% 1-2 times a week, and 6% of children have parents who report never reading to them. White mothers are 2.2 times more likely than Hispanic mothers, and 1.3 times more likely than Black mothers, to read to their children every day. Mothers who have more than a high school education are 1.3 times more likely to read to their child every day than mothers with only a high school diploma, and 1.8 times more likely than mothers with less than a high school education. Sixty-eight percent of married mothers report reading to their child every day, whereas 22% of never-married mothers and 9% of separated/divorced mothers report reading to their children daily.

It is not just the quantity and frequency but the quality of these interactions that has been linked to children's cognitive and social-emotional outcomes. For example, children's creativity has been shown to be related to the quality of parent-child reading interactions, and children's perceived competence was related to both the quantity and quality of parent-child reading.

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Parent/family literacy programs

Definition: Adult literacy programs teach parents how to read and write, typically in English. Family literacy programs include direct parent-child interactions based around literacy tasks as well as opportunities for parents to develop their literacy abilities by focusing on issues such as family and community problems, child-rearing concerns, home language and culture, and interactions with the school system. Family literacy programs are based on the idea that literacy is both social and cultural and is best developed within the daily activities of a family.

Summary of findings:

Adult literacy programs have been found to positively influence both the frequency and quality of parent-child reading interactions. Family literacy programs have been found to improve children's early literacy development and language skills.

The number of family literacy programs has grown over the past decade, yet there is no one model that explains all variations of parent-child learning situations. Successful programs do, however, share several characteristics. These include: addressing parents' personal goals, valuing families' home languages, viewing families from a resource model rather than a deficit model, providing families access to information and resources that will encourage success for children, and encouraging shared literacy experiences in homes rather than imposing a school-like transfer of skills from parent to child.

One particular program, Project EASE (Early Access to Success in Education), was designed to increase the frequency and quality of language interactions through book-centered activities and to educate parents about and provide opportunities for parent-child interaction. Participating parents worked on improving their literacy skills through parent education sessions, at-school parent/child activities, and at-home book-mediated activities, and they received information about ways to strengthen vocabulary, extend narrative understanding, develop letter recognition and sound awareness, produce narrative retellings, and understand exposition. A yearlong evaluation of Project EASE showed a significant increase in language skills for kindergarten children whose parents participated in Project EASE. The program most dramatically benefited children who were at the greatest risk for heaving reading problems.

A national evaluation of the federal family literacy program Even Start suggested that it had a positive influence on the availability of reading materials in the home, parents' expectations of their children's success in school, and children's skills related to school readiness. However, for both adults and children, the positive effects were either similar to control groups that had not received the Even Start intervention, or, in the case of children, the control group had caught up with the Even Start group by the start of formal schooling.

Reach Out and Read is a book distribution and family literacy program being implemented in pediatric offices. The program consists of three components: 1) placing volunteer readers in

the waiting room, 2) offering counseling about literacy development by pediatricians, and 3) providing books to families of young children. Several evaluations of this program have demonstrated that the intervention increases book-sharing activities in the family, particularly for low-income and Hispanic families.

The parent literacy component of Early Head Start showed significant positive effects on a range of parenting behaviors. Participating parents were observed to be more emotionally supportive, had significantly higher scores on measures of the home environment, provided more support for their child's language and learning, and were also more likely to read daily to or with their children.

Potential barriers to participation in adult and family literacy programs include a shortage of such programs in convenient locations, a lack of awareness among non-literate parents of young children about these programs, lack of transportation to program sites, a lack of child care during program hours, and an inability to cover the cost of the program.

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Parent knowledge and skills

Definition: Parents are well-informed about child development, and know what kinds of parenting behaviors facilitate optimal child learning and growth.

Summary of findings:

Many experts agree that in order for parents to be effective caregivers for their children, they must possess certain knowledge, skills, attitudes and interpersonal abilities. There is a strong consensus that parent-child interaction is enhanced when parents display qualities of sensitivity, responsiveness, reciprocity and support. In addition, parents must know how to facilitate their child's cognitive/language, social-emotional, and physical development and well-being, what are appropriate discipline practices, how to create a safe and stimulating home environment, how to prevent child injury, how to select high quality child care, and possess knowledge about other critical issues that parents of young children must contend with.

Studies indicate that when parents are provided with information, they practice more responsible and safe parenting behaviors which lead to improved child outcomes. A study on the effect of parental education on motor vehicle restraints combined with subsidized devices (i.e. lending car seats) showed improved safety behavior and decreased injury. Educational campaigns about the importance of bicycle helmets combined with legislation requiring their use also proved to be effective.

Another example of parent knowledge leading to better parenting behaviors and improved child outcomes is the Parents as Teachers (PAT) program. PAT is a parent-education program that includes home visiting and begins prenatally or at birth. Home visitors called parent educators teach parenting skills, child development education, and school readiness. Evaluations of two randomized trials of PAT were completed for two communities: 1) Northern California (Salinas Valley) which is primarily a Latino community and 2) four counties in Southern California primarily for adolescent parents. The two evaluations showed small positive effects on parent knowledge, attitudes, and behavior, and no reported gains in child development or health when compared to control groups. Subgroup analyses did reveal that children in Spanish-speaking Latino families benefited more than English speaking families with significant gains in cognitive, communication, social, and self-help development. Analyzing subgroups within the teenager group, those who received both PAT services and comprehensive case management services helped mothers the most. Likewise, families in Salinas Valley that received more intensive services showed more benefits than families with fewer services. Results from the study suggest that home visits (parent education) produced about a one-month developmental advantage per 10 visits for participating children.

While some parent knowledge may be derived through formal classes or programs, family members and service providers - including prenatal care providers, pediatric health care providers, child care, home visitors, and others who have regular contacts with young children

and/or their parents - have an important role to play in educating parents about child development and related issues.

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Parent support programs

Definition: Programs that provide parents with emotional support to enhance their sense of connection to their community and increase their capacity for childrearing.

Summary of findings:

The goal of parent support is to help parents develop and utilize available psychological and material resources to help their families and themselves. Parent support approaches often focus on the social context of parenthood, and on techniques to enhance a family's social network, social support and community linkages as buffers against stress and isolation. Moreover, parent support groups reflect the social and cultural needs of a particular population and help form linkages through referrals and outreach efforts. Some parent support programs are formal programs run by professionals with training in this area. Other programs may be more informal in nature, such as peer-to-peer mentoring or intergenerational support groups run by members of the community.

Less stress and greater family and community support have been shown to increase the quality of parenting. A study showed that single mothers in need of assistance who received help from others showed fewer depressive symptoms and were less likely to punish their children. Evaluations of parent support programs have shown positive short-term effects on child competence, maternal behaviors, and long-term effects on family education level, family size, and financial self-support. One study indicated that the strength of a program's effect is associated with the number of program contacts with a family and the range of services offered to the family.

Cultural competence, or the extent to which the program is sensitive and responsive to the unique needs and attributes of its target population, can present a barrier to participation in parent support programs. This is of particular importance when the target population includes non-English-speaking parents who cannot participate in an English-only support program, or immigrants and others whose beliefs about children and parenting may differ significantly from the general population. Essential features of culturally-competent programs include: 1) treating families with respect, 2) providing choices that identify with family priorities and concerns, 3) helping families make informed decisions, 4) providing support and knowledge that is empowering to parents.

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Parental mental health

Definition: A state of well-being in which parents are able to use their cognitive and emotional capabilities, function in society, and meet the demands of everyday life; a state of well-being in which parents are free of mild to severe mental health problems that would inhibit appropriate parenting practices and the development of optimal relationships with their young children.

Summary of findings:

In the United States in any one year, approximately 13% of adults of reproductive age suffer from depression, and another 2% suffer from panic disorder, indicating that moderate mental illnesses affect large numbers of families and children. Mothers and fathers of children under age 3 are particularly at risk, with rates of depression in these parents estimated at 12-19%. Maternal depression occurs in a mild form in approximately 40% of all mothers and in a moderate or severe form in approximately 10% of mothers during the immediate postpartum period. Severe mental illnesses, including manic-depressive disorder and schizophrenia, are less common, occurring in approximately 2% of the population, but produce greater impairments in parenting than do other mental illnesses. Severely mentally ill parents are at risk for homelessness and substance abuse, further jeopardizing their parenting capacities. While the number of parents with major mental illnesses is small, their service needs, and the costs of failing to address those needs, are substantial.

One of the greatest predictors of social and emotional outcomes is a young child's relationship with his or her parent/primary caregiver, in part because children learn to regulate their emotional responses to individuals and events through their perception of their caregiver's behavior. If a parent responds in a predictable manner to a young child's cues and needs, that child learns to rely on the caregiver to help regulate her response to stressful situations and, over time, begins to self-regulate.

Parental mental illness can interfere with the normal development of parent-child attachment relationships and lead to poor child developmental outcomes. If a parent's responses to a young child's cues and needs are inappropriate, inconsistent or ineffective, the child can experience prolonged episodes of unregulated stress and, in extreme cases, fail to develop self-regulating abilities such as the ability to calm oneself down after being startled or the ability to put oneself to sleep. Studies have shown that depressed parents communicate and respond less to their children's needs and display negative behavior that interferes with their children's language development, problem-solving, and attention. For example, mothers who suffer from clinical depression have difficulty responding appropriately to their infants, are often "out of sync" with their developing children, and frequently fail to respond adaptively to their infants' emotional signals. Studies suggest that these mothers are either more intrusive and controlling, or less attentive and engaged than non-depressed mothers. This prolonged exposure to stress hormones of a young child can even affect the synapses in the cortex, and can conceivably change the physical structure of the brain. The high prevalence of depression, attachment difficulties, and posttraumatic stress among mothers living in poverty

serves to undermine their empathy, sensitivity and responsiveness to their children, placing their children at particular risk.

Parents who suffer from severe or chronic stress, who have substance abuse problems, or who have depression or other mental health problems are less likely than other parents to be able to respond in a sensitive and consistent manner to their child's emotional cues and needs. These parents may need targeted services to both address their own problems and help them develop the skills and behaviors they need to promote optimal social-emotional development in their children. A balance of population-oriented prevention and support services, together with more intensive and coordinated services for higher levels of need, represents the most efficient way to prevent and treat parental mental health problems.

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Parental mental health treatment

Definition: High quality mental health services that are provided to parents of young children in order to identify and treat parental mental illness ranging from postpartum depression to more severe problems such as schizophrenia. Sometimes these services include a case management component. Parental mental health services must address three types of concerns and needs: 1) the relatively low-cost mild mental health concerns and needs of the entire population of parents with young children, 2) the higher-cost, but somewhat less prevalent, issues associated with moderate mental illness, and 3) the highest-cost, but relatively rare, issues associated with severe mental health problems in parents of young children.

Summary of findings:

Programs specifically designed to help parents with mental illness and their families have been developed over the past two decades. Relatively few programs for mentally ill parents and their families are in operation, and there is a great need to integrate and coordinate across and within systems to better serve these families. Through a mail survey to the UMMS National Network mailing list of programs and providers of services of parents with mental illness in the U.S., at least 50 programs for parents with mental illness were reported. Approximately 25 of these programs were specially planned for parents with mental illness and the other 25 programs were for another general population. Programs originated from three basic sources: 1) adult mental health system, 2) child welfare system, 3) inpatient psychiatry units with hospitalized pregnant women. In addition, programs were also formed from state and city homelessness and substance abuse programs. The study found that programs recognized that traditional services did not meet the needs of parents with mental illness. Programs that were specifically created for these parents required coordination of services to meet the complex needs of these families. Programs had similar goals of: 1) addressing basic needs such as housing and financial support, 2) improving parents' coping and problem-solving skills, 3) improving parenting skills, and 4) enhancing child development. Many services also focused only on solving a patient's problem rather than on prevention of future problems.

The services and interventions provided by the programs were very diverse and were categorized by the comprehensiveness and family-centeredness of the services that programs provided. The higher levels of comprehensiveness were related to higher levels of family-centeredness. More comprehensive services usually had case management and home-based services. Several programs had targeted outcomes and the more comprehensive programs tended to have more general goals. Coordination of services and collaboration among providers were important for helping families.

Because of the adverse effects of parental mental illness on young children, services that effectively meet the needs of parents with mild-to-severe mental health problems will promote the well-being of their children. Even simple and inexpensive interventions, such as

improving communication between the departments of mental health, child protective services, child and family services, and general medical services, can have a positive impact in improving parental health and functioning.

Moderators that help lessen the negative impact of the relationship between parental mental illness and child outcomes include spousal or partner characteristics, environmental stress and support, and child characteristics, cognitive styles, and interpersonal skills. Therapeutic intervention may also enhance moderating factors and two intervention programs have shown positive results. First, the Thresholds Mother's Project in Chicago provided comprehensive services for mothers with serious mental illness and their young children (0 to 5 years) (Musick et al., 1987). Mothers attended parent education classes on child development and received mental health treatment. A five-year study of this project showed improved outcomes for both mothers and children. Mothers showed improved attention skills, social adjustment, and adjustment to work and parenting roles. Children had increased scores in Developmental Intelligence, Intelligence Quotient, and social competence and adaptive skills. A second evaluation was on a program for families with a parent with an affective illness. The study showed improvements in parent and child behaviors and attitudes that promote better child outcomes (Beardslee et al., 1996, 1997). The program provided education to parents and children about the parents' illness and the effects of the illness on the family. Positive changes included better family and parent-child communication, increased communication between parents and children about depression, and use of new family/parenting coping strategies. Children showed improved understanding of parental illness, and better adaptive functioning while some showed differences following the intervention.

Barriers to use of parental mental health services include the stigma associated with mental illness, a lack of awareness among parents about the availability of mental health services, a shortage of conveniently located services, an inability of parents to afford to pay for those services, and an inability among pediatricians, child care providers, and prenatal care providers to identify and make referrals for parental mental health problems. These barriers can be addressed through public education and outreach that de-stigmatize mental illness, through the availability of both privately- and publicly-funded counseling and social service at locations such as WIC sites, child care centers and schools, and through provider education and training about parental mental health problems.

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Parental Physical Health

Definition:
Good physical health is a state of well-being that includes more than the absence of disease or illness. Having good physical health also has do to with physical fitness and taking care of one's body by eating well, exercising, and practicing behaviors that promote good health and prevent future problems.

Summary of findings:

As caretakers and role models of their children, parents should take care of their own health to set a good example and be physically capable to care for their children. Taking care of young children requires stamina and endurance. Healthy parents may have more energy and as a result be more available and attentive to meet the needs of their children. A study shows that children ages 0-5 who have low-income single parents in poor health are less likely to be read to on a daily basis. Single parents bear greater responsibility for the care of their children and those in poor health may not have sufficient energy levels for quality interaction with their children every day.

To maintain good health, parents should eat well and exercise to stay physically active. Parents who require medical treatment should follow recommendations of a physician to maintain good health so that they can spend quality time with their children. Prevention of future complications is also important to prolong an active, healthy life. Eating well and staying physically active as well as having safe and healthy habits promote positive behaviors that children can learn from through example. Wearing safety belts while driving a car, deciding not to smoking, and avoiding excessive intake of alcohol are habits that promote good health. Good health is an investment for a better future and the amount of return is dependent upon how well one takes care of his or her body. Choosing to exercise regularly and eat a well-balanced and nutritious diet along with making other decision that lead to positive behaviors lead to better health. Parents who frequently and consistently make choices that prevent poor health and favor their own good health are also helping to enhance their young children's developmental outcomes.

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Parents provide a safe and healthy home environment

Definition: Parents use knowledge about child safety to protect their children from accidental and intentional injury both in and out of the child's home.

Summary of findings:

An average yearly medical cost from childhood injuries is estimated to be greater than $117 million for children ages 0-5 years in California (1996-97). The California Health Interview Survey (CHIS) shows that few young children (6.5%) sustain injuries that are serious enough to require medical advice or treatment. Injuries are more common among toddlers and children of preschool age than among infants, affecting 7.6% of children 3-4 years, 7.7% of children 1-2 years, and 1.9% of children under one year of age. These injuries result from many different types of accidents. The most common single reason for accidents is an accidental fall (43%). About 7.8% of injuries requiring medical attention are caused by motor vehicles or by bicycle injuries. Most accidents occur in the home (60%). Other common locations for injuries are at school, day care, and recreation areas.

Home safety measures such as padding sharp corners, turning down the thermostat of the hot water heater, and locking cabinets can reduce injuries for young children. Riding unrestrained is the greatest risk factor for death and injury among children riding in motor vehicles. In 1996, it is estimated that 85 percent of infants (children under age 1) were restrained while riding in motor vehicles. However, data on restraining children in motor vehicles declined as a child's age increased. Only 60 percent of children ages 1 to 4 and 65 percent of children ages 5 and over were restrained by child safety seats or safety belts. Unrestrained children are more likely to be injured in motor vehicle crashes than children who have protection from a child seat or seat belt.. When used correctly, child safety seats reduce the risk of death by 71 percent for infants (under age 1) and by 54 percent for toddlers (ages 1 to 4). Moreover, child safety seats reduce the need for hospitalization by 69 percent for children ages 4 and under. It has been estimated that in 1995 about 280 children from ages 0-4 were saved as a result of child safety seats. Child safety seats and safety belts reduce health care costs by preventing injury and decreasing the numbers of children hospitalized for motor accidents. Children who are not placed in safety seats and do not wear seat belts are more severely injured in accidents and have shown to have hospital costs of 60 to 70 percent higher than children with safety restraints. The CSN Economics and Insurance Resource Center estimates that every child safety seat saves the United States $85 in medical costs and $1,275 in indirect costs to the public.

Research has shown that one of the most important predictors of unintentional childhood injury at home is a lack of information among parents about how to prevent it.

A study reviewed literature to provide information about the most effective forms of safety interventions. Examples of interventions that have been effective in reducing unintentional child injury include: bicycle helmet legislation, area wide traffic calming measures, child safety restraint legislation, child resistant containers to prevent poisoning, and window bars to prevent falls. Interventions effective in changing parental behavior include bicycle helmet education and legislation, child restraint legislation, child restraint loan schemes, child restraint educational campaigns, pedestrian education aimed at the child/parent, provision of smoke detectors, and parent education on home hazard reduction. Parent education on the use of seat belts and child safety seats has been shown to be effective in increasing overall driving safety. Training parents about safety at home has also shown benefits in reducing hazards by keeping chemicals out of the reach of children and installing safety appliances to protect children from harm. Moreover, parents who believe in practicing safe habits and understand risk are more likely to model responsible behaviors to their children.

According to official government data, 1.2 % of children are seriously maltreated each year. This statistic is widely believed to be an underestimate. Studies of adults who were sexually abused during childhood indicate that only about 10% of children report abuse to a professional.

Child abuse and neglect is associated with both short and long term negative effects on child development. Children who are victims of abuse or neglect have been shown to have reduced scores on tests of academic performance, lower social competence and self-control, show less empathy for others, have difficulty recognizing others' emotions, and are more likely to be insecurely attached to their parents. Adults who were abused as children are at a higher risk for developing psychopathology.

Factors within the parental background affecting risk of child abuse include parental age, educational attainment, and history of psychiatric illness. For mothers specifically, history of sexual abuse and absence of her father during childhood have also been shown to predict child abuse. Domestic violence during the first 6 months of child rearing is also significantly related to child maltreatment.

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Parents provide child nutritious diet

Definition: Children eat healthy, nutritious, age-appropriate foods that promote optimal growth and physical development.

Summary of findings:

Children must receive sufficient calories and nutrients for healthy growth and development, and develop healthy eating habits early in life in order to avoid major health problems such as obesity and heart disease later in life. In addition to promoting optimal growth and physical development, an adequate amount of required nutrients is also important for optimal brain development and function.

Barriers to children receiving a nutritious diet are lack of knowledge among parents about what children should be eating, poor parental eating habits, and parents' inability to afford nutritious foods for their children.

To overcome some of these barriers, federal programs including the Food Stamp Program, the National School Lunch Program, WIC and TANF provide low-income families with in-kind transfers of food or by providing cash or vouchers that can be used to purchase food.

However, the 2001 California Health Interview Survey (CHIS) data revealed low participation in these programs among eligible adults: among the estimated 4.95 million adults in families with incomes low enough to be eligible for food stamps, only 10.2% reported actually receiving food stamps, and among adults below 130% of poverty who experience hunger, 80.5% (approximately 358,000 adults) were not in the Food Stamp Program.

Service providers including prenatal care, pediatric care, child care, and others who have regular contacts with young children and/or their parents have an important role to play in educating parents about the best diet for their children.

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Parks and Playgrounds

Definition: Outdoor area set aside for recreation, exercise, and play. Parks and playgrounds may have equipment such as swings and slides.

Summary of findings:

Parks and playgrounds are outdoor spaces where young children can play with peers and develop motor skills. Engaging in physical play with other children helps a child develop social skills and build relationships. Playground equipment provides opportunities for young children to apply their imagination and learn new physical activities. Learning how to climb and run are examples of exercise that help young children improve their physical strength and endurance. Exercise is an important component of a healthy lifestyle and has also been shown to help reduce stress and increase self esteem. All children feel a sense of accomplishment as they successfully achieve new activities. Special playground equipment should also be available for children with special needs so that they can enjoy physical play and exploration.

According to the National Program for Playground Safety (NPPS), over 200,000 children are injured on America's playgrounds each year. Safety guidelines and injury prevention should be followed by parents and developers of playgrounds so that young children will be protected from harm. Parents should supervise young children and note the playground equipment's safety standards before their children play. When children play outdoors, parents should also make sure their children wear sufficient sunscreen to protect from harmful UV rays. As children grow, they should be encouraged to follow safety guidelines and learn about the benefits of exercise to better enjoy playtime activities.

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Pediatric health care

Definition: Children have access to well-trained pediatric health professionals who in addition to providing well-child care, immunizations and treatment of childhood illness and injury can perform developmental assessments that identify physical, mental and developmental disabilities and problems, make referrals to appropriate specialists for treatment, and provide anticipatory guidance to parents about a range of critical issues relating to the health and development of their young children.

Summary of findings:

Regular consultations with a pediatrician, family physician, or other health care provider with expertise in children's health are essential to ensuring early detection and diagnosis of health and developmental problems. However, while access to a health care provider is necessary, it is not sufficient to ensure that children receive the package of preventive and developmental services they need. Without appropriate content and quality of health care, many cognitive, speech, language and other developmental problems and issues will go unidentified, parents will not receive important counseling to help the, stimulate their children's cognitive and social-emotional capacities, and children's health and school readiness will be in jeopardy.

Pediatric health care represents a major opportunity to promote children's health and development since, in the majority of cases they see both young children and their parents more frequently early in a child's life than any other service provider. Moreover, studies indicate that parents are very likely to listen to take appropriate action on behalf of their children in response to advice from a pediatrician or nurse, so that these providers have an real opportunity to influence parenting knowledge and behaviors in a positive way.

Unfortunately, available evidence suggests that many pediatric health care providers are ill-equipped to address the psychological, social, economic and environmental determinants of health, utilize individual and community-based health promotion and prevention strategies, and advocate on behalf of children and families for more comprehensive and integrated community-based services.

Barriers to pediatric health care in terms of access may include a shortage of such providers, a shortage of culturally competent providers or providers of the same racial or ethnic group as families with young children, and a lack of health insurance coverage among many families with young children.

Barriers to pediatric health care in terms of quality may include inadequate time during the office visit, inadequate training of physicians, ineffective clinical practices in terms of physicians' ability to communicate effectively with parents, a lack of connection between pediatric health care providers and other community-based service providers, and insufficient reimbursement rates to incentivize the provision of developmental services.

Access to routine health care is particularly problematic for children with special health care needs, especially those who are poor, minority children who live with their mother or someone other than their parents, or those without insurance or an identifiable regular medical provider.

Many of these barriers could be remedied by strategies such as increased insurance reimbursement rates, improved provider education and training, and integration and coordination of health care and other services for young children and their families.

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Pediatric health care provider education and training

Definition: Pre-service classes or programs that prepare pediatric health care providers to optimize the health and well-being of the children they serve; in-service education and skill-building opportunities for current pediatric health care providers that enable them to improve the quality of the services they provide.

Summary of findings:

Pediatric health care provider education and training is key to ensuring high-quality pediatric care, which in turn plays a key role in promoting the health and development of young children. However, available evidence suggests that existing education and training for pediatric health care providers is often insufficient to enable these providers to meet the needs of young children and families.

Physicians receive only 1-2 months' exposure to child development in their residency training, which is inadequate to acquire the basic knowledge and clinical skill to provide individualized developmental care to families. In addition, physicians spend their entire training experience perfecting skills based upon a medical disease model that is inappropriate for most developmental and behavioral concerns, which are not diseases and which exhibit a wide range of normative variation. Finally, physicians receive little clinical training in effective communication techniques that are crucial to helping parents make adjustments around developmental issues.

Addressing this gap in the quality of pediatric health care provider education and training will require innovative approaches to ensuring that these providers have the skills and tools needed to provide high quality health care, identification of and referrals for problems, and anticipatory guidance and support to young children and their parents. It will be critical for these approaches to include more than the traditional competencies most medical schools focus on, and to recognize that the determinants of child health are not limited to biomedical factors but also encompass complex emotional, social, economic, and environmental influences.

A groundbreaking program at the UCLA Medical School – the Community Health and Advocacy Training Program in Pediatrics (CHAT) – is 1) preparing residents to assume roles as active community collaborators in future pediatric practices, 2) transforming the academic generalist and specialist care model by integrating new knowledge, tools, and skill development that enhance the pediatrician's ability to promote health and development and prevent disease and disability in the context of family and community needs, 3) equipping residents, faculty and community practitioners with skills and competencies to act as effective leaders and agents of change in their respective communities, and 4) engaging community advocates, providers, and families in the collaborative development of an exemplary comprehensive, community-based pediatric training and care program.

In addition to improving pre-service provider education and training, education linked to quality improvement strategies should be promoted for child health providers who are already

practicing. This would go beyond routine continuing medical education (CME), and would utilize practice reengineering techniques that have been demonstrated to be effective in other clinical areas, such as the approach that the National Initiative for Children's Healthcare Quality (NICHQ) is spearheading. In addition, efforts such as Bright Futures – the Department of Health and Human Services' program that offers existing providers materials, tools and training regarding the provision of health supervision to families of young children – have been found to be effective.

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Pediatric oral health care

Definition: Providers that offer young children preventative care and treatment of oral health problems. Specific services provided include teeth cleanings, fluoride treatments, sealants, the provision of hygiene instructions and recommendations for dietary changes as needed to promote oral health, and the identification and treatment of developmental problems of teeth.

Summary of findings:

Studies suggest that children from minority groups, homeless children, low-income children, and children with special needs receive fewer dental health services than other children, and therefore show a greater frequency of oral health problems. This is true despite the fact that low-income children are actually more likely than other children to have dental insurance through public health insurance programs, indicating that barriers other than a lack of insurance are leading to infrequency use of pediatric oral health services among these populations. Such barriers may include a lack of education for parents about the importance of these services, a lack of knowledge among parents about the inclusion of these services in their insurance benefits package, and a shortage of pediatric dentists from particular racial or ethnic backgrounds.

Research indicates that annual dental exams provide preventive care, facilitate early diagnosis and treatment of oral health problems, and prevent the development of chronic oral health problems among young children. Untreated or chronic oral health problems can cause severe toothaches, oral abscesses, destruction of bone, and spread of infection via the bloodstream, and can also result in other health problems due to inability to eat healthy and nutritious foods and insufficient sleep due to pain. Untreated or chronic oral health problems can also inhibit children's concentration and engagement in educational and other activities that help prepare them for and succeed in school. Finally, the pain and infection resulting from untreated or chronic oral health problems can cause speech problems in young children.

Dental insurance has been shown to increase utilization of pediatric oral health services and children's oral health (except in certain populations as noted above), although many children in the United States – more than 11 million in 1998 – had no such insurance. Having an adequate number of pediatric dentists available in the community also permits more widespread use of oral health services.

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Preconception and prenatal care

Definition: Health care for women of reproductive age that offer preconceptional counseling and family planning services in addition to a range of regular health care services; health care specially designed for expectant mothers that monitor their health and the health of their fetusus, and offer information about proper nutrition, exercise and behavior during pregnancy, as well as information about optimal parenting practices and behaviors that will benefit children after birth and throughout childhood. Preconception and prenatal care providers should also be able to identify problems such as depression, substance abuse and domestic violence, and make referrals to appropriate specialists and treatment programs.

Summary of findings:

A review of the literature on the benefits of preconceptional and prenatal care indicates that these services promote healthy behaviors both during and following pregnancy that are associated with healthy births and improved child developmental outcomes. These include breastfeeding, good nutrition, exercise, infant safety, home safety, regular checkups, and immunizations. Prenatal care can also reduce risk-taking behaviors including unhealthy nutrition and stress that have been shown to adversely impact children's health and development. Finally, prenatal care has been shown to reduce the obstetrical and neonatal complications of perinatal substance abuse.

Despite the improvement in prenatal care utilization, significant disparities in its use persisted among different populations in California . Pregnant women who are racial minorities, have less than 13 years of education, are teenagers under 20 years of age, are unmarried, or have Medi-Cal are less likely to receive early prenatal care. The strongest and most consistent barrier to early and adequate prenatal care is the low valuation of prenatal care in the eyes of both expectant mothers and providers. Other barriers identified include transportation difficulties, inhospitable institutional practices (long waits, poor communication, inconvenient clinic hours, rude personnel, culturally incompetent surroundings, and complicated registration procedures), fear of doctors and medical procedures, ambivalence or denial about pregnancy, and lack of a partner or family support.

Barriers to preconceptional care include the fact that many American women do not know about it. In addition, many providers are unaware of the benefits of preconceptional care and therefore fail to promote it. Another barrier is the perception that preconception care is for women who are actively trying to get pregnant.

Cultural competency presents a major barrier to both preconception and prenatal care, yet there is little monitoring to ensure cultural competency in preconception and prenatal care. Finally, there is currently inadequate coordination of various prenatal services among different providers, such as weak links between prenatal services and pregnancy testing sites, and poor service coordination between prenatal care providers and WIC program, to enable identification of and referral for various problems.

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Preconception/prenatal care provider education and training

Definition: Pre-service classes or programs that prepare women's health care providers to optimize the health and well-being of the women they serve; in-service education and skill-building opportunities for current women's health care providers that enable them to improve the quality of the services they provide.

Summary of findings:

Training prenatal care providers is important to ensure that the health, education, and support needs of pregnant women and mothers, and the health and developmental needs of their young children are met. Prenatal care encompasses a range of services and sets the healthy development and well-being of mother and child. For this reason, it is important to integrate services and cross-train those who directly provide care to pregnant women to provide the most comprehensive care. The family physician can provide guidance through preconception care to birth. Designing a curriculum and delivery system in family medicine training programs would be useful.

In some circumstances, prenatal care providers can directly affect early childhood development. Examples include: support of breastfeeding by the obstetrician. identification and referral of the mother with postpartum and persistent depression or other mental health problems, and promotion and counseling on good nutrition by the midwife or the health educator. These opportunities to enhance early childhood development by prenatal care providers are largely missed today because of systems fragmentation. It is our hope that Proposition 10 will provide the "glue" for a more integrated, more seamless system that will better serve women and children in California.

Proposition 10 monies can be used to support local efforts to cross- train the reproductive health and children's health care workforce. For example, prenatal care providers can be trained to discuss parenting, family planning providers can be trained to screen for childhood immunization, and well-baby care providers can be trained to promote preconceptional care. Title V or Title X funds can also be leveraged for these efforts.

A recent study found that internal medicine residents' levels of preconception care knowledge and management skills were low while their attitudes on learning were high. This suggests that the current curriculum for primary care training in internal medicine should be improved so that residents are better prepared to provide preconception care to women of reproductive age.

Another study shows that training prenatal care providers on to provide guidance on preterum labor (occurring less than 34 weeks) can increase patient education and opportunities for preventive treatment. In this case, prenatal care providers were asked to provide knowledge

on and distribute literature on preterm labor (PTL) and preterm birth (PTB) to their patients. Statistically significant increases were found in providers who had educational material about PTL and PTB, who reported giving the educational material to all women, and who reported talking about signs and symptoms of PTL and PTB with all women. Women also were more likely to report that their prenatal care providers talked with them about PTL and PTB. The study also found an increased number of babies born preterm who received antenatal steroids to ensure normal lung development and to prevent the incidence of respiratory distress syndrome (RDS). These results show that providing knowledge and materials to health care providers can help increase preventive care and educate women about PTL and PTB.

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Substance abuse treatment for parents and expectant mothers

Definition: Support programs, case management, and treatment services that help parents overcome their addiction to alcohol, tobacco and elicit drugs.

Summary of findings:

Parental substance abuse is widespread. According to national surveys, as many as 11% of all newborns have been prenatally exposed to illicit drugs. (This figure greatly understates the extent of prenatal exposure in that it measures drug use only with days before delivery and doesn't take into account prenatal use of tobacco or alcohol, which have a potentially more serious prenatal effect in terms of numbers of children effected and the magnitude of those effects.) Up to 11% of children in the U.S. live with a parent who is an alcoholic or needs treatment for illicit drug abuse.

Many studies have shown that substance abuse negatively affects the physical and mental health of young children, and that by identifying and addressing parental substance abuse problems, sub-optimal child cognitive and social-emotional development can be averted. Parental substance abuse can have a lasting effect on young children's health and well being through prenatal or early childhood exposure. Examples of its effects range from mental retardation and neurodevelopmental deficits to low birthweight and asthma, to the failure of young children to form secure attachments because of their parents' inability to give them sustained attention. Tobacco in particular has profound consequences both before and after birth. It adversely affects the supply of oxygen and nutrients to the fetus and has a generally negative effect on both development and survival.

Only a small percentage of children and families in need of services because of parental substance abuse are ever identified or receive services. Some of the barriers to parental substance abuse treatment and related services for affected children and family members include poor identification of exposure and risk among both parents and children, inadequate prevention efforts that eliminate or reduce substance abuse among parents, inadequate public education about the effects of even relatively mild parental substance abuse problems, and a shortage of interventions targeted to young children whose parents are substance abusers.

Successful substance abuse programs include several emphases:

- Services to the whole family rather than programs that address children's and parents' problems separately
- Repeated client engagement, since clients who stay in treatment longest have the best outcomes
- Non-ATOD services—including job services, mental health counseling, and health services—to women who have many problems besides their addiction
- Child development services built into treatment programs
- Treatment that includes after-care and follow-up services

- Interagency coordination: A program run by a single agency may lack needed connections with other agencies whose support is critical to program success
- A clear focus on frontline services—e.g.,WIC programs, pediatricians' or obstetricians' offices, family planning clinics—where young children or women in their child-bearing years are most likely to be seen by professionals and others able to detect ATOD-related needs

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Systems change/infrastructure building

Cultural competence

Identifying the cultural values and beliefs of people from various backgrounds should be considered when providing services to a diverse population. A program that values diversity, respects different cultures, and incorporates the cultural and linguistic needs of families requires frequent evaluation to make improvements in service delivery. Four recommended strategies to integrate cultural competence into programs are discussed.

First, people should be hired who reflect the racial, cultural and linguistic background of the children and families being served. Those providing direct services should communicate in the same language as the children and families of the community. Speaking the same language not only allows communication but also leads to a better understand of the needs of the population served. In addition, workers should identify with cultural and/ or racial issues that are integrated in the lives of these children and families. Second, to improve cultural competence there should be increasing awareness and understanding through (in-service and pre-service) professional development. Training staff by providing knowledge and teaching skills to enhance understanding and awareness of culture is an important component. Third, parents should receive education about the implications of diversity for child rearing and child care. Having parents understand that the child care center values diversity and is making an effort to incorporate the various cultural backgrounds of the children will unify parents. Fourth, engaging individuals from the served communities in program design and making policy decisions will help shape strategies for integrating cultural competence. Both families and child care providers should engage in an interchange of ideas to make planning decisions that reflect the cultural values and needs of the community.

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Partnerships
Service integration/ coordination

- Number of partnerships and/or formal collaborations formed by service organizations as a result of First 5
- Number/percentage increase in the number of agencies providing services at shared locations (co-located services).

Interactions among a comprehensive set of service components make up an early childhood development system. Opportunities to improve a system result through changing the interactions of these elements. By enhancing coordination of existing resources, better results are achieved through a more efficient process. Stronger, more comprehensive linkages across levels can occur if organizations work together and programs focus on the broader goal

of early childhood development. Research has shown that providing young children with coordinated services including a stimulating learning environment, quality health care, and a caring, safe home environment, leads to prevention and early intervention to attain more positive developmental outcomes.

The Linkages for Prevention project was a three year study beginning in July 1994 that took place in Durham, North Carolina. This study designed, implemented, and assessed a health-care system to improve the organization and delivery of preventive services for children under age 2 and their mothers (mostly low-income). The goal was to change the processes of preventive care delivery by integrating fragmented organizations and improving delivery of services. As a result of changing the processes of delivery, positive effects in children's health outcomes were expected. The researchers developed a health care system-level approach to combine multiple care delivery processes at three levels: community, practice, and family.

Policies that combine funding streams to support multi-level interventions will help provide services to other communities. For community-level interventions, the focus should be on building leadership, working on coordination of organizations, and developing financing strategies to affect change. At the practice-level, interventions should create plans to implement, spread, and sustain innovative strategies. Finally, family-level interventions should provide families with training and skills to enhance their outcomes. The system as a whole should work together and improve each component's function. As a result, the system should provide a more efficient delivery process that expands its services to reach more families.

Partnerships help bring service providers together to aggregate resources and more effectively and efficiently serve populations in need. By integrating service providers, families in need of services may receive support and guidance for multiple, complex needs. Many families require multiple services such as a child care for an older sibling, prenatal care for the mother, and health care for the entire family. If one center provided various services and made referrals for others, the family would save time and resources in receiving support.

Many individual programs provide similar services and are fragmented. Moreover, providers compete for funding and a more efficient system would result if these services consolidated to provide integrated and coordinated services. By avoiding duplication and coordination of similar strategies, the community would receive better and more complete services. These problems can be resolved by service providers working together and providing centers that offer comprehensive services. Gardner recommends that groups learn to work together through four levels of increasing interaction. First, information should be exchanged to learn what other agencies are doing and how they are serving children and families in the community. Second, joint projects should be planned, and partners should recognize that through collaboration goals will be accomplished that could not be achieved without working together. Third, creating a system made up of more than one agency requires working together to change the rules. Communication among different service providers and redesigning rules can be a major barrier to integrating services. To overcome this barrier, all agencies and service providers must work together by sharing responsibility in planning and creating new rules. Fourth, the system as a whole must also change in order for all

components to operate efficiently. Integration of services takes effort and time from all agencies and requires sharing a vision of providing services for children and their families through an effective and efficient system.

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Margolis PA, Stevens F, Bordley WC, Stuart J, Harlan C, Keyes-Elstein L, and Wisseh S. (2001). From Concept to Application: The Impact of a Community-Wide Intervention to Improve the Delivery of Preventive Services to Children. Pediatrics. Vol. 108. No. 3 September 2001.

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Funding sustainability

- Number/percentage of funded programs that have a fund raising plan for current year and for at least 1 year into the future.
- Number/percentage of funded programs with long-term funding sources.

Tobacco taxes are likely to be a declining source of revenue. Therefore, the county commissions should plan for the sustainability of new initiatives from the outset. They should be cautious about initiating new programs and services that may be unsustainable, and they should actively consider ways to make their dollars go further. This may include using them to leverage other federal and state funding, creating more flexibility in existing categorical funding streams, developing public-private partnerships, and seeking ways to make the best (or better) use of dollars already in the system, including using new resources to influence the expenditure of existing appropriations. An important foundation for sustainability is an outcomes-based accountability framework. Proposition 10 commissions will more effectively be able to engage partners and leverage resources if they can document that their work is achieving desired results.

Issues for Consideration:

- What financing strategies will make the money go further?
- Are there ways to manage the new funding so that it grows and expands the funding base?
- What efforts will be needed to build and sustain stable public support so that California counties have the resources and the flexibility to respond effectively to changing needs and priorities in the future?

Hayes C, *Financing Early Childhood Initiatives: Making the Most of Proposition 10,* in N Halfon, E Shulman, M Shannon and M Hochstein, eds., Building Community Systems for Young Children, UCLA Center for Healthier Children, Families and Communities, 2000.

Community empowerment

- Number/percentage of families receiving First 5 funded programs who participate in the planning and evaluation process.

Providing communities with knowledge about child development will generate greater awareness. A knowledgeable community will be more likely to address the needs of the community at large. As community members learn about factors necessary for optimal child development, they will request effective strategies. Moreover, community members will become more involved with funding and organization activities of services and resources that support such initiatives.

Data system development/Accountability

- Number/percentage of First 5 funded programs who successfully use the shared data collection software.
- Number/percentage of kindergarten classrooms participating in annual school readiness assessment.

Developing a cohesive and integrated data system enables a community to not only view records of services provided, but also allows for program evaluation of services. A program evaluation would allow for revising strategic planning and examining outcomes to make informed decisions that better meet the needs of the community served. Evaluation of process and outcome measures provides accountability to the community to show that the outcomes of the initiatives match the needs of the children and families receiving services.

Transportation

Definition: Method of carrying people from one place to another usually by a vehicle such as a car, airplane, train, or bus. Subsidized travel and the use of public transportation can help eliminate barriers for families to acquire needed services and commute to workplaces.

Families who do not own a car or do not have access to public transportation face travel barriers and may often depend on others to reach a particular destination. Other family members or friends may offer assistance in traveling to a doctor's appointment or getting to a parent-teacher meeting at school. However, on a daily basis, the extra time and planning required to travel may hinder families from accessing services. Overcoming these obstacles requires solutions through transportation subsidies and increased access to public transportation so individual families can gain independence in commuting to their jobs and acquiring needed services. Transportation at little or no cost can help eliminate barriers to access health care and find more employment opportunities that are further than walking distance. Public transportation is a common way for members of a community to go to work, access health care and child care, and shop at grocery stores. Common modes of public transportation include buses, trains, and metro rails. Subsidies and other types of financial assistance for acquiring transportation can help low-income families obtain reimbursement for traveling expenses to and from work and service providers. Therefore, by offering transportation assistance to those in need, more families are able to gain independence by earning a living and reaching needed services such as placing their children in child care.

The U.S. Administration of Children and Families (ACF) recognizes that by offering financial assistance to obtain transportation, families will be better able to meet their needs. Examples of solutions that the ACF recommends in eliminating transportation barriers include: providing transportation allowances and transit passes, arranging for agencies to share costs of transportation services, investing in commute projects to improve transportation networks to employers, and reimbursing clients for work-related and job seeking travel expenses. Other innovative strategies proposed by the ACF include contracting with private companies to provide used cars to TANF recipients/financial support to provide a car and subsidize costs of transporting needy children to child care. The Southern Institute on Children and Families suggests that a regional work group made up of public and private agencies involved in transportation services to create ways to improve access to transportation for low-income families. They suggest that the work group identifies strategies to coordinate transportation services to better serve these families. In addition, especially in rural areas, the work group is encouraged to find ways to help low-income families to acquire personal automobiles. The Institute also suggests further assistance to low-income families who own a car to stop automobile asset testing for families applying for child health coverage, child care assistance and other benefits. These strategies are examples of solutions to help low-income families to better access transportation so that more families benefit from services and reach employers.

References:

The Southern Institute on Children and Families. http://www.kidsouth.org/transportation/ For more information, see the Southern Institute's resulting report published in February 1998, *Southern Regional Initiative to Improve Access to Benefits for Low Income Families with Children*

The U.S. Administration of Children and Families (ACF) http://www.acf.dhhs.gov/programs/ofa/funds2.htm

Treatment for children with developmental delays

Definition: Children with cognitive and learning disabilities such as speech or language problems, attention deficit disorders and any other problems that might interfere with a child's growth and development are identified and treated by a qualified professional.

Summary of findings:

According to a national report of American children by the Federal Interagency Forum on Child and Family Statistics, among children with behavioral or cognitive limitations, 21% have attention deficit disorder (ADD). According to ADD, the following are percentages of children with specific behavioral/developmental conditions that limit activities: 17% mental retardation, 10% learning disability, 9% autism, and 43% other. About one-quarter (23%) of young children with problems that limit daily activity have a behavioral or mental health condition, and only a small percentage of children with an activity limitation (5%) have both a physical and mental condition. Young children with cognitive and language disabilities who are not exposed to formal intervention generally exhibit compromised performance on standardized developmental measures.

High quality interventions can help young children with developmental delays or disabilities achieve short-term gains on standardized cognitive and social measures, with the benefits of treatment for varying depending on type and severity of the disability. Few interventions have been shown to lead to long-term benefits for these children, although several studies have shown that children with autism who receive intensive preschool interventions and specialized services in middle school continue to show improvement. When interventions for young children with developmental disabilities are more structured and focused on the child-caregiver relationship, greater improvements in cognitive and social-emotional outcomes have been found.

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Shonkoff JP and Hauser-Cram P. Early intervention for disabled infants and their families: A quantitative analysis. Pediatrics 80:650-658.

Treatment of chronic disease and disabilities for children

Definition: Children with chronic disease or physical disabilities receive services that either alleviate or manage these problems in order to minimize their adverse effect on child development and participation in everyday activities. Chronic disease includes non-communicable diseases such as cystic fibrosis, juvenile diabetes, asthma, epilepsy, juvenile arthritis and haemoglobinopathies. These and other special health conditions typically require comprehensive, ongoing care, rather than a "diagnose and treat" approach, and patient support and a multidisciplinary team of care providers may be necessary.

Summary of findings:

It is estimated that by the year 2020, chronic conditions will contribute to more than 60% of the global burden of disease. One quarter of TANF-enrolled children have chronic illnesses.

CHIS shows that approximately 3.4% of California children under age 5 have a physical, behavioral, or mental condition that limits or prevents a child from participating in age-appropriate childhood activities (CHIS survey). The majority (64%) of young children in California with an activity limitation have a physical condition. Asthma is the most common chronic health condition affecting young children, and about 10% of young children ages 1-4 years in California have ever been diagnosed by a doctor as having asthma. According to a national report of American children by the Federal Interagency Forum on Child and Family Statistics, among children with physical limitations, 33% have asthma. Following asthma, here are percentages of children with specific physical conditions that limit activities: 12% cerebral palsy, 11% vision difficulties, 6% neuromuscular disorder, 4% hearing problem, and 34% other. About one-quarter (23%) of young children with a condition that limits daily activities have a behavioral or mental health condition, and only a small percentage of children with an activity limitation (5%) have both a physical and mental condition.

To the extent that chronic disease and physical disabilities interfere with a child's ability to interact with other children and form lasting relationships with peers, these problems can negatively impact a child's social-emotional development and mental health, and their success in group settings such as schools. Certain problems, such as ear infections that lead to loss of hearing, can pose a threat to children's speech and language development, and therefore their cognitive success.

A literature review on medical care for children with chronic childhood illness shows that the impact on overall child development has more to do with the illness, degree of disability, and function of the family than on the specific diagnosis. Prognosis, medical information, and predictability allow for greater control and management of an illness. The threat of an illness to a child's life and development, the need for medical intervention, and conditions that limit activities all affect a child's life experience. The entire family is affected by a child's illness and care that addresses needs and concerns of both the child and family will be more advantageous. By providing education and support to the whole family, the family gains control

and functions together to help the child. Another aspect that promotes stability is continuity of care by setting and provider. Both the setting and provider can offer coordination of all services and specialists necessary to meet a child's needs. Coordinating various services not only offers more comprehensive and better care, but the manageability of a child's illness also increases. A provider that is available to coordinate care with a child's preschool or day care and interacts with parents to give medical guidance regarding daily concerns, will help the family learn the best way to support their child's health. A provider that addresses non-disease dimensions such as a child's self-esteem and interaction with peers, enhances a child's social, emotional, physical, and cognitive development. Coordination of both non-disease and disease-based care offers greater predictability and control for a child and his or her family as well as better developmental outcomes for the child.

A recent national child health survey found that there is substantial variation in access to routine medical care among children with special health care needs, indicating that many of these children probably are not receiving appropriate treatment for these problems. Poor, minority children who lived with their mother or someone other than their parents, or those without insurance or an identifiable regular medical provider, were most likely to experience financial barriers to access or were less apt to seek care than other children with comparable needs.

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Limitations in usual childhood activity may be caused by time-limited, acute problems such as fractures in addition to longer term, chronic conditions. For those children identified with an activity limitation, CHIS asked parents to identify the type of condition (physical, mental or emotional problem) that affects the child as well as the specific condition from a list of the most common chronic conditions. *America's Children: Key National Indicators of Well-Being 2002*. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office.

Ultimate Outcomes

The three ultimate outcomes leading to school readiness were adapted from the National Education Goals Panel (NEGP) recommendations for children's readiness for school. The NEGP states that a child's school readiness is determined from:

- Physical well-being and motor development
- Social and emotional development
- Approaches to learning
- Language development and communicative skills
- Cognition and general knowledge

The NEGP defines each of these components as follows:

Health and physical development

Healthy children enjoy a robustness that allows them to engage actively and vigorously in the full range of life experiences. Alert and energetic, they are able to give their full attention to learning experiences. When children do have health problems, treatment is essential to prevent harmful effects on children's school preparedness and success. In many cases, children with disabilities or chronic health problems are able to use their other strengths to compensate for the difficulties they experience from a potentially limiting condition. Children's health - which is repeatedly linked to school performance by a growing body of research - is clearly an important thread in the complex fabric that is school readiness.

Emotional well-being and social competence

Children's school experience is more positive and productive when they have a sense of personal well-being, grounded in stable, caring relationships in their early lives. Unhappy, fearful, or angry children are preoccupied, unable to give their full attention and engagement to learning experiences. A solid base of emotional security and social competence enables children to participate fully in learning experiences and form good relationships with teachers and peers. In building and maintaining such relation ships, key social skills are: respecting the rights of others, relating to peers without being too submissive or overbearing, being willing to give and receive support, and treating others as one would like to be treated. To the extent that children develop these social skills and attitudes, they function better in the school setting.

Approaches to learning

Just as we adults approach our lives and work in different ways, children vary widely in their approaches to learning. Some children are intellectually playful and open to new learning tasks, while others are more deliberate and slower to experiment or take on new challenges. Following through on difficult tasks is

natural to some children but foreign to others. Some children are far more reflective than others. Although the phrase approaches to learning as an umbrella term for individuals attitudes, habits, and learning styles has only recently been adopted by educational researchers, the concept is not new to anyone who knows children. We cannot help but see that children's school success, like adults effectiveness in the workplace, depends not simply on academic skills but also on motivation, learning style, and habits and attitudes.

Communicative skills

Through language, children are able to learn and communicate many things, from finding out how people in other countries live, to telling school friends about something that happened at home. In the course of their communication with teachers and peers and eventually in reading and writing, children construct understandings and acquire knowledge related to various school subjects. Language proficiency has long been recognized as a key predictor of school success, and it is important to emphasize that skills of communication go far beyond vocabulary or grammar. Moreover, research has begun to document the wide variations in how children show their language competence, partly as a function of the differing cultural and linguistic experiences they have had.

Cognition and general knowledge

To live is to learn, and by the time children enter school, they have already taken major steps in becoming competent learners. They are learning to observe and to note similarities and differences; they are developing skills of solving problems and of asking questions. By this age, children have also acquired many ideas about their natural and social world. They may think about where the rain comes from, why things live and die, and how cars move. Such skills and ideas, reflecting an array of experiences i n the early years, are what help make children ready to acquire the wealth of knowledge and information that they can draw on in new learning situations.

The critical pathways we have designed based on theoretical research have combined the five components into three:

Optimal health and development

- Number/percentage of children whose parents rate them as in very good or excellent health.

  Free from illness/disease
  - Number/percentage of children ages 0-5 who have asthma
  - Number/percentage of children with no dental caries at age 5
  - Number/percentage of children age 5 with untreated dental problems

- Optimal social-emotional development and mental health

- Learning/comprehension skills and cognitive development

School Readiness

- Number/percentage of children entering kindergarten ready for school as determined by assessments completed by teachers.

The National Education Goals Panel (1997). *Getting a Good Start in School.* Washington, DC: National Education Goals Panel.

Appendix C

STANDARDIZED OUTCOME PERFORMANCE MEASURES

FIRST 5 VENTURA COUNTY
AUGUST 2004

DIRECT SERVICE AND PROVIDER CAPACITY BUILDING STRATEGIES

UCLA
CENTER FOR HEALTHIER CHILDREN, FAMILIES AND COMMUNITIES

TABLE OF CONTENTS

I. DIRECT SERVICES
A. Family Support & Education Services

1. Community R&R to health and social services
1a. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Community R&R to health and social services; Recursos y Referencias de la comunidad a servicios sociales y de salud				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, le dimos (insierte número) referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Community R&R to health and social services; Recursos y Referencias de la comunidad a servicios sociales y de salud				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: Por alguna de las referencias que usted no recibió servicios, fue porqué: Response options: Opciones para la respuesta: • You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por teléfono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills needed • El proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Al llegar, usted tuvo que esperar demasiado tiempo Getting services conflicted with other responsibilities at home or at work Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

2. Case management /Service coordination

2a. #/% participants very satisfied with help they receive in coordinating services

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Case Management /Service coordination; Manejo de casos/Coordinación de servicios				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% participants who are very satisfied with the help they receive in coordinating the services they need				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Thinking about the services that you have received at this program, how satisfied or dissatisfied are you with the help you have received in coordinating services for you (or your child)? Would you say: Al pensar en los servicios que ha recibido en este programa, ¿qué tan satisfecho o insatisfecho se sintió con la ayuda que recibió en la coordinación de servicios para usted (o su niño/a)? Usted diría que: Response options: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied Opciones para la respuesta: muy satisfecho, algo satisfecho, algo insatisfecho, o muy insatisfecho	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSCSHCN

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Case Management /Service coordination; Manejo de casos/Coordinación de servicios				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% participants who are very satisfied with the help they receive in coordinating the services they need				
2	How well or poorly do you think this program communicates with other providers to help coordinate the services you (or your child) need/s. Would you say their communication is: ¿Qué tan bien o mal cree usted que éste programa se comunica con otros proveedores para ayudar en coordinar servicios que usted (o su niño/a) necesitan? ¿Usted diría que su comunicación es: Response options: excellent, good, fair, poor, communication not needed, dk Opciones para la respuesta: excelente, bien, igual, mal, la comunicación no se necesitaba, ns	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSCSHCN

2. Case Management /Service coordination; Coordinación de servicios
2b. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Case Management /Service coordination; Coordinación de servicios				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, le dimos (insierte número) referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Case Management /Service coordination; Coordinación de servicios				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: Por alguna de las referencias que usted no recibió servicios, fue porqué: Response options: Opciones para la respuesta: • You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por teléfono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills needed • El proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Getting services conflicted with other responsibilities at home or at work • Al llegar, usted tuvo que esperar demasiado tiempo Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

3. Enrollment/assistance with TANF/WIC/food stamps, or food program
3a. #/% of those that remain enrolled for 3 months

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Enrollment/assistance with TANF/WIC/food stamps, or food program; Inscripción/asistencia con TANF/WIC/estampillas para comestibles, o programa para comestibles				
Outcome on Critical Pathways:	Access				
Outcome Measure:	#/% of those that remain enrolled for 3 months				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	As a result of our program, were you able to enroll in [*insert name of program*]? Cómo resultado de nuestro programa, ¿pudo usted registrarse en *[insierte el nombre del programa]* Response options: Yes, No, Prefer not to say, Don't know Opciones para la respuesta: Sí, No, Prefiero no decir, No lo sé If yes, are you still enrolled in *[insert name of program]*? Si dijo sí, ¿aún esta registrado en [*insierte el nombre del programa]* Response options: Yes, No, Prefer not to say, Don't know Opciones para la respuesta: Sí, No, Prefiero no decir, No lo sé After you enrolled, were you able to receive services or benefits? Después de que se registró, ¿pudo usted recibir servicios o beneficios? Response options: Yes, No, Prefer not to say, Don't know Opciones para las respuestas: Sí, No, Prefiero no decir, No lo sé	Self-administered questionnaire OR interview, phone interview, or document review	Participant	Post-test 3 months follow up	New measure

4. Provision of food, clothes, emergency funds, housing or other basic needs
4a. #/% participants reporting improved safety/health at home

Strategy: Direct Service	
Activity Category:	Family support, education and services
Activity Description:	Provision of food, clothes, emergency funds, housing or other basic needs; Provisiones de comida, ropa, fondos de emergen alojamiento u otras necesidades básicas
Outcome on Critical Pathways:	Parents provide a safe and healthy home environment
Outcome Measure:	#/% participants reporting improved safety/health at home

	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Sourc*
1	How would you rate the level of difficulty in meeting the *[either insert "basic" or insert the specific resource that the program provides to participant such as "nutritional", "clothing", etc]* needs of your children ¿Cómo clasificaría el nivel de dificultad en satisfacer *[puede insertir "básico" o insertir el recurso específico que el programa proporciona al participante tal cómo, "nutrición", "ropa", etc*] las necesidades de sus hijos? Response options: Very difficult, Difficult, Easy, Very easy Opciones para la respuesta: Muy difícil, Difícil, Fácil, Muy fácil	Self-administered questionnaire OR interview	Participants	Pre/post-test	New measure

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Provision of food, clothes, emergency funds, housing or other basic needs; Provisiones de comida, ropa, fondos de emergen alojamiento u otras necesidades básicas				
Outcome on Critical Pathways:	Parents provide a safe and healthy home environment				
Outcome Measure:	#/% participants reporting improved safety/health at home				
2	As a result of this program, I am able to meet the *[either insert "basic" or insert the specific resource that the program provides to participant such as "nutritional", "clothing", etc]* needs of my children. Como resultado de este programa, yo estoy capacitada en satisfacer las *[puede insertir "básico" o insertir el recurso específico que el programa proporciona al participante tal cómo, "nutrición", "ropa", etc]* necesidades de mis hijos. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participants	Post-test	New measure

4. Provision of food,
4b. #/% participants reporting improved provision of healthy diet

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Provision of food, clothes, emergency funds, housing (Specific to food assistance); Provisiones de comida, ropa, fondos de emergencia, alojamiento (Relacionado a la asistencia de comida)				
Outcome on Critical Pathways:	Parents provide a safe and healthy home				
Outcome Measure:	#/% participants reporting improved provision of healthy diet				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	In a typical week, how often are you able to provide a healthy and nutritious diet for your young children. En una semana normal, ¿qué tan seguido puede usted proveer una dieta saludable y nutritiva a sus hijos pequeños? Response options: Number of days per week Opciones para la respuesta: Número de días por semana	Self-administered questionnaire OR interview	Participant	Pre/post- test	New measure

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Provision of food, clothes, emergency funds, housing (Specific to food assistance); Provisiones de comida, ropa, fondos de emergencia, alojamiento (Relacionado a la asistencia de comida)				
Outcome on Critical Pathways:	Parents provide a safe and healthy home				
Outcome Measure:	#/% participants reporting improved provision of healthy diet				
2	As a result of this program, I am able to provide a more healthy and nutritious diet for my young children. Como resultado de este programa, yo tengo capacidad de proveer una dieta más saludable y nutritiva a mis hijos pequeños. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

5. Transportation services or vouchers
5a. #/% participants who report improved access to needed services

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Transportation services or vouchers; Servicios o vales para transportes				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% participants who report improved access to needed services				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	How difficult is it for you to get transportation to needed services? ¿Qué tan difícil es para usted conseguir transporte a los servicios necesitados? Response options**:** Very difficult, Somewhat difficult, Somewhat easy, Very easy Opciones para la respuesta: Muy difícil, Algo difícil, Algo fácil, Muy fácil	Self-administered questionnaire OR interview	Participant	Pre/post-test	New measure
2.	As a result of the transportation services provided by this program, I am able to get to the services I need. Como resultado de los servicios de transportes proveídos por este programa, yo puedo ir a los servicios que necesito. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

6. Safety education and injury/violence prevention (Child abuse prevention)
6a. #/% participants demonstrating knowledge around discipline/anger management

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Child abuse prevention); Educación de medidas de seguridad y prevención contra daño/violencia (Prevención contra el abuso infantil)				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around discipline/anger management				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child. a) First, how about raising your voice or yelling? b) How about spanking? c) How about taking away a toy or treat? d) How about giving a time-out that is making (CHILD) take a break from whatever activity {he/she} is involved in? e) How about explaining to (CHILD) why {his/her} behavior is not appropriate. Los padres varían mucho en los métodos que usan para responderle a los niños quiénes se están portando mal. . Por cada método alistado más abajo, por favor indique si usted usa ese método seguido, algunas veces, rara la vez, o nunca a) Primeramente, ¿qué tal elevar su voz o gritar? b) ¿Qué tal dar nalgadas? c) ¿Qué tal quitar algún juguete o placer? d) ¿Qué tal imponer un límite de tiempo, es decir hacer que (NIÑO) tome un descanso forzoso de la actividad en la cuál (él/ella) esta participando? e) ¿Qué tal explicándole a su (NIÑO) el porqué el comportamiento de {él/ella} no es apropriado. Response options: Often, Sometimes, Rarely, Never Opciones para la respuesta: Seguido, Algunas veces, Rara la vez, Nunca	Self-administered questionnaire OR interview	Participants	Pre/post-test	Adapted from NSECH

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Child abuse prevention); Educación de medidas de seguridad y prevención contra daño/violencia (Prevención contra el abuso infantil)				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around discipline/anger management				
2	As a result of this program, I know more about how to discipline my child. Como resultado de este programa, sé más de cómo disciplinar a mi hijo/a. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New Measure

7. Safety education and injury/violence prevention (Unintentional injury)
7a. #/% participants demonstrating knowledge around safety/injury prevention

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Unintentional injury); Educación de medidas de seguridad y prevención contra daño/violencia (daño involuntario)				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around safety/injury prevention				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	When transporting a child under 20 pounds or under 6 months of age the following is the safest practice: Al transportar a un niño/a menos de 20 libras o menor de 6 meses de edad, cuál de las siguientes prácticas es la más segura: Response options: a) Child car seat placed in the front seat with car seat facing forward; b) Child car seat placed in the back seat facing forward; c) Child car seat placed in the front seat with car seat facing backward; d) Child car seat placed in the back seat facing backward Opciones para la respuesta: a) Asiento de coche para el niño/a puesto en el asiento delantero volteado hacia el frente; b) Asiento de coche para el niño/a puesto en el asiento trasero volteado hacia el frente; c) Asiento de coche para el niño/a puesto en el asiento delantero volteado hacia atrás; d) Asiento de coche para el niño/a puesto en el asiento trasero volteado hacia atrás	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from resource materials on the National Highway Transportation Safety Administration website Correct response: d

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Unintentional injury); Educación de medidas de seguridad y prevención contra daño/violencia (daño involuntario)				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around safety/injury prevention				
2	What should you do if you suspect your child has taken poison? a) Drink water b) Stick your fingers down his/her throat to cause regurgitation c) Administer Syrup of Ipecac d) Call poison control ¿Qué debe de hacer si usted sospecha que su hijo/a ha tomado veneno? a) Tomar agua b) Métale sus dedos a la garganta del niño/a para causar vómito c) Administrar Jarabe de Ipecacuana d) Llamar al centro para el control de venenos	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from materials on the American Association of Poison Control Centers website http://www.aapcc.org Correct response: d

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Unintentional injury); Educación de medidas de seguridad y prevención contra daño/violencia (daño involuntario)				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around safety/injury prevention				
3	As a result of this program, I am better able to protect my child from injury. Como resultado de este programa, estoy mejor preparada para proteger a mi hijo/a de heridas. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

7b. #/% participant's homes found to be safe

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Unintentional injury); Educación de medidas de seguridad y prevención contra daño/violencia (daño involuntario)				
Outcome on Critical Pathways:	Parents provide a safe and healthy home environment				
Outcome Measure:	#/% participants homes found to be safe				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	This program has helped me make my home safer for my children. Este programa me ha ayudado a segurar my hogar para mis hijos. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New Measure
2	Do you have a smoke alarm in your home/apartment? ¿Tiene usted un detector de humo en su casa/apartamento? Response Options yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from the National Safe Kids Campaign Home Safety sheet Correct answer: yes

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Safety education and injury/violence prevention (Unintentional injury); Educación de medidas de seguridad y prevención contra daño/violencia (daño involuntario)				
Outcome on Critical Pathways:	Parents provide a safe and healthy home environment				
Outcome Measure:	#/% participants homes found to be safe				
3	Do you have window treatments (i.e. blinds, drapes, curtains) with cords? If so, are the cords hanging loosely at their usual length, cut short or wrapped? ¿Tiene usted tratadas las ventanas (por ejemplo, persianas, tápices, cortinas) con cuerdas? Si es así, están las cuerdas colgando sueltas a su nivel normal, cortadas, or amarradas? Response options: Hanging loosely, Cut off, Wrapped, Don't know Opciones a la respuesta: Colgando sueltas, Cortadas, Amarradas, No lo sé	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from materials on "Protecting Young Children in the Home" Correct answer: Wrapped

8. Parenting education

8a. #/% participants demonstrating knowledge around parenting

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Parenting education; Educación familiar				
Outcome on Critical Pathway:	Parent knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around parenting/child development/other topic specified				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
	See following pages				

PRE-TEST

Parenting Education Classes/Workshops - Children 0-9 months	
At birth, all of a baby's organs are completely developed except one. Which one is it:	□ Lungs □ Brain □ Heart □ stomach
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward
	Pre-test

Parenting Education Classes/Workshops - Children 10-18 months	
The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Pre-test

Parenting Education Classes/Workshops - Children 19 months up to 6th Birthday	
The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Pre-test

Post Test

Parenting Education Classes/Workshops - Children 0-9 months				
This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same? Este programa habló con usted acerca de varios temas. Por cada tema alistado más abajo, usted diría que su conocimiento: ha aumentado mucho, ha aumentado un poco, o se ha mantenido igual?				
Topic Tema	**Increased a lot Aumentó mucho**	**Increased Somewhat Aumentó un poco**	**Stayed about the same Se ha mante-nido igual**	**Topic not discussed El tema no se habló**
The kinds of behaviors you can expect from your child Los tipos de comportamientos que espera de su hijo/a				
Breastfeeding Amamantar				
When to introduce solid foods Cuando presentar comidas sólidas				
How to position your child when he/she goes to sleep Cómo acomodar a su hijo/a cuando él/ella se duerme				
What to do with your child's night waking and fussing Qué hacer cuando despierta su hijo/a cuando despierta y se queja en la noche				
How your child grows and learns Cómo crece y aprende su hijo/a				
How your child communicates Cómo su hijo/a se comunica				
Importance of reading to your child La importancia de leerle a su hijo/a				
What your child is able to understand Lo que su hijo/a es capáz de entender				
How your child responds to you and other adults Cómo su hijo/a responde a usted y a otros adultos				
Using a car seat El usar un asiento para el coche				
How to make your house safe Cómo asegurar su casa				
Issues related to childcare Questiones relacionados con el cuidado infantil				

At birth, all of a baby's organs are completely developed except one. Which one is it: Cuando nace el bebé, todos sus órganos estan completamente desarrollados con la excepción de uno. ¿Cuál es?:	□ Lungs/Púlmones □ Brain/Cerebro □ Heart/Corazón □ stomach/Estómago
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys

	□ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward
Thinking about the topics discussed in this program, would you say that your confidence in parenting your child has: Pensando en los temas hablados en este programa, usted diría que su confianza como padre en criar a su hijo ha: □ increased a lot/ha aumentado mucho □ increased somewhat/ha aumentado un poco □ stayed about the same/se ha mantenido igual □ decreased somewhat/ha disminuido un poco □ decreased a lot/ha disminuido mucho Post test	

Parenting Education Classes/Workshops - Children 10-18 months				
This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?				
Topic	**Increased a lot**	**Increased somewhat**	**Stayed about the same**	**Topic not discussed**
The kinds of behaviors you can expect from your child				
How your child might start to explore away from you				
Guidance and discipline techniques				
Toilette training				
Issues related to food and feeding				
Giving vitamins to your child				
What to do with your child's night waking and fussing				
Bed and naptime routines				
How your child grows and learns				
Words and phrases your child uses and understands				
Importance of reading to your child				
How your child learns to get along with other children				
Using a car seat				
How to make your house safe				
Issues related to childcare				

The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.				
Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Thinking about the topics discussed in this class/workshop, would you say that your confidence in parenting your child has: □ increased a lot □ increased somewhat □ stayed about the same
□ decreased somewhat □ decreased a lot Post-test

Parenting Education Classes/Workshops - Children 19 months up to 6th Birthday				
This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?				
Topic	**Increased a lot**	**Increased somewhat**	**Stayed about the same**	**Topic not discussed**
The kinds of behaviors you can expect from your child				
Guidance and discipline techniques				
Toilette training				
Issues related to food and feeding				
Vitamins				
Bed and naptime routines				
How your child grows and learns				
Words and phrases your child uses and understands				
Importance of reading to your child				
How your child learns to get along with other children				
Using a car seat				
How to make your house safe				
Teaching child about dangerous situations, places or things				
Issues related to childcare				

The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Thinking about the topics discussed in this class/workshop, would you say that your confidence in parenting your child has: □ increased a lot □ increased somewhat □ stayed about the same □ decreased somewhat □ decreased a lot

Post-Test

9. Parent/caregiver support

9a. #/% participants reporting adequate social support and social ties

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Parent/caregiver support; Apoyo del padre/cuidador				
Outcome on Critical Pathways:	Parental mental health				
Outcome Measure:	#/% participants reporting adequate social support and social ties				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Is there someone you can turn to for day to day emotional help while parenting? ¿Hay alguién con quién pueda contar día tras día para apoyo emocional mientras usted cría a sus hijos? Response options: Yes, No, Don't know, Prefer not to say Opciones para la respuesta: Sí, No, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSECH

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Parent/caregiver support; Apoyo del padre/cuidador				
Outcome on Critical Pathways:	Parental mental health				
Outcome Measure:	#/% participants reporting adequate social support and social ties				
2	I have the social/emotional support that I need to help me raise my young children. Tengo el apoyo social/emocional que necesito para ayudarme a criar a mis hijos pequeños. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	New measure

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Parent/caregiver support; Apoyo del padre/cuidador				
Outcome on Critical Pathways:	Parental mental health				
Outcome Measure:	#/% participants reporting adequate social support and social ties				
3	This program has helped me feel I have the social/emotional support that I need to raise my young children. Éste programa me ha ayudado a sentir que tengo el apoyo social/emocional que necesito para criar a mis hijos pequeños. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New Measure

10. Parent/caregiver support (Only for Foster Parent Programs)
10a . #/% of foster parents retained at 6 and 12 months after receipt of services

Strategy: Direct Service	
Activity Category:	Family support, education and services
Activity Description:	Parent/caregiver support (Only for Foster Parent Programs); Apoyo de padre/cuidador (Sólo para programas de padres de crianza)
Outcome on Critical Pathways:	Parental mental health
Outcome Measure:	#/% of foster parents retained at 6 and 12 months after receipt of services

	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Is this participant still serving as a foster parent? ¿Todavía está éste participante asistiendo cómo padre de crianza? Response options: yes, no, don't know Opciones para la respuesta: sí, no, no lo sé	Document review	Staff	6 month follow-up and 12 month follow-up	New Measure

11. Family planning

11a. #/% participants reporting unwanted pregnancies within 6 months

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Family planning; Planificación familiar				
Outcome on Critical Pathways:	Parental mental health				
Outcome Measure:	#/% participants reporting unwanted pregnancies within 6 months				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Have you become pregnant since receiving family planning services at this program? ¿Ha salido emabarazada desde que recibió servicios de planificación familiar de este programa? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no lo sé, prefiero no decir If yes, right before you became pregnant, did you yourself want to have a(nother) baby? Si dijo sí, antes de que saliera emabarazada, ¿usted misma quería tener un (otro) bebé? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	6 month follow up	Adapted from CDC National Survey of Family Growth

12. Adult literacy

12a. #/% participants demonstrating improved literacy

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Adult literacy; Alfabetización de adultos				
Outcome on Critical Pathway:	Parent/family literacy				
Outcome Measure:	#/% participants demonstrating improved literacy				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	As a result of this program, my ability to read in my primary language has improved. Como resultado de éste programa, mi habilidad para leer en mi lengua nativa ha mejorado. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones de respuestas: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	Derived from Participant retrospective self-assessment: Peisher, A., Swell, M., Kirk, R.,, Outcome Accountability for Family Support Programs, Volume II,

Strategy: Direct Service					
Activity Category:	Family support, education and services				
Activity Description:	Adult literacy; Alfabetización de adultos				
Outcome on Critical Pathway:	Parent/family literacy				
Outcome Measure:	#/% participants demonstrating improved literacy				
	As a result of this program, my ability to read in my secondary language has improved. Como resultado de éste programa, mi habilidad para leer en mi segunda lengua ha mejorado. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones de respuestas: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	Derived from Participant retrospective self-assessment: Peisher, A., Swell, M., Kirk, R.,, Outcome Accountability for Family Support Programs, Volume II,
	In a typical week, how often do you or any other family member *read or show pictures books* to your young children? En una semana normal, ¿qué tan seguido, usted u otro familiar le *leen o le muestran un libro de dibujos* a su hijo/a? Response options: Number of days per week Opciones para la respuesta: Número de días por semana	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSECH

B. Health Education & Services

13. Health insurance enrollment/assistance
13a. #/% participants enrolled, have a PCP, made appointment, saw PCP

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Health insurance enrollment/assistance; Inscripción/asistencia de seguro médico				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% participants enrolled, have a PCP, made an appointment, saw a PCP at follow up				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Was your child successfully enrolled in (name of program)? ¿Estuvo su hijo/a registrado exitósamente en (nombre del programa)? If yes, is your child still enrolled in (name of program)? Si dijo sí, ¿aún esta su hijo/a registrado en (nombre del programa)? If yes, has your child been assigned to a doctor/physician? Si dijo sí, ¿está su hijo/a asignado a un doctor/médico? Have you made an appointment for your child to visit the doctor/physician? ¿Ha hecho usted una cita para que su hijo/a vea a un doctor/médico? Have you taken your child to see the doctor/physician? ¿Ha llevado a su hijo/a con un doctor/médico? Response options: Yes, No, Don't know, Prefer not to say Opciones para la respuesta: Sí, No, No lo sé, Prefiero no decir About how long has it been since your child last visited his/her doctor/physician? ¿Cómo cuánto tiempo ha pasado desde que su hijo/a vio a su doctor/médico? Response options; less than 3 months; 3 months up to 6 months, 6 months up to 1 year ago, 1 year up to 2 years ago; 2 years up to 5 years ago; more than 5 years ago; has never visited; Prefer not to say; don't know Opciones para la respuesta: menos de 3 meses; de 3 meses a 6 meses, de 6 meses a un año, de 1 año a 2 años, de 2 años a 5 años, más de 5 años, nunca ha visitado al doctor; Prefiero no decir; no lo sé	Self-administered questionnaire OR interview, phone interview, or document review	Participant	6-month follow-up	New measures

14. Tobacco cessation education or prevention (prenatal)
14a. #/% participants demonstrating knowledge about negative effects of smoking

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)				
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies				
Outcome Measure:	#/% participants demonstrating knowledge about negative effects of smoking				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	If parents smoke, their children are more likely to: Si los padres fuman, los hijos probablemente: Response options: Smoke, have breathing problem, have more colds and chest infections, all of the above Opciones para la respuesta: Fuman, tienen problemas respiratorios, tienen más resfríos e infecciones del pecho	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from Naval Medical Center, San Diego – Health Promotion Programs Correct response: all of the above

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)				
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies				
Outcome Measure:	#/% participants demonstrating knowledge about negative effects of smoking				
2	Women who smoke are more likely to have babies whose birth weight is: Es más probable que mujéres que fuman tendrán bebés quiénes pesan: Response options: Low, Average, High, Don't know, Prefer not to say Opciones para las respuesta: Bajo, Normal, Grande, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from CDC "Tobacco Use and Reproductive Outcomes – Fact Sheet" Correct response: low
6	Which trimester is smoking the most harmful to your unborn child? ¿Cuál trimestre es el más perjudicial a su futuro bebé? Response options: First, Second, Third, Don't know, Prefer not to say Opciones para la respuesta: El primero, El segundo, El tercero, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from CDC "Tobacco Use and Reproductive Outcomes – Fact Sheet" Correct response: Third

14. Tobacco cessation education or prevention (prenatal)
14b. #/% participants who have quit or smoke less as a result of the program

Strategy: Direct Service	
Activity Category:	Health education and services
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies
Outcome Measure:	#/% participants who have quit or smoke less as a result of the program

	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Do you now smoke cigarettes every day, some days, or not at all? Actualmente, usted fuma cigarros todos los días, algunos días, o no fuma nada? Response options: every day, some days, or not at all, Don't know, Prefer not to say Opciones para la respuesta: todos los días, algunos días, o no fumo nada, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 1-month follow-up	CHIS

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)				
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies				
Outcome Measure:	#/% participants who have quit or smoke less as a result of the program				
2	Do you mostly smoke inside the house or outside the house? ¿Usted fuma por lo general adentro de la casa o afuera? Response options: Inside, outside, Don't know, Prefer not to say Opciones para la respuesta: Adentro, afuera, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 1-month follow-up	New measure
3	As a result of this program, Cómo resultado de este programa, Response options: I no longer smoke, I smoke a lot less, I smoke somewhat less, I smoke about the same, I smoke somewhat more, I smoke a lot more, don't know, prefer not to say Opciones para la respuesta: Ya no fumo, fumo mucho menos, fumo un poco menos, fumo casi igual, fumo un poco más, fumo mucho más, no lo sí, prefiero no decir	Self-administered questionnaire OR interview	Participant	1-month follow-up	New measure

15. Tobacco cessation

15a. #/% participants demonstrating knowledge about negative effects of smoking

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)				
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies				
Outcome Measure:	#/% participants demonstrating knowledge about negative effects of smoking				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	If parents smoke, their children are more likely to: Si los padres fuman, los hijos probablemente: Response options: Smoke, have breathing problem, have more colds and chest infections, all of the above Opciones para la respuesta: Fuman, tienen problemas respiratorios, tienen más resfríos e infecciones del pecho	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from Naval Medical Center, San Diego – Health Promotion Programs Correct response: all of the above

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation education or prevention – (prenatal education); Educación o prevención de cesación del tabaco—(educación prenatal)				
Outcome on Critical Pathways:	Expectant mothers have healthy pregnancies				
Outcome Measure:	#/% participants demonstrating knowledge about negative effects of smoking				
2	Women who smoke are more likely to have babies whose birth weight is: Es más probable que mujéres que fuman tendrán bebés quiénes pesan: Response options: Low, Average, High, Don't know, Prefer not to say Opciones para las respuesta: Bajo, Normal, Grande, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from CDC "Tobacco Use and Reproductive Outcomes – Fact Sheet" Correct response: low
3	Secondhand smoke is smoke that is involuntarily inhaled by nonsmokers from other people's cirgarettes. If a child is exposed to secondhand smoke, it can cause (check all that apply) Response options: lower respiratory tract infections in young children; asthma in children; pneumonia in young children; cold; ear infections; flu; bronchitis; coughing and wheezing	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from Childhood Asthma Foundation

15. Tobacco cessation

15.b #/% participants not smoking at end of program and 6 month follow up

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation; Cesación de tabaco				
Outcome on Critical Pathway:	Parents provide a safe and healthy home environment				
Outcome Measure:	#/% participants not smoking at end of program and 6 month follow up				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Do you now smoke cigarettes every day, some days, or not at all? Actualmente, ¿usted fuma cigarros todos los días, algunos días, o no fuma nada? Response options: every day, some days, or not at all, Don't know, Prefer not to say Opciones para la respuesta: todos los días, algunos días, no fumo nada, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 3-month follow-up	CHIS
2	Do you mostly smoke inside the house or outside the house? ¿Usted fuma por lo general adentro de la casa o afuera? Response options: Inside, outside, Don't know, Prefer not to say Opciones para la respuesta: Adentro, afuera, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 3-month follow-up	New measure

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Tobacco cessation; Cesación de tabaco				
Outcome on Critical Pathway:	Parents provide a safe and healthy home environment				
Outcome Measure:	#/% participants not smoking at end of program and 6 month follow up				
3	As a result of this program, Como resultado de este programa, Response options: I no longer smoke, I smoke a lot less, I smoke somewhat less, I smoke about the same, I smoke somewhat more, I smoke a lot more, don't know, prefer not to say Opciones para la respuesta: Ya no fumo, fumo mucho menos, fumo un poco menos, fumo casi igual, fumo un poco más, fumo mucho más, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	3-month follow-up	New measure

16. Mental health assessments or services
16a. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Mental health assessments or services; Servicios o evaluaciones de salud mental				
Outcome on Critical Pathway:	Parental mental health and parental physical health				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, nosotros le dimos (insierte el número) de referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Mental health assessments or services; Servicios o evaluaciones de salud mental				
Outcome on Critical Pathway:	Parental mental health and parental physical health				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: Por alguna de las referencias que usted no recibió servicios, fue porqué: Response options: Opciones para la respuesta: • You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por teléfono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills needed • El proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Al llegar, usted tuvo que esperar demasiado tiempo Getting services conflicted with other responsibilities at home or at work Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

16. Mental health assessments or services
16b. #/% participants with improved mental health

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Mental health assessment or service; Servicio o evaluación de salud mental				
Outcome on Critical Pathways:	Parental mental health				
Outcome Measure:	#/% participants with improved mental health				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During the past month, how much of the time were you a happy person? Durante el último mes, ¿qué tanto del tiempo se sintió como una persona contenta? How much of the time during the past month have you been a very nervous person? ¿Qué tanto del tiempo en el último mes se ha sentido como una persona nerviosa? How much of the time during the past month have you felt calm and peaceful? ¿Qué tanto del tiempo en el último mes se ha sentido tranquilo y pacífico? How much of the time during the past month have you felt downhearted and blue? ¿Qué tanto del tiempo en el último mes se ha sentido desanimado y triste? How much of the time during the past month have you felt so down in the dumps that nothing could cheer you up? ¿Qué tanto del tiempo en el último mes se has sentido tan deprimido que nada lo podía alentar? Response options: a) all of the time; b) most of the time ; c) a good bit of the time; d) some of the time; e) a little of the time ; f) none of the time ; g) don't know Opciones para la respuesta: a) siempre; b) casi siempre; c) varias veces; d) algunas veces; e) pocas veces; f) nunca; g) no lo sé	Self-administered questionnaire OR interview OR interview	Participant	Pre/post-test	MHI-5, NSECH

17. Substance abuse treatment/screening
17a. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Substance abuse treatment/screening; Tratamiento/filtración de abuso de sustancias				
Outcome on Critical Pathway:	Parental mental health and parental physical health				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, nosotros le dimos (insierte el número) de referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Substance abuse treatment/screening; Tratamiento/filtración de abuso de sustancias				
Outcome on Critical Pathway:	Parental mental health and parental physical health				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: Por alguna de las referencias que usted no recibió servicios, fue porqué:Response options: Opciones para la respuesta: • You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por teléfono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills needed • El proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Al llegar, usted tuvo que esperar demasiado tiempo Getting services conflicted with other responsibilities at home or at work Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

18. Prenatal and birth care and education

18a. #/% participants not smoking during pregnancy

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Prenatal and birth care and education; Educación prenatal y de cuidado de nacimiento				
Outcome on Critical Pathways:	Children are born healthy				
Outcome Measure:	#/% participants not smoking during pregnancy				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Do you now smoke cigarettes every day, some days, or not at all? Actualmente, ¿usted fuma cigarros todos los días, algunos días, o no fuma nada? Response options: every day, some days, or not at all, Don't know, Prefer not to say Opciones para la respuesta: todos los días, algunos días, no fumo nada, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 3-month follow-up	CHIS

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Prenatal and birth care and education; Educación prenatal y de cuidado de nacimiento				
Outcome on Critical Pathways:	Children are born healthy				
Outcome Measure:	#/% participants not smoking during pregnancy				
2	Do you mostly smoke inside the house or outside the house? ¿Usted fuma por lo general adentro de la casa o afuera? Response options: Inside, outside, Don't know, Prefer not to say Opciones para la respuesta: Adentro, afuera, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre-test & 3-month follow-up	New measure
3	As a result of this program, Como resultado de este programa, Response options: I no longer smoke, I smoke a lot less, I smoke somewhat less, I smoke about the same, I smoke somewhat more, I smoke a lot more, don't know, prefer not to say Opciones para la respuesta: Ya no fumo, fumo mucho menos, fumo un poco menos, fumo casi igual, fumo un poco más, fumo mucho más, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	3-month follow-up	New measure

18. Prenatal and birth care and education
18b. #/% participants demonstrating knowledge around parenting

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Prenatal and birth care and education; Educación prenatal y de cuidado de nacimiento				
Outcome on Critical Pathways:	Children are born healthy				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around parenting/child development/other topic specified				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
	See pre and post test below				

Prenatal and birth care and education - Children 0-9 months	
At birth, all of a baby's organs are completely developed except one. Which one is it:	□ Lungs □ Brain □ Heart □ stomach
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
How often should newborns breastfeed?	□ at least 4-6 times a day □ at least 6-8 times a day □ at least 8-12 times a day □ whenever they cry
What is the minimum number of months that it is recommended that mothers breastfeed?	□ 6 months □ 12 months □ 18 months □ none of the above
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward Pre-test

Prenatal and birth care and education - Children 0-9 months				
This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?				
Topic	**Increased a lot**	**Increased somewhat**	**Stayed about the same**	**Topic not discussed**
The kinds of behaviors you can expect from your child				
Breastfeeding				
When to introduce solid foods				
How to position your child when he/she goes to sleep				
What to do with your child's night waking and fussing				
How your child grows and learns				
How your child communicates				
Importance of reading to your child				
What your child is able to understand				
How your child responds to you and other adults				
Using a car seat				
How to make your house safe				
Issues related to childcare				

At birth, all of a baby's organs are completely developed except one. Which one is it:	□ Lungs □ Brain □ Heart □ stomach
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
How often should newborns breastfeed?	□ at least 4-6 times a day □ at least 6-8 times a day □ at least 8-12 times a day □ whenever they cry
What is the minimum number of months that it is recommended that mothers breastfeed?	□ 6 months □ 12 months □ 18 months □ none of the above
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward
Thinking about the topics discussed in this program, would you say that your confidence in parenting your child has: □ increased a lot □ increased somewhat □ stayed about the same □ decreased somewhat □ decreased a lot Post-test	

20. Breastfeeding assistance/education
20a. #/% mothers demonstrating knowledge regarding breastfeeding

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Breastfeeding assistance/education; Educación/asistencia amamantamiento				
Outcome on Critical Pathways:	Mothers breastfeed children				
Outcome Measure:	#/% mothers demonstrating knowledge/skills regarding breastfeeding				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	How often should newborns breastfeed? ¿Qué tan seguido se le debe de dar de mamar a los recién nacidos? Response options: a) at least 4-6 times a day; b) at least 6-8 times a day; c) at least 8-12 times a day; d) whenever they cry. Opciones para la respuesta: a) por lo menos 4-6 veces al día; b) por lo menos 6-8 veces al día; c) por lo menos 8-12 veces al día; d) cada vez que lloran.	Self-administered questionnaire OR interview	Participant	Pre/post-test	http://Pediatrics.about.com correct response: c
2	What is the minimum number of months recommended that mothers should breastfeed? ¿Cuánto tiempo es el mínimo número de meses que se les recomienda a las madres que den de mamar? Response options: a) 6 months; b) 12 months; c) 18 months; d) none of the above Opciones para la respuesta: a) 6 meses; b) 12 meses; c) 18 meses; d) ninguna de las respuestas indicadas	Self-administered questionnaire OR interview	Participant	Pre/post-test	http://Pediatrics.about.com correct response: b

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Breastfeeding assistance/education; Educación/asistencia amamantamiento				
Outcome on Critical Pathways:	Mothers breastfeed children				
Outcome Measure:	#/% mothers demonstrating knowledge/skills regarding breastfeeding				
3	The best way to feed a two-month old baby is with La mejor manera de darle de comer a un bebe de dos meses es Response options: a) Breast milk only, b) Formula only, c) Breast milk and formula, d) Not sure Opciones para la respuesta: a) Sólo leche de pecho, b) Sólo fórmula, c) leche de pecho y fórmula, d) No estoy seguro	Self-administered questionnaire OR interview	Participant	Pre/post-test	UCB Study (State Evaluation of First 5 Parent Kit) Correct response: a
4	The best age to start feeding your baby cereal or other solid foods is: La mejor edad para darle de comer a su bebé cereal u otra comida sólida es: Response options: Between zero and three months old, Between four to six months old, Seven or more months old, Not sure Opciones para la respuesta: a) Entre cero y tres meses, b) Entre cuatro a seis meses, d) Siete o más meses, e) No estoy seguro	Self-administered questionnaire OR interview	Participant	Pre/post-test	UCB Study (State Evaluation of First 5 Parent Kit) Correct response: b
5	This program addressed my questions and concerns regarding breastfeeding. Éste programa se dirigió a las preguntas y preocupaciones que tenía hacia amamantamiento. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

20. Breastfeeding assistance/education
20b. #/% mothers Breastfeeding up to 6 months postpartum

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Breastfeeding assistance/education; Educación/asistencia amamantamiento				
Outcome on Critical Pathways:	Mothers breastfeed children				
Outcome Measure:	#/% mothers who breastfeed their babies through 6 months of age (up to 6th month postpartum)				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
	1a. Did you ever breast-feed your baby? Yes No (stop) 1a. ¿Usted le dio de mamar a su bebé? Sí No (pare) 1b. Do you still breast-feed your baby? Yes (stop) No 1b. ¿Todavía le esta dando de mamar a su bebé? Sí (pare) No 1c. How old was your baby when you stopped breast-feeding? Less than one week One week or more: specify number of weeks: _____weeks 1c. ¿Qué edad tenía su bebé cuando usted paró de darle de mamar? Menos de una semana Más de una semana: especifique el número de semanas:_____ semanas	Self-administered questionnaire OR interview	Participant	6 months post-partum	New Measure

21. Well-baby or well-child check ups
21a. #/% participants up to date on immunizations

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Well-baby or well-child check ups; Chequeo de el bienestar del bebé o del niño/a				
Outcome on Critical Pathways:	Optimal health and development				
Outcome Measure:	#/% participants up to date on immunizations				
*Version #**	*Question*	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	What is the status of your child's immunizations? ¿Cuál es el estado de las inmunizaciones de su hijo/a (más pequeño)? Response options: Received no shots, Received some shots, Received all shots recommended by doctor Opciones para la respuesta; No recibió inmunizaciones, Recibió algunas, Recibió todas las que recomendó el docotor	Self-administered questionnaire OR interview	Participant	Post-test	SRI
2	Is this child up-to-date for age on his/her immunizations ¿Está éste niño/a al corriente para su edad con las inmunizaciones? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Document review	Staff	Post-test	New measure

21. Well-baby or well-child check ups
21b. #/% participants demonstrating knowledge around child health

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Well-baby or well-child check ups; Chequeo de el bienestar del bebé o del niño/a				
Outcome on Critical Pathways:	Optimal health and development, optimal social-emotional development and learning/comprehension skills and cognitive development				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around child health				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
	See below				

Well-baby or Well-child checkups - Children 0-9 months	
At birth, all of a baby's organs are completely developed except one. Which one is it:	□ Lungs □ Brain □ Heart □ stomach
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward
Well-child care visits are visits that are made to a doctor or other healthcare provier who take sof your child when he/she is NOT sick but needs a check-up or a shot. *Visitas de bienestar-infantil son visitas que se hacen con el doctor o algun proveedor de salud que miran a su hijo/a cuando él/ella NO estan enfermos pero necesitan un chequeo o una vacuna.* How important or unimportant do you think well-child check-ups are for the helath and development of your child? ¿Qué tan importante o nada importante cree usted que son los chequeos del beinestar-infantil para la salud y el desarrollo de su hijo/a? Would you say that they are: □ Very important □ Somewhat important □ Not important at all □ Not sure Diría usted que son: * Muy importante *Algo importante * Nada importante * No esta seguro	
	Pre test

Well-baby or Well-child checkups - Children 10-18 months	
The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Well-child care visits are visits that are made to a doctor or other healthcare provier who takes of your child when he/she is NOT sick but needs a check-up or a shot.

How important or unimportant do you think well-child check-ups are for the helath and development of your child?

Would you say that they are: □ Very important □ Somewhat important □ Not important at all □ Not sure

Pre-test

Well-baby or Well-child checkups - Children 19 months up to 6th Birthday	
The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Well-child care visits are visits that are made to a doctor or other healthcare provier who takes of your child when he/she is NOT sick but needs a check-up or a shot.

How important or unimportant do you think well-child check-ups are for the helath and development of your child?
Would you say that they are: □ Very important □ Somewhat important □ Not important at all □ Not sure

	Pre-test

Well-baby or Well-child checkups - Children 0-9 months

This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?

Topic	Increased a lot	Increased somewhat	Stayed about the same	Topic not discussed
The kinds of behaviors you can expect from your child				
Breastfeeding				
When to introduce solid foods				
How to position your child when he/she goes to sleep				
What to do with your child's night waking and fussing				
How your child grows and learns				
How your child communicates				
Importance of reading to your child				
What your child is able to understand				
How your child responds to you and other adults				
Using a car seat				
How to make your house safe				
Issues related to childcare				

Well-child care visits are visits that are made to a doctor or other healthcare provier who takes of your child when he/she is NOT sick but needs a check-up or a shot.
Visitas de bienestar-infantil son visitas que se hacen con el doctor o algun proveedor de salud que miran a su hijo/a cuando él/ella NO estan enfermos pero necesitan un chequeo o una vacuna.

Think about the last time you took your child for a well-child check-up at this program. How many minutes would you say the doctor or healthcare provider who examined your child in the room with you? Piense en la última vez que llevó a su hijo/a para un chequeo de bienestar-infantil en este programa. ¿Cuántos minutos diría usted que pasó el doctor o proveedor infantil con su hijo/a en el cuarto con usted?	_____ (minutes) _____(minutos)

Think about the last time you took your child for a well-child check-up at this program. Was the time that the doctor or healthcare provider spent with you:
Piense en la última vez que llevó a su hijo/a a un chequeo de bienestar-infantil en este programa. El tiempo que pasó el doctor o el proveedor de salud con usted era:
□ Too much time/Demasiado tiempo □ About the right amont of time/Muy buen tiempo □ Not enough time/No era suficiente tiempo □ Not sure/No estoy seguro

How important or unimportant do you think well-child check-ups are for the helath and development of your child?
¿Qué tan importante o nada importante cree usted que son los chequeos del beinestar-infantil para la salud y el desarrollo de su hijo/a?
Would you say that they are: □ Very important □ Somewhat important □ Not important at all □ Not sure
Diría usted que son: * Muy importante *Algo importante * Nada importante * No esta seguro

At birth, all of a baby's organs are completely developed except one. Which one is it:	□ Lungs □ Brain □ Heart □ stomach
Newborns should be put to sleep	□ On their stomachs □ On their backs □ However they sleep best □ Not sure
The best way to feed a two-month old baby is with	□ Breast milk only □ Formula only □ Breast milk and formula □ Not sure
The best age to start feeding your baby cereal or other solid foods is:	□ 0 – 3 months old □ 4-6 months old □ 7 or more months old □ Not sure
The most important way for babies to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
When transporting a child under 20 pounds or under 6 months of age the following is the safest practice:	□ Car seat placed in the front seat, facing forward □ Car seat placed in the back seat, facing forward □ Car seat placed in the front seat, facing backward □ Car seat placed in the back seat, facing backward

Thinking about the topics discussed in this program, would you say that your confidence in parenting your child has:
□ increased a lot □ increased somewhat □ stayed about the same □ decreased somewhat □ decreased a lot

Post-test

Well-baby or Well-child checkups - Children 10-18 months

This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?

Topic	Increased a lot	Increased somewhat	Stayed about the same	Topic not discussed
The kinds of behaviors you can expect from your child				
How your child might start to explore away from you				
Guidance and discipline techniques				
Toilette training				
Issues related to food and feeding				
Giving vitamins to your child				
What to do with your child's night waking and fussing				
Bed and naptime routines				
How your child grows and learns				
Words and phrases your child uses and understands				
Importance of reading to your child				
How your child learns to get along with other children				
Using a car seat				
How to make your house safe				
Issues related to childcare				

Well-child care visits are visits that are made to a doctor or other healthcare provier who takes of your child when he/she is NOT sick but needs a check-up or a shot.

Think about the last time you took your child for a well-child check-up at this program. How many minutes would you say the doctor or healthcare provider who examined your child in the room with you? _____

Think about the last time you took your child for a well-child check-up at this program. Was the time that the doctor or healthcare provider spent with you: □ Too much time □ About the right amont of time □ Not enough time □ Not sure

How important or unimportant do you think well-child check-ups are for the helath and development of your child? Would you say that they are: □ Very important □ Somewhat important □ Not important at all □ Not sure

The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The best time to start reading to your child is:	□ During the first year □ From ages 2-4 years □ At start of kindergarten □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Thinking about the topics discussed in this class/workshop, would you say that your confidence in parenting your child has:
□ increased a lot □ increased somewhat □ stayed about the same □ decreased somewhat □ decreased a lot

Post

Well-baby or Well-child checkups - Children 19 months up to 6th Birthday

This program talked to you about a variety of topics. For each topic listed below, would you say that your knowledge: increased a lot, increased somewhat, or stayed about the same?

Topic	Increased a lot	Increased somewhat	Stayed about the same	Topic not discussed
The kinds of behaviors you can expect from your child				
Guidance and discipline techniques				
Toilette training				
Issues related to food and feeding				
Vitamins				
Bed and naptime routines				
How your child grows and learns				
Words and phrases your child uses and understands				
Importance of reading to your child				
How your child learns to get along with other children				
Using a car seat				
How to make your house safe				
Teaching child about dangerous situations, places or things				
Issues related to childcare				

Well-child care visits are visits that are made to a doctor or other healthcare provier who takes of your child when he/she is NOT sick but needs a check-up or a shot.

Think about the last time you took your child for a well-child check-up at this program. How many minutes would you say the doctor or healthcare provider who examined your child in the room with you? _____

Think about the last time you took your child for a well-child check-up at this program. Was the time that the doctor or healthcare provider spent with you:

□ Too much time □ About the right amont of time □ Not enough time □ Not sure

How important or unimportant do you think well-child check-ups are for the helath and development of your child? Would you say that they are:

□ Very important □ Somewhat important □ Not important at all □ Not sure

The most important way for your child to learn is:	□ Watching educational TV □ Playing with toys □ Playing with adults □ Not sure
The most important thing when looking for good quality childcare is:	□ New toys and equipment □ Caregivers who teach the alphabet and numbers □ Caregivers who respond well to the children □ Not sure
In a typical week, how many times per week do you or any other family member *read or show pictures books* to your child?	_____ (Number of days per week)
What should you do if you suspect your child has taken poison?	□ Drink water □ Administer Syrup of Ipecac □ Stick your fingers down his/her throat to cause regurgitation □ Call poison control

Parents vary a lot in the methods they use to respond to children who are misbehaving. For each method listed below, please indicate if you use that method often, sometimes, rarely, or never with your child.

Methods	Often	Sometimes	Rarely	Never
First, how about raising your voice or yelling?				
How about spanking?				
How about taking away a toy or treat?				
How about giving a time-out that is making your child take a break from whatever activity {he/she} is involved in?				
How about explaining to your why {his/her} behavior is not appropriate.				

Thinking about the topics discussed in this class, would you say that your confidence in parenting your child has:

□ increased a lot □ increased somewhat □ stayed about the same □ decreased somewhat □ decreased a lot

post

22. Health screenings
22a. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Health screenings; Filtración de salud				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, nosotros le dimos (insierte el número) de referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Health screenings; Filtración de salud				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: Por alguna de las referencias que usted no recibió servicios, fue porqué:Response options: Response options: • Opciones para la respuesta:You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por telefono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills needed • El proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Al llegar, usted tuvo que esperar demasiado tiempo Getting services conflicted with other responsibilities at home or at work Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

23. Immunizations

23a. #/% participants up to date on immunizations at follow up

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Immunizations; Inmunizaciones				
Outcome on Critical Pathways:	Free of illness/disease				
Outcome Measure:	#/% participants up to date on immunizations at follow up				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	What is the status of your child's immunizations? ¿Cuál es el estado de las inmunizaciones de su hijo/a (más pequeño)? Response options: Received no shots, Received some shots, Received all shots recommended by doctor Opciones para la respuesta; No recibió inmunizaciones, Recibió algunas, Recibió todas las que recomendó el docotor	Self-administered questionnaire OR interview	Participant	Post-test	OSERS
2	Is this child up-to-date for age on his/her immunizations ¿Está este niño/a al corriente para su edad con las inmunizaciones? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Document review	Staff	Post-test	New measure

24. Oral health treatment, screening or prevention
24a. #/% participants with oral health problems successfully treated

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention (Maternal and/or Pediatric); Prevención o filtración, tratamiento de salud oral (Maternal y/o Pediatra)				
Outcome on Critical Pathway:	Free of illness/disease, access and parent knowledge and skills				
Outcome Measure:	#/% participants with oral health problems successfully treated				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	About how long has it been since *[choose either "you" or "your child"]* last visited a dentist, dental hygienist or orthodontist? ¿Cómo cuánto tiempo ha pasado desde que *[escoga ya sea "usted" o "su hijo/a más pequeño/a]* visitó a un dentista, un higienista dental, o un ortodona? Response options; less than 3 months; 3 months up to 6 months, 6 months up to 1 year ago, 1 year up to 2 years ago; 2 years up to 5 years ago; more than 5 years ago; has never visited; Prefer not to say; don't know Opciones para la respuesta: menos de 3 meses; de 3 meses at 6 meses, de 6 meses a un año, de 1 año a 2 años; de 2 años a 5 años; más de 5 años; nunca ha visitado; Prefiero no decir, no lo sé When you first started to receive services at this program did *[choose either "you" or "your child"]* have a dental problem that needed to be treated? Cuando usted empezó a recibir servicios en este programa, ¿usted *[escoga ya sea "usted" o "su hijo/a más pequeño/a"]* tenía algún problema dental que necesitaba tratamiento? Response options: yes, know, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	CHIS New measure

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention (Maternal and/or Pediatric); Prevención o filtración, tratamiento de salud oral (Maternal y/o Pediatra)				
Outcome on Critical Pathway:	Free of illness/disease, access and parent knowledge and skills				
Outcome Measure:	#/% participants with oral health problems successfully treated				
1 Cont.	If yes, did this program treat *[choose either "your" or "your child's"]* dental problem successfully? Si dijo sí, ¿Tuvo este programa éxito en su *[escoga ya sea "usted" o "su hijo/a"]* problema dental? Response options: yes, know, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir If no, did this program refer *[choose either "you" or "your child"]* to another dental provider to get this problem treated? Si dijo no, este programa le refirió *[escoga ya sea "usted" o "su hijo/a más pequeño/a"]* a otro proveedor dental para que le ayudaran con su problema? Response options: yes, know, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir If yes, did you seek dental treatment? Si dijo sí, ¿buscó used tratamiento dental? Response options: yes, know, don't know, prefer not to say Opciones para las respuestas: sí, no, no lo sé, prefiero no decir				

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention (Maternal and/or Pediatric); Prevención o filtración, tratamiento de salud oral (Maternal y/o Pediatra)				
Outcome on Critical Pathway:	Free of illness/disease, access and parent knowledge and skills				
Outcome Measure:	#/% participants with oral health problems successfully treated				
1 Cont	If yes, did *[choose either "you" or "your youngest child"]* receive dental treatment services as a result of this referral? Si dijo sí, ¿acaso *[escoga ya sea "usted" o "su hijo/a más pequeño/a]* recibió los servicios del tratamiento dental como resultado de esta referencia? Response options: yes, know, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir				
2	Did *[choose either "you" or "your child]* get all the dental care that was needed? ¿Acaso *[escoga ya sea "usted" o "su hijo/a"]* recibió todo el cuidado dental que necesitaba? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir If no, are *[choose either "you" or "your youngest child]* still in the process of getting treatment? Si dijo no, ¿está *[escoga ya sea "usted" o "su hijo/a más pequeño/a"]* aún en el proceso de recibir tratamiento? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

24. Oral health treatment, screening or prevention
24b. #/% participants carries-free after 6 months of oral health services

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and parent knowledge and skills				
Outcome Measure:	#/% participants carries-free after 6 months of oral health services				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Does this participant have any dental caries (cavities) six months after they began receiving services from your program? ¿Tiene este participante alguna carie dental en los seis meses después de que empezó a recibir servicios de su programa? Response options: yes, know, don't know Opciones para la respuesta: sí, no, no lo sé	Medical chart review	Staff	6 month follow-up	New measure

24. Oral health treatment, screening or prevention
24c. #/% participants demonstrating knowledge around oral health

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and Participants knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around oral health				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	When should you begin cleaning your young children's's teeth? ¿Cuándo debe de empezar a limpiarle los dientes a sus hijos pequeños? Response options: a) When they are 3 years old; b) When they are 12 months old; c) As soon as they get their first tooth; d) Once they have 4-5 teeth Opciones para la respuesta: a) A los 3 años; b) A los 12 meses; c) Al momento que les salga el primer diente; d) Cuando tengan 4-5 dientes	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm http://pediatrics.about.com Correct responses: c

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and Participants knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around oral health				
	Baby Bottle Tooth Decay is caused by prolonged contact with: (check all that apply) Response options: a bottle of formula, milk, juice, water, sugared drinks, etc.				
2	Which of the following can be a sign of a cavity? ¿Cuál de las siguientes opciones puede ser seña de una carie? Response option: a) a tooth that hurts; b) a tooth that is sensitive to hot or cold foods or liquids; c) a tooth that is stained or discolored; d) all of the above Opciones para la respuesta: a) un diente que duela; b) un diente sensible a comidas o líquidos calientes o fríos; c) un diente que esta manchado o descolorido; d) todas las respuestas dadas	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm http://pediatrics.about.com Correct responses: d

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and Participants knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around oral health				
3	Your young children should visit a dentist: Sus hijos pequeños deben de visitar a un dentista: Response options: a) only if he has a problem; b) at least once a year for checkups; c) every other year; d) at least every six months for checkups Opciones para la respuesta: a) sólo si tiene un problema; b) por lo menos una vez al año para chequeos; c) cada tercer año; d) por lo menos cada seis meses para chequeos	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm http://pediatrics.about.com Correct responses: d

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and Participants knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around oral health				
4	How old should a young child be when they first visit the dentist: A qué edad debe se le debe de llevar a un niño/a pequeño/a al dentista la primera vez: Response options: ____ (years) ____ (months) Opciones para la respuesta: ____(años) ____(meses)	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm http://pediatrics.about.com Correct responses: Pediatricians: 1 year First 5: 1.5 years AAP says 3 years

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Oral health treatment, screening or prevention; Prevención o filtración, tratamiento de salud oral				
Outcome on Critical Pathway:	Free of illness/disease, access and Participants knowledge and skills				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around oral health				
5	Children begin needing fluoride supplements: Niños empiezan a necesitar suplementos de fluoruro: Response options: a) at birth; b) by age 6 months; c) at around age 3 years; d) never, fluoride supplements can stain their teeth. Opciones para la respuesta: a) al nacer; b) a los 6 meses; c) alrededor de los 3 años; d) nunca, suplementos de fluoruro puede manchar sus dientes.	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm http://pediatrics.about.com Correct responses: b
6	The health of a mother's mouth can directly affect the health of her developing baby before he/she is born La salud oral de la madre puede afectar directamente la salud del desarrollo del bebé antes de que él/ella haya nacido Response options: true, false. Opciones para la respuesta: verdadero, falso.	Self-administered questionnaire OR interview	Participant	Pre/post-test	Derived from: www.cdc.gov/oralhealth/factsheets/brushup-quiz/htm correct response: true

25. Nutrition education and assessments

25a. #/% participants demonstrating knowledge around nutrition

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Nutrition education and assessments; Evaluación y educación de nutrición				
Outcome on Critical Pathway:	Parents provide child nutritious diet				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around nutrition				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Do you think the best age to start feeding your baby cereal or other solid foods is? La mejor edad para darle de comer a su bebé cereal u otra comida sólida es: Response options: Between zero and three months old, Between four to six months old, Seven or more months old, You're not sure, Prefer not to say Opciones para la respuesta: Entre cero y tres meses, Entre cuatro a seis meses, Siete o más meses, No estoy seguro	Self-administered questionnaire OR interview	Participant	Pre/post-test	UCB Study (State Evaluation of First 5 Parent Kit) Correct response: b
2	The best way to feed a two-month old baby is with La mejor manera de darle de comer a un bebe de dos meses es Response options: Breast milk only, Formula only, Breast milk and formula, Prefer not to say Opciones para la respuesta: Sólo leche de pecho, Sólo fórmula, leche de pecho y fórmula, No estoy seguro	Self-administered questionnaire OR interview	Participant	Pre/post-test	UCB Study (State Evaluation of First 5 Parent Kit) Correct response: a

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Nutrition education and assessments; Evaluación y educación de nutrición				
Outcome on Critical Pathway:	Parents provide child nutritious diet				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around nutrition				
3	A 4 year old should eat: Un niño/a de 4 años debe de comer: Response options: a) 3 servings of vegetables each day and 2 servings of fruits each day; c) 2 servings of vegetables each day and 2 servings of fruits each day; d) 1 serving of vegetable and 1 serving of fruit each day Opciones para la respuesta: a) 3 porciones de verduras al día y 2 porciones de frutas al día; c) 2 porciones de verduras al día y 2 porciones de frutas al día; d) 1 porción de verduras y 1 porción de frutas al día	Self-administered questionnaire OR interview	Participant	Pre/post-test	http://pediatrics.about.com correct response: a
4	At what age can you begin giving your young children 2% or low fat milk? ¿A qué edad se le puede dar a sus hijos leche baja en calorías o 2%? Response options: a) 6 months; b) 12 months; c) 18 months; d) 2 years. Opciones para la respuesta: a) 6 meses; b) 12 meses; c) 18 meses; d) 2 años	Self-administered questionnaire OR interview	Participant	Pre/post-test	http://pediatrics.about.com correct response: d

Strategy: Direct Service					
Activity Category:	Health education and services				
Activity Description:	Nutrition education and assessments; Evaluación y educación de nutrición				
Outcome on Critical Pathway:	Parents provide child nutritious diet				
Outcome Measure:	#/% participants demonstrating knowledge, skills, behavior around nutrition				
5	I know how to provide a healthy and nutritious diet for my young children. Sé cómo proveer una dieta saludable y nutritiva para mis hijos pequeños. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones de respuestas: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Pre/post- test	New measure
6	As a result of this program, I know how to provide a more healthy and nutritious diet for my young children. Como resultado de este programa, sé cómo proveer una dieta más saludable y nutritiva para mis hijos pequeños. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones de respuestas: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New measure

C. Child Development Services

26. Developmental screenings/assessments
26a. #/% of children found to have a developmental delay

Strategy: Direct Service			
Activity Category:	Child development services		
Activity Description:	Developmental screenings/assessments; Filtraciones/evaluaciones de desarrollo		
Outcome on Critical Pathway:	Access		
Outcome Measure:	#/% of children who received a screening that were found to have a developmental delay		
Question		*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*
Did this program tell you that your child has any of the other following disabilities or special needs? (Check all that apply.) ¿~~Algún doctor o algún profesional de salud le ha dicho~~ ¿Éste programa le dijo que su hijo/hija tiene alguna de las sigueintes incapacidades o una necesidad especial? (Marque a todos los que aplican.) Response Options: ☐ A serious emotional disturbance ☐ A specific learning disability ☐ Autism or pervasive developmental disorder ☐ A speech impairment ☐ Deafness or another hearing impairment ☐ Blindness or another visual impairment ☐ An orthopedic impairment ☐ Another health impairment lasting 6 months or more ☐ No ☐ No answer/prefer not to say Opciones para la respuesta: ☐ Un problema emocional grave ☐ Un problema específico de aprendizaje ☐ Autista o un trastorno de desarrollo penetrante ☐ Un impedimento de lenguaje ☐ Sordera o algún otro impedimento de oído ☐ Ceguera o algún otro impedimento de visión ☐ Un impedimento ortopédico ☐ Otro impedimento de salud que haya durado 6 meses o más ☐ No ☐ Sin respuesta/prefiero no decir			

26. Developmental screenings/assessments
26b. #/% referrals for which services were received

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Developmental screenings/assessments; Filtraciones/evaluaciones de desarrollo				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for needed services. Durante las los previas previos visitas contactos, nosotros le dimos (insierte el número) de referencia/s para servicios necesitados. For how many of these referrals did you seek services? ¿De éstas referencias cuántos servicios solicitó? For how many of these referrals did you receive services? ¿De éstas referencias cuántos servicios recibió?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Developmental screenings/assessments; Filtraciones/evaluaciones de desarrollo				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% referrals for which services were received				
2	For any referrals where you did not receive services, was it because: • Por alguna de las referencias que usted no recibió servicios, fue porqué: Response options: Opciones para la respuesta • You couldn't get through to the program staff on the phone • No pudo comunicarse con el personal del programa por teléfono • You couldn't get an appointment soon enough • No pudo conseguir una cita con tiempo • The provider was not open when you could get there • La oficina del proveedor estaba cerrada cuando usted podría ir • Transportation was a problem • El medio de transporte era un problema para usted • You didn't have enough money • No tenía suficiente dinero • The type of service you needed was not available from this provider • El tipo de servicio que usted necesitaba no se lo podía dar este proveedor • The program staff did not speak your language • El personal de este programa no hablaba su idioma • The provider did not have the skills neededEl proveedor no tenía la habilidad que se necesitaba • Once you got there, you had to wait too long • Al llegar, usted tuvo que esperar demasiado tiempo Getting services conflicted with other responsibilities at home or at work Al obtener estos servicios, tuvo usted conflicto con sus responsabilidades de su hogar de su trabajo	Self-administered questionnaire OR interview	Participant	Post-test	NSCSHCN

26. Developmental screenings/assessments

26c. #/% of parents who feel the program addressed their concerns about their child's development

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Developmental screenings/assessments; Filtraciones/evaluaciones de desarrollo				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% of parents who feel the program addressed their concerns about their child's development				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Did the staff at this program ask if you have concerns about your young children's learning, development, or behavior? ¿Le preguntaron el personal de este programa si usted tenía preocupaciones acerca del aprendizaje, desarrollo, o comportamiento de su hijo? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	Adapted from PHDS Plus 9/25/00

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Developmental screenings/assessments; Filtraciones/evaluaciones de desarrollo				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% of parents who feel the program addressed their concerns about their child's development				
2	Do you have any concerns about your young children's learning, development, or behavior? ¿Tiene usted alguna preocupación acerca del aprendizaje, desarrollo, o comportamiento de sus hijos? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir If yes, did the staff at this program give you specific information to address these concerns? Si dijo sí, le dieron, el personal de este programa, información para tartar estas preocupaciones? Response options: yes, no, don't know, prefer not to say Opciones para la respuesta: sí, no, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	Adapted from PHDS Plus 9/25/00

27. Recreational/physical activities for children
27a. # hours/week participants engage in recreational/physical activities

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Recreational/physical activities for children; Actividades recreacionales/físicas para los niños				
Outcome on Critical Pathways:	Children engage in physical activity and play				
Outcome Measure:	# hours/week participants engage in recreational/physical activities				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Thinking about your child's free time on MONDAY THROUGH FRIDAY, on a typical day, about how many hours did he/she usually engage in recreational/physical activity? Cuando piensa en el tiempo libre de su hijo/a del LUNES A VIERNES, en un día normal, ¿cómo cuántas horas participó en actividades recreacionales/físicas?	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from CHIS
2	Thinking about your child's free time on SATURDAY AND SUNDAY, on a typical day, about how many hours did he/she usually engage in recreational/physical activity? Cuando piensa en el tiempo libre de su hijo/a del SÁBADO Y DOMINGO, en un día normal, ¿cómo cuántas horas participó en actividades recreacionales/físicas?	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from CHIS

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Recreational/physical activities for children; Actividades recreacionales/físicas para los niños				
Outcome on Critical Pathways:	Children engage in physical activity and play				
Outcome Measure:	# hours/week participants engage in recreational/physical activities				
3	Would you say that this program resulted in your child being more or less active? Would you say he/she is: ¿Diría usted que este programa ha resultado en que su hijo sea más activo o menos activo? ¿Diría usted que él/ella es: Response options: a lot more active, somewhat more active, about the same, somewhat less active, a lot less active, don't know, prefer not to say Opciones para la respuesta: mucho más activo, algo más activo, casi igual, algo menos activo, mucho menos activo, no lo sé, prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	New Measure

27. Recreational/physical activities for children
27b. # hours of television participants watch per week

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Recreational/physical activities for children; Actividades recreacioneles/físicas para los niños				
Outcome on Critical Pathways:	Children engage in physical activity and play				
Outcome Measure:	# hours of television participants watch per week				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Thinking about your child's free time on MONDAY THROUGH FRIDAY, on a typical day, about how many hours does he/she usually watch TV?" Cuando piensa en el tiempo libre de su hijo/a del LUNES A VIERNES, en un día normal, ¿cómo cuántas horas mira la televisión?	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from CHIS
2	Thinking about your child's free time on SATURDAY AND SUNDAY, on a typical day, about how many hours does he/she usually watch TV?" Cuando piensa en el tiempo libre de su hijo/a del SÁBADO Y DOMINGO, en un día normal, ¿cómo cuántas horas mira la televisión?	Self-administered questionnaire OR interview	Participant	Pre/post-test	Adapted from CHIS

28. Family literacy

28a. #/% participants demonstrating improved child literacy-promoting behaviors

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Family literacy programs; Programas familiares de alfabetización				
Outcome on Critical Pathway:	Participants/family literacy				
Outcome Measure:	#/% participants demonstrating improved child literacy-promoting behaviors				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	In a typical week, how often do you or any other family member *sing songs* with your young children? En una semana normal, ¿qué tan seguido, usted u otro familiar, *cantan canciones* con sus hijos más pequeños? Response options: Number of days per week Opciones para la respuesta: Número de días por semana	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSECH
2	In a typical week, how often do you or any other family member *tell stories* to your young children? En una semana normal, ¿qué tan seguido, usted u otro familiar, le *cuentan cuentos* a sus hijos más pequeños? Response options: Number of days per week Opciones para la respuesta: Número de días por semana	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSECH

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Family literacy programs; Programas familiares de alfabetización				
Outcome on Critical Pathway:	Participants/family literacy				
Outcome Measure:	#/% participants demonstrating improved child literacy-promoting behaviors				
3	In a typical week, how often do you or any other family member *read or show pictures books* to your young children? En una semana normal, ¿qué tan seguido, usted u otro familiar le *leen o le muestran un libro de dibujos* a su hijo/a? Response options: Number of days per week Opciones para la respuesta: Número de días por semana	Self-administered questionnaire OR interview	Participant	Pre/post-test	NSECH
4	As a result of this program, my ability to read has improved. Como resultado de este programa, mi habilidad de leer ha mejorado. Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones de respuestas: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	Derived from Participant retrospective self-assessment: Peisher, A., Swell, M., Kirk, R.,, Outcome Accountability for Family Support Programs, Volume II,

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Family literacy programs; Programas familiares de alfabetización				
Outcome on Critical Pathway:	Participants/family literacy				
Outcome Measure:	#/% participants demonstrating improved child literacy-promoting behaviors				
5	The best time to start reading to your child is: El mejor tiempo para empezar a leerle a su hijo/a es: Response options: a) During the first year, b) When they are ages 2-4, c) When they are in kindergarten (5-6 yrs), d) Not sure Opciones para la respuesta: a) Durante el primer año, b) Cuando están entre los 2-4 años de edad, c) cuando están en kindergarten (5-6 años), d) No estoy seguro	Self-administered questionnaire OR interview	Participant	Pre/post-test	UCB Study (State Evaluation of First 5 Parent Kit) Correct response: a

29. Early education programs for children/parents (preschool)
29a. #/% increase in children who have fully mastered the four results areas of the preschool-aged DRDP

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Early education programs for children/parents (preschool); Programas de educación temprana para los niño/padres (preescuela)				
Outcome on Critical Pathway:	Optimal health, social-emotional and learning comprehension (school readiness)				
Outcome Measure:	#/% increase in children who have fully mastered the four results areas of the preschool-aged DRDP				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	See following pages for Desired Results Developmental Profile (DRDP) Veáse las siguientes páginas para los Resultados Deseados del Perfil del Desarrollo (DRDP)	Observational Assessment of preschoolers	Teacher	Pre-post-test	http://www.cde.ca.gov/sp/cd/ci/documents/drdp4.doc

Desired Results Developmental Profile: 3 Years Through Prekindergarten

Theme	Child Desired Result 1: Children are personally and socially competent. Note: (Shaded Measures are those used to create Mini-DRDP for summer preschool programs)	Observation	Not Yet	Emerging	Almost Mastered	Fully Mastered	Comments/Observations
	Indicator 1: Children show self-awareness and a positive self-concept.						
Self-awareness	1. Identifies self by categories of gender, age, or social group (e.g., "I'm a boy," "I'm not a baby," "This is my brother.")	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Self-concept	2. Demonstrates confidence in own abilities (e.g., leads teacher to show block structure that he/she put together; "I can climb to the top of the big slide all by myself!")	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	Indicator 2: Children demonstrate effective social and interpersonal skills.						
Interactions with adults	3. Seeks adult help when appropriate (e.g., asks adult for assistance to open bottle of paint)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	4. Responds to and makes verbal greetings at appropriate times (e.g., responds with "good morning;" "hi," or "goodbye," if prompted by familiar adult)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Interactions with peers	5. Engages in cooperative pretend play activities with peers (e.g., plays house, builds a spaceship, creates fantasy role play with peers)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	6. Negotiates with peers to resolve social conflicts with adult guidance (e.g., agrees to alternatives like sharing or taking turns)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	7. Expresses empathy or caring for others (e.g., consoles or comforts a friend who is crying)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	

	Indicator 3: **Children demonstrate effective self-regulation of their behavior.**			
Self-regulation	8. Comforts self with adult guidance (e.g., goes to quiet area or requests favorite book to be read when upset; identifies emotion he/she is feeling)	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
	9. Exhibits impulse control and self-regulation (e.g., uses appropriate words or sign language to show anger when a toy is taken by another child, waits for turn on playground equipment, shows some patience)	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
	10. Follows rules when participating in routine activities (e.g., handles toys with care, joins group for snack or circle time, tolerates transitions)	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
	Indicator 4: **Children show awareness, acceptance, understanding, and appreciation of others' special needs, gender, family structures, ethnicities, cultures, and languages.**			
Acceptance of diversity	11. Shows concern about fairness within peer group regardless of group differences (e.g., "Everyone gets a turn" when engaged in group activity; "That's not fair.")	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
	Indicator 5: **Children show growing abilities in communication and language.**			
Language comprehension	12. Follows two-step requests that are sequential but not necessarily related (e.g., "Please pick up the ball and then get your coat.")	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
Language expression	13. Engages in conversations that develop a thought or idea (e.g., tells about a past event, asks how something works)	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	
	14. Participates in songs, rhymes, games, and stories that play with sounds of language (e.g., claps out sounds or rhythms of language; creates own rhyming words through songs, fingerplays, chants)	A B	⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭ ⬭	

Language expression	15. Experiments with new vocabulary, uses more complex grammar and parts of speech (e.g., uses plural forms of nouns, such as “balls” or “fishes,” uses future or past tense, or uses pronouns, such as “he,” “she,” “I,” “you”)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Theme	**Child Desired Result 2: Children are effective learners.**	**Observation**	**Not Yet**	**Emerging**	**Almost Mastered**	**Fully Mastered**	**Comments/Observations**
	Indicator 1: Children are interested in learning new things.						
Interest in learning	16. Observes and examines natural phenomena through senses (e.g., notices different types of bugs, asks why it rains)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	17. Combines activities, materials, and equipment in new ways (e.g., builds tent by using sheet or blanket around table, uses Play-Doh to make pretend food)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	Indicator 2: Children show cognitive competence and problem-solving skills through play and daily activities.						
Cognitive competence	18. Acts out plays, stories, or songs (e.g., uses body and sounds to express rhythm; makes up plays or songs about common fables, stories, or familiar characters)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	19. Completes increasingly complex puzzles (e.g., single, cut-out figures to four-piece interlocking to eight- or ten-piece puzzles)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	20. Stays with or repeats a task (e.g., finishes a puzzle, asks that block structure be left to work on after snack, makes a really long Play-Doh snake out of many pieces)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	

	Indicator 3: Children show interest in real-life mathematical concepts.						
Number concepts	21. Counts to ten by rote memorization (e.g., recites numbers from one to ten)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	22. Uses size words, such as “many,” “big,” and “little,” appropriately	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	23. Understands that numbers represent quantity (e.g., can get three apples out of the box, asks for two more crackers, can put out one napkin for each child)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
Measure, order, and time	24. Uses measuring implements (e.g., uses tool in sand and water play, helps measure ingredients for a cooking project)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	25. Orders objects from smallest to largest (e.g., orders various circle sizes, nests cups, lines up from shortest to tallest)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	26. Demonstrates an understanding of different rates of speed (e.g., “fast” and “slow”)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
Math concepts	27. Describes how items are the same or different (e.g., “This ball is bigger than that one,” “My shirt is the same as Marcus’s.”)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	28. Matches and names simple patterns (e.g. , “boy-girl-boy-girl,” “red-blue-red-blue)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	
	29. Estimates (e.g., “I’m as tall as the yellow bookshelf,” “I think there are about 20 marbles in that jar.”)	A	⬭	⬭	⬭	⬭	
		B	⬭	⬭	⬭	⬭	

	Indicator 4: Children demonstrate emerging literacy skills.						
Reading skills	30. Understands that letters make up words (e.g., knows some of the letters in his or her name)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	31. Recognizes print in the environment (e.g., recognizes signs around the room as labels for "Puzzles," "Toys," or "Books")	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	32. Makes three or more letter-sound correspondences	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Interest in books and other written materials	33. Pretends to read books	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	34. Engages in discussion about books (e.g., predicts events in a story, retells main events from a story in order)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	35. Draws a picture related to a story and talks about his or her drawing	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Writing	36. Uses pretend writing during play activities (e.g., scribbles lines and shapes)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	37. Uses strings of repeated letter-like symbols as pretend writing	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	38. Writes three or more letters or numbers	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	

Theme	Child Desired Result 3: Children show physical and motor competence.	Observation	Not Yet	Emerging	Almost Mastered	Fully Mastered	Comments/Observations
	Indicator 1: **Children demonstrate an increased proficiency in motor skills.**						
Gross-motor skills	39. Avoids obstacles (e.g., moves about the room without bumping into objects)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	40. Pedals a tricycle	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	41. Jumps forward with both feet together	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	42. Kicks a large ball	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	43. Catches a large ball with two hands	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	44. Shows rhythmic movement (e.g., marches or moves to music)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	45. Gets dressed with minimal help (e.g., puts on coat, hat, and boots with minimal help)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	46. Skips or gallops	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	

Fine-motor skills	47. Manipulates two small objects at the same time (e.g., stringing beads)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	48. Uses tools with increasing precision (e.g., crayons, scissors)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	49. Fastens buttons	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Theme	**Child Desired Result 4: Children are safe and healthy.**	**Observation**	**Not Yet**	**Emerging**	**Almost Mastered**	**Fully Mastered**	**Comments/Observations**
	Indicator 1: Children show an emerging awareness and practice of safe and healthy behavior.						
Healthy habits	50. Tries new food on own	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	51. Washes and dries hands before eating and after toileting	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	52. Takes care of own toileting needs	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
Safe behavior	53. Communicates dangerous behavior to another (e.g., tells someone not to throw rocks or sand)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	54. Knows how to follow routines in emergency situations (e.g., fire or earthquake drills)	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	
	55. Knows first and last name	A B	⬭ ⬭	⬭ ⬭	⬭ ⬭	⬭ ⬭	

30. Early education programs for children/parents (summer preschool programs)
30a. % increase in children fully mastered the results areas of the preschool-aged Mini-DRDP

Strategy: Direct Service	
Activity Category:	Child development services
Activity Description:	Early education programs for children/parents (summer preschool programs); Programas de educación temprana para los niños/padres (programas de preescuelas de verano)
Outcome on Critical Pathway:	Optimal health, social-emotional and learning comprehension (school readiness)
Outcome Measure:	% increase in children who have fully mastered the results areas of the preschool-aged Mini-DRDP

	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Refer to shaded items in previous table for the Desired Results Developmental Profile (DRDP) Dirígase a los puntos sombreados que se encuentran en la lista para los Resultados Deseados del Perfil del Desarrollo (DRDP)	Observational Assessment of preschoolers	Teacher	Pre-post-test	Adapted from http://www.cde.ca.gov/sp/cd/ci/documents/drdp4.doc

31. Early childhood education/child care R&R
31a. #/% of participants for which child care was received

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Early childhood education/child care R&R; Recursos y Referencias para cuidado infantil/ educación temprana para los niños				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% of participants for which child care was received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	During previous contacts, we provided you with (insert number) of referral/s for child care. Durante las los previas previos visitas contactos, nosotros le dimos (insierte el número) de referencia/s para cuidado infantil. For how many of these referrals did you seek child care? ¿De éstas referencias cuántos servicios solicitó para cuidado infantil? Did you obtain child care as a result of this/these referral/s? ¿Cómo resultado de éstas referencias, pudo usted obtener cuidado infantil?	Self-administered questionnaire OR interview	Participant	Post-test	New measure

32. Early childhood education/child care subsidies or vouchers

32a. #/% recipients reporting increased satisfaction with child care provider (affordability, quality, parental life-course development)

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Early childhood education/child care subsidies or vouchers; Subsidios o vales para educación temprana para niños/ cuidado infantil				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% recipients reporting increased satisfaction with child care provider				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Before receiving this subsidy were you **paying** for childcare? Antes de recibir este subsidio, ¿estaba usted **pagando** por el cuidado de su hijo/a? Response options: Yes, No, Don't know, Prefer not to say Opciones para la respuesta: Sí, No, No lo sé, Prefiero no decir If yes, was it: Si dijo sí, fue: Response options: Very difficult to pay for, Somewhat difficult to pay for, Not at all difficult to pay for, Don't know, Prefer not to say Opciones para la respuesta: Muy difícil para pagar, Algo difícil para pagar, Nada difícil para pagar, No lo sé, Prefiero no decir If no, why not? (Check all that apply) Si dijo no, ¿por qué? (Marque a todos los que aplican) Response options: Was receiving free child care, Did not need child care, Did not want child care, Could not find child care, Could not afford child care, Don't know, Prefer not to say Opciones para la respuesta: Ya estaba recibiendo cuidado infantil, No necesitaba cuidado infantil, No quería cuidad infantil, No podía encontrar cuidado infantil, No podía pagar por cuidado infantil, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Participant	Post-test	CfE survey developed for SCCF program

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Early childhood education/child care subsidies or vouchers; Subsidios o vales para educación temprana para niños/ cuidado infantil				
Outcome on Critical Pathway:	Access				
Outcome Measure:	#/% recipients reporting increased satisfaction with child care provider				
2	1. Has this program made it easier for you to: ¿Le ha facilitado este programa a: **Yes / No / N/A** A. Accept a job? Aceptar un trabajo? — o / o / o B. Keep a job? Mantener su empleo? — o / o / o C. Accept a better job? Aceptar un trabajo mejor? — o / o / o D. Attend education or training? Asistir en educación o en entrenamiento? — o / o / o E. Select a higher quality provider for your child? — o / o / o	Self-administered questionnaire OR interview	Participant	Post-test	Adapted from DRDP Parent Survey

33. Kindergarten transition programs
33a. #/% participants reporting good transition to kindergarten

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Kindergarten transition programs; Programas de transición al Kindergarten				
Outcome on Critical Pathway:	Not currently on pathways: potential – Participants knowledge and skills				
Outcome Measure:	#/% participants reporting good transition to kindergarten				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Kindergarten transition programs; Programas de transición al Kindergarten				
Outcome on Critical Pathway:	Not currently on pathways: potential – Participants knowledge and skills				
Outcome Measure:	#/% participants reporting good transition to kindergarten				
1	There are a variety of things that might happen before your child starts kindergarten. Please tell us which ones, if any, this program helped you with: Hay varias cosas que pueden pasar antes de que su hijo/a empiece el kindergarten. Por favor díganos cuáles cosas, si acaso alguna, le pudo ayudar este programa:Response options: Opciones para la respuesta: a. Invited you and your child to visit the kindergarten classroom and school before the school year began a. Le invitaron a usted y a su hijo/a a visitar el salón de kindergarten y la escuela antes de que el año escolar empezara b. Sent home information on how to get me and my child ready for the move to kindergarten b. Le mandaron información en cómo preparme a mí y a mi hijo/a para la transición al kindergarten c. Introduced me to my child's kindergarten teacher c. Me presentaron a la maestra de kindergarten d. Provided me with a workshop, materials, or advice about how to get ready to move to kindergarten d. Me dieron un taller, materiales, o consejos en cómo prepararme para la transición al kindergarten e. Other (Please specify): e. Otro (Por favor especifique):	Self-administered questionnaire OR interview	Participant	Post-test (upon kindergarten entry)	SRI: Kindergarten Family Interview

Strategy: Direct Service					
Activity Category:	Child development services				
Activity Description:	Kindergarten transition programs; Programas de transición al Kindergarten				
Outcome on Critical Pathway:	Not currently on pathways: potential – Participants knowledge and skills				
Outcome Measure:	#/% participants reporting good transition to kindergarten				
	Do you think that what this program did to get you and your child ready for the move to kindergarten was: Usted cree que lo que hizo este programa para usted y para su hijo para transicionarlo al kindergarten fue: Response options: More than needed; Less than needed; About right; Dk; refused Opciones para la respuesta: Más de lo que se necesitaba; Menos de lo que se necesitaba; Más o menos; NS; rehusó	Self-administered questionnaire OR interview	Participant	Post-test (upon kindergarten entry)	SRI: Kindergarten Family Interview
	Thinking about what it was like for you and your child when [he/she] started kindergarten. Do you think that starting kindergarten was: Pensando en cómo le fue a usted a su hijo/a cuando [él/ella] empezo el kindergarten. ¿Usted cree que el empezar el kindergarten fue: Response options: Very easy, Somewhat easy, Somewhat hard, Very hard , dk, rf Opciones para la respuesta: Muy fácil, Algo fácil, Algo difícil, Muy difícil, ns, rehusó	Self-administered questionnaire OR interview	Participant	Post-test (upon kindergarten entry)	SRI: Kindergarten Family Interview

D. Parent Satisfaction

34. All programs– Parent Satisfaction

34a. #/% participants who strongly agree or agree that they were generally satisfied with the services they received

Strategy: Direct Service					
Activity Category:	All – Parent Satisfaction				
Activity Description:	All Programs – Parent Satisfaction; Todos los programas—Satisfacción de los padres				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% participants who strongly agree or agree that they were generally satisfied with the services they received				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Has this program given you the information and/or assistance that you needed? ¿Le ha dado este programa la información y/o asistencia que usted necesitaba? Response options: yes, no, dk Opciones para la respuesta: sí, no, ns If no, why not? Si dijo no, ¿por qué no?	Self-administered	Participants	Post-test	Adapted from PHDS and NSCSHCN

Strategy: Direct Service					
Activity Category:	All – Parent Satisfaction				
Activity Description:	All Programs – Parent Satisfaction; Todos los programas—Satisfacción de los padres				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% participants who strongly agree or agree that they were generally satisfied with the services they received				
2	How often did this program do the following: ¿Qué tan seguido hizo lo siguiente el programa para usted: • Take time to understand your (or your child's) specific needs • Tomó el tiempo para entender las necesidades específicas de usted (o de su hijo/a) • Respect you as an expert about your child • Mostró respeto hacia usted como experto de su hijo/a • Build your confidence as a parent • Animó su confianza cómo padre • Ask about how you are feeling as a parent • Se le preguntó como se siente como padre • Take time to understand you and your family and how you prefer to raise child • Tomó el tiempo para entenderle a usted y a su familia en como prefiere criar a su hijo • Talk to you about issues in your community that may affect your child's health and development • Hablarle de cosas que suceden en su comunidada que puedan afectar el desarrollo y salud de su hijo/a Response options: never, sometimes, usually, always, DK, RF Opciones para la respuesta: nunca, algunas veces, usualmente, siempre, NS, Rehusó	Self-administered	Participants	Post-test	PHDS

Strategy: Direct Service					
Activity Category:	All – Parent Satisfaction				
Activity Description:	All Programs – Parent Satisfaction; Todos los programas—Satisfacción de los padres				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% participants who strongly agree or agree that they were generally satisfied with the services they received				
3	Have you ever had a hard time understanding any person that works at the program because they did not speak your language? ¿Alguna vez a tenido problemas en entender a una persona que trabaja en el programa porque esa persona no hablaba su idioma? Response options: yes, no, dk Opciones para la respuesta: sí, no, ns	Self-administered	Participants	Post-test	New Measure
4	Thinking about the environment at the program, would you say that it is clean and safe: Pensando en el medio ambiente del programa, diría usted que estaba limpio y seguro: Response options: never, sometimes, usually, always, DK, Opciones para la respuesta: nunca, aveces, usualmente, siempre, NS	Self-administered	Participants	Post-test	New Measure
5	How satisfied or dissatisfied are you with the program location? Would you say: ¿Qué tan satisfecho o instaisfecho se siente con el local del programa? Diría usted: Response options: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied Opciones para la respuesta: muy satisfecho, algo satisfecho, algo insatisfecho, o muy insatisfecho	Self-administered	Participants	Post-test	New Measure

Strategy: Direct Service					
Activity Category:	All – Parent Satisfaction				
Activity Description:	All Programs – Parent Satisfaction; Todos los programas—Satisfacción de los padres				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% participants who strongly agree or agree that they were generally satisfied with the services they received				
6	How satisfied or dissatisfied are you with the hours that the program is open? Would you say: ¿Qué tan satisfecho o insatisfecho se siente con las horas de operación del programa? Diría usted que: Response options: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied Opciones para la respuesta: muy satisfecho, algo satisfecho, algo insatisfecho, o muy insatisfecho	Self-administered	Participants	Post-test	New Measure
7	If you were asked how likely or unlikely would you be to recommend this program to your friends or family? Would you say: Si se le preguntara que que tan probable o improbable sería que usted recomendara este programa a sus amigos o familiars? Usted diría: Response options: very likely, somewhat likely, somewhat unlikely , or not at all likely? Opciones para la respuesta: muy probable, algo probable, algo improbable, o nada probable?	Self-administered	Participants	Post-test	Adapted from NSECH

Strategy: Direct Service					
Activity Category:	All – Parent Satisfaction				
Activity Description:	All Programs – Parent Satisfaction; Todos los programas—Satisfacción de los padres				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% participants who strongly agree or agree that they were generally satisfied with the services they received				
8	Thinking about the services that you (or your child) received at this program, how satisfied or dissatisfied are you with these services? Would you say: Pensando en los servicios que usted (o su hijo/a) recibió en este programa, que tan satisfecho o insatisfecho esta con estos servicios? Diría usted que: Response options: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied Opciones para la respuesta: muy satisfecho, algo satisfecho, algo insatisfecho, o muy insatisfecho	Self-administered	Participants	Post-test	Adapted from NSCSCHN

II. PROVIDER CAPACITY BUILDING

35. All Providers receiving provider capacity building serivces

35a. #/% of Providers very satisfied with serivces

Strategy: Provider Capacity Building/Support					
Activity Category:	All – Providers receiving provider capacity building services				
Activity Description:	All				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% Providers very satisfied with serivces				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	How satisfied or dissatisfied are you with the professional development and/or resources you received from this program? Would you say: ¿Qué tan satisfecho o insatisfecho esta con el desarrollo professional y/o con los recursos que usted recibió de este programa? Diría usted que: Response options: very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied Opciones para la respuesta: muy satisfecho, algo satisfecho, algo insatisfecho, o muy insatisfecho	Self-administered	Providers	Post-test	Adapted from NSCSCHN

Strategy: Provider Capacity Building/Support					
Activity Category: All – Providers receiving provider capacity building services					
Activity Description: All					
Outcome on Critical Pathway: Quality					
Outcome Measure: #/% Providers very satisfied with serivces					
2	Thinking about the professional development and/or resources you received from this program, have they been organized in a way that makes them easy to use? Would you say this is : Pensando en el desarrollo professional y/o los recursos que recibió de este programa, han sido organizados en tal manera que es fácil para usarlos? Usted diría que esto es: Response options: always true, usually true, sometimes true, or never true Opciones para la respuesta: siempre es cierto, usualmente es cierto, a veces es cierto, o nunca es cierto	Self-administered	Participants	Post-test	Adapted from NSCSCHN
3	How likely or unlikely would you be to recommend this program to another provider such as yourself? Would you say: ¿Qué tan probable o improbable sería en recomendar este programa a otro proveedor tal como usted? Usted diría que: Response options: very likely, somewhat likely, somewhat unlikely , or not at all likely? Opciones para la respuesta: muy probable, algo probable, algo improbable, o nada probable?	Self-administered	Participants	Post-test	Adapted from NSECH

Strategy: Provider Capacity Building/Support					
Activity Category:	All – Providers receiving provider capacity building services				
Activity Description:	All				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% Providers very satisfied with serivces				
4	Has this program given you the technical assistance, information and/or support that you need to improve the quality of care you provide to children? Le ha dado este programa la asistencia técnica, información y/o apoyo que usted necesita para mejorar la calidad de cuidado que usted le da a sus hijos? Response options: yes, no, dk Opciones para la respuesta: sí, no, ns				

Strategy: Provider Capacity Building/Support					
Activity Category: All – Providers receiving provider capacity building services					
Activity Description: All					
Outcome on Critical Pathway: Quality					
Outcome Measure: #/% Providers very satisfied with serivces					
5	o The program has made me more aware of training and professional development opportunities in early childhood education o Este programa me ha ayudado a estar más conciente de las oporutnidades del desarrollo professional y de entrenamientos para la educación temprana para los niños o The program has given me opportunities to meet others working in the child care field o Este programa me ha dado la oportunidad de conocer a otras personas que trabajan en el campo de cuidado infantil o The program has made me feel more respected as a professional o Este programa me ha ayudado a sentirme respetado cómo profesional o The program has increased my interest in staying in the child care field o Este programa ha aumentado mi interés en quedarme en el campo de cuidado infantil o The program has improved my skills as a child care provider o Este programa ha mejorado mi habilidad cómo proveedor de cuidado infantil Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Provider	Post-test	First 5 CA/PACE CARES Matching Funds Evaluation survey

36. Other provider training/professional development, information (specify)
36a. #/% Participants demonstrating improved knowledge, skills, behavior

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Other provider training/professional development, information (specify); Información, desarrollo profesional/entrenamiento de otro proveedor (especifique)				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% Participants demonstrating improved knowledge, skills, behavior				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	Please rate the following aspects of the training: Por favor clasifique los siguientes aspectos del entrenamiento: Overall quality of workshop La calidad total del taller Clarity of agenda La claridad del orden del día Met stated objectives Se cumplieron los objetivos Response options: poor, fair, good, excellent Opciones para la respuesta: malo, mediano, bueno, excelente	Self-administered questionnaire OR interview	Provider	Post-test	New Measure

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Other provider training/professional development, information (specify); Información, desarrollo profesional/entrenamiento de otro proveedor (especifique)				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% Participants demonstrating improved knowledge, skills, behavior				
2	As a result of this program, I have gained knowledge about the topics discussed. Como resultado de este programa, he obtenido conocimiento sobre el tema hablado Response options: Strongly disagree, Disagree, Agree, Strongly agree, Prefer not to say Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo, Prefiero no decir	Self-administered questionnaire OR interview	Provider	Post-test	New Measure
3	I feel this training has significantly increased my ability to [*insert training objective*]. Siento que este entrenamiento ha aumentado significativo mi habilidad de *[insierte el objetivo del entrenamiento]* Response options: Strongly disagree, Disagree, Agree, Strongly agree Opciones para la respuesta: Firmemente no estoy de acuerdo, No estoy de acuerdo, Firmemente estoy de acuerdo	Self-administered questionnaire OR interview	Provider	Post-test	New Measure

37. Provider Capacity bulding - Licensing/accreditation
37a. #/% provider getting licensed/accredited

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Provider training - Licensing/accreditation; Entrenamiento para el proveedor—Licenciatura/acreditación				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% provider getting licensed/accredited				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	**<u>Accreditation</u>** As a result of this program did you: (Check all that apply) Como resultado de este programa, usted: (Marque a todas las que aplican) Response options: Begin the process of accreditation, Made progress towards accreditation, Become accredited, Opciones para la respuesta: Empezó el procedimiento de acreditación, Avanzó hacia su acreditación, Obtuvo su acreditación	Self-administered questionnaire OR interview	Provider	Post and 6 month follow up	

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Provider training - Licensing/accreditation; Entrenamiento para el proveedor—Licenciatura/acreditación				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	#/% provider getting licensed/accredited				
	<u>Licensing</u> As a result of this program did you: (Check all that apply) Como resultado de este programa, usted: (Marque a todas las que aplican) Response options: Begin the process of becoming licensed, Made progress towards licensing, Receive license Opciones para la respuesta: Empezó el procedimiento de obtener su licencia, Avanzó hacia obtener su licencia, Recibió su licencia				

38. Provider Capacity bulding – Incentives/stipends
38a. Increase in retention due to incentives/stipends

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Other provider training/professional development, information (specify); Información, desarrollo profesional/entrenamiento de otro proveedor (especifique)				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	Increase in retention due to incentives/stipends				
	Question	*How is the information collected?*	*Who responds to your request for information?*	*When is the information collected?*	*Source*
1	How likely is it that you will leave the child care field in the next three years? Will you: ¿Cuál es la probabilidad que usted deje la carrera de cuidado infantil en los próximos tres años? Usted: Response options: Definitely leave, Probably leave, Probably stay, Definitely stay, Don't know, Prefer not to say Opciones para la respuesta: Definitivamente se irá, Probablemente se irá, Probablemente se quedará, Definitavamente se quedará, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Provider	Pre/Post-test	First 5 CA/PACE CARES Matching Funds Evaluation survey

Strategy: Provider Capacity Building/Support					
Activity Category:	Provider training, professional development, information:				
Activity Description:	Other provider training/professional development, information (specify); Información, desarrollo profesional/entrenamiento de otro proveedor (especifique)				
Outcome on Critical Pathway:	Quality				
Outcome Measure:	Increase in retention due to incentives/stipends				
2	Are you still in the childcare field? ¿Aún esta en el campo de cuidado infantil? Response options: Yes, No, Don't know, Prefer not to say Opciones para la respuesta: Sí, No, No lo sé, Prefiero no decir If yes, how likely is it that you will leave the child care field in the next three years? Will you: ¿Cuál es la probabilidad que usted deje la carrera de cuidado infantil en los próximos tres años? Usted: Response options: Definitely leave, Probably leave, Probably stay, Definitely stay, Don't know, Prefer not to say Opciones para la respuesta: Definitivamente se irá, Probablemente se irá, Probablemente se quedará, Definitavamente se quedará, No lo sé, Prefiero no decir If no, why did you leave the child care field? (Check all that apply) Is it because: Si dijo no, ¿por qué dejó la carrera de cuidado infantil? (Marque a todas las respuestas que aplican) Es porque: Response options: Took a job in a K through 12 school, Left to get a certificate or degree in the child care field, Left to get certificate or degree in another field, Moved or relocated, Left to make more money at another job, Found another job that was more interesting, Received limited or no benefits, Were not able to work during the scheduled hours, Did not want to work with young children anymore, Wanted more recognition for the work you did as a child care provider, Other, Don't know, Prefer not to say Opciones para la respuesta: Tomó un trabajo en una escuela de K a 12, Dejó la carrera para recibir un certificado o título en el campo de cuidado infantile, Dejó la carrera para recibir un certificado o título en otro campo, Se mudó o se trasladó, Dejó la carrera porque le ofrecieron más dinero en otro trabajo, Encontró otro trabajo que le interesaba más, Recibía nada de beneficios o beneficios limitados, No le era possible trabajar durante el horario dado, Ya no quería trabajar con niños pequeños, Quería más reconocimiento por el trabajo que hacía cómo proveedor de cuidado infantil, Otra razón, No lo sé, Prefiero no decir	Self-administered questionnaire OR interview	Provider	6 month follow up	First 5 CA/PACE CARES Matching Funds Evaluation survey