



Policy Scan: Desired Results and Achieving Improvement in a System of Early Identification and Intervention in Los Angeles County

A Report by the First 5 LA Early Developmental Screening and Intervention (EDSI) Strategic Partnership

September 2007

*Prepared by
Moira Inkelas, Sarah Martinez, Leila Espinosa, Marlene Zepeda,
Kathryn Smith, Joanna Mackie, Thomas Rice, Lou Brown*



Summary

First 5 LA created the Early Developmental Screening and Intervention (EDSI) strategic partnership to improve early identification and intervention for young children with developmental or behavioral problems. Early identification refers to helping parents and young children with developmental issues at an early stage when intervention is more effective and less resource-intensive. It also can include preventing possible future problems in learning, development and behavior through the efforts of parents, teachers, and primary care clinicians. Although parents, providers and policy makers value the concept of early identification, current performance falls short of what is possible. National studies show that up to 50% of children with delays and up to 70% of developmental problems are not identified until school entry. The current resources, policies and patterns of care are not driving the outcomes that are possible. Improvement seems elusive because there is not one system but many systems, and we lack a common set of desired results and shared responsibility for the outcomes of early identification and intervention.

EDSI will achieve its goals through supporting change at the level of parents and early childhood professionals involved in early identification (pediatric clinicians and early care and education personnel), identifying successful strategies as well as barriers to achieving desired results, and encouraging a more favorable environment for improvement through policy. The purpose of this report is to provide a picture of how the policy environment can facilitate desired results in early identification and intervention. This report (1) describes the system that we seek to improve and how the policy environment shapes the current approach to early identification and intervention and (2) identifies ways of leveraging current efforts and resources to support systematic improvement.

Acknowledgement

We extend our deepest appreciation to the individuals who shared their perspectives and details about their programs and disciplines with the EDSI team, and to members of the EDSI Steering Committee who have provided invaluable guidance on the conceptualization and direction of the EDSI strategic partnership. The authors also recognize the substantial contributions of Elizabeth Gonzalez and Teresa Nuno at First 5 LA and guidance from Peter Margolis at the Cincinnati Children's Hospital Medical Center, Center for Health Care Quality and Helen DuPlessis at the UCLA Center for Healthier Children, Families and Communities. Responsibility for the content and recommendations within this report rests with the authors.

This report is a product of the First 5 LA Early Developmental Screening and Intervention Strategic Partnership. The authors are responsible for the content.

Suggested Citation: Policy Scan: Desired Results and Achieving Improvement in a System of Early Identification and Intervention in Los Angeles County.

CONTENTS

INTRODUCTION

- Importance of early identification and intervention
- Creating a favorable policy environment for achieving EDSI goals

A SYSTEM OF EARLY IDENTIFICATION AND INTERVENTION

- Focus on supporting families
- Principles underlying effective recognition and response
- A systems model

ROLES OF EARLY CHILDHOOD PROFESSIONALS

- A role for early care and education providers: Building on existing relationships
- A role for pediatric clinicians: Monitoring development in primary care settings
- A role for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): Reaching young children within communities
- The role of specialized programs: Promoting prevention and responding to identified concerns
- The role of First 5 investments: Vision, innovation and stewardship

TAKING STEPS TOWARD A FAVORABLE POLICY ENVIRONMENT

1. Achieving a Shared Vision of a System for Early Identification and Intervention
2. System Leadership and Collaboration
3. Performance Measurement at All Levels
4. Continuous Learning Culture
5. Strengthening Incentives and Motivation for Effective Care and Supports
6. Population-Based Supports
7. Capacity and Capability to Care for Families

CONCLUSION

EXHIBITS

- Exhibit 1: System Functions for Early Identification and Promoting Healthy Development
- Exhibit 2: Current Roles of Public Agencies/Population-Based Programs in System Functions
- Exhibit 3: Improvement Areas for Achieving Desired System Functions and Outcomes
- Exhibit 4: Creating a Favorable Environment: Improvement Areas, Types of Strategies, and Current Leveraging Opportunities

INTRODUCTION

First 5 LA created the Early Developmental Screening and Intervention (EDSI) strategic partnership to improve early identification and intervention for young children with developmental or behavioral problems. Much of the performance gap between current and desired results from a gap between what we know works and what we do. The EDSI approach to narrowing the gap is based on the model of improvement. This model takes a system from one level to a higher level of performance by supporting systematic change. At the service level where parents interact with early childhood professionals (the “micro system”), we can create change by understanding what we trying to accomplish, agreeing on how we will know that change is an improvement over how care is currently provided, and sharing changes that will result in the desired improvement. The organizational and policy level (the “macro system”) can support micro system changes through strategies that facilitate and reward improvement.

This is an exciting time to pursue systematic change given all of the activity underway. The purpose of this report is to provide a picture of how the policy environment can facilitate desired results in early identification and intervention. Key challenges and opportunities can be detailed and addressed in future EDSI-sponsored policy summits and other child health planning venues. This report (1) describes the system that we seek to improve and how the policy environment shapes the current approach to early identification and intervention and (2) identifies ways of leveraging current efforts and resources to support systematic improvement.

Importance of Early Developmental Screening and Intervention

Early identification refers to identifying problems at an early stage when intervention is more effective and less resource-intensive (Dworkin 2004; Glascoe & Dworkin 1993). It is also an approach to help parents of young children with concerns that if addressed by parents, teachers, and primary care clinicians might not lead to later problems in learning and development (Dworkin 2004; Hall 2003). Ideally, early identification is a regular part of contacts between parents and early childhood professionals. Most recently, the Frank Porter Graham Center has described an early intervening system called “Recognition and Response” (Coleman et al. 2006).¹ This early childhood approach was designed to help parents and teachers respond to learning concerns in young children prior to the need for special education and formal evaluation and before the child is at risk of school failure. The terms of recognition and response are attractive for early childhood providers as well as parents because they frame the process of early identification as a positive and preventive strategy.

Despite general agreement that identifying concerns and problems early makes sense, the process is falling short of what is possible. National studies show that up to 50% of children with delays and up to 70% of developmental problems are not identified until school entry (Glascoe & Dworkin 1993). This happens for a number of reasons at the provider and the systems level. First, development is a transactional process rather than as a predictable unfolding of milestones. Each child is unique and can develop skills in a range of domains—motor and language, for example—at a different time than a sibling or other children of the same age. It can be difficult to predict which parental concerns or observations by early childhood professionals about a child’s development, behavior and learning will actually lead to

later delays. Often identifying subtle problems among young children and distinguishing a problem from natural variation in development requires knowing the child and family and monitoring development over a period of time. Second, effective early identification involves the parent as a partner in identifying and addressing concerns. Parents have the greatest impact on a child's development and are a vital part of any intervention, and they also make the decisions about their child's environment and what services and supports they will use. Finally, the early childhood professionals who are best positioned to identify problems early are not always well prepared for effective recognition and response. For example, pediatric clinicians often report limitations in the scope and nature of their training, and the availability of valid tools that can easily fit into the typical office flow. Both clinicians and teachers report needing more capability in working with parents as partners in care, particularly when parents and providers have different perspectives about a concern or observation regarding a young child.

At the same time that providers encounter such challenges, our early childhood systems are not driving the results that are possible. Improvement seems elusive in part because there is not one system but many systems, some organized and others less so. No single type of provider, public program, or sector manages all of the resources or has the relationships that are needed to achieve desired results for young children. The long history of incremental federal and state program development in early childhood, while reflecting the public's unique interest in supporting young children, has produced staggering complexity. The nature of early childhood development also puts a major strain on systems that were designed with strict rules about eligibility and need. Because development is a dynamic, transactional process, they do not fit neatly into the diagnostic and even risk-based criteria that work for adults. The specific need may largely focus with the child, with the parent or family, or with the interaction between the child and parent. As a result of developmental complexity and administrative rules designed for managing specialized resources, parents and young children frequently find themselves caught in a cycle of screening and referral within the fragmented service system. There is a great need to develop capacity in Los Angeles County to monitor and support young children's development at all levels: health promotion, prevention, and intervention.

The First 5 LA Early Developmental Screening and Intervention (EDSI) strategic partnership responds to this need by creating more systematic approaches to monitoring and supporting child development within Los Angeles County. Outcomes for young children can be vastly improved through clarifying roles and expectations of early childhood professionals, making better use of observations about development and making well child visits more effective in helping clinicians identify concerns about behavior and development, improving communication between early childhood professionals and parents (as well as among different professionals), and using existing specialized resources more efficiently. Such changes will help pediatric clinicians and early care and education professionals provide more effective support and also link parents with appropriate and timely supports within their communities. By developing and testing strategies, EDSI will:

- improve clinician and ECE roles in identifying developmental and behavioral concerns, promoting optimal development, and linking parents with community supports, and
- put forth sustainable solutions to the challenges of recognition and response in Los Angeles County.

Creating a Favorable Policy Environment for Achieving EDSI Goals

Creating a policy environment that supports EDSI goals is essential for accelerating the process of improvement and for continued progress over time. The policy environment for EDSI includes not only the rules and regulations that influence resource allocation and the day-to-day practice of early childhood professionals but the extent to which vision and leadership drive the system toward desired results. Policymakers have a vital role in enabling both social and financial sustainability of improvement. This will make it possible to maintain the results achieved during the EDSI project, continue spread of these results throughout the county, and build on these results to achieve further improvements in early childhood outcomes.

The *social* aspect of sustainability depends largely upon perceptions of value and feasibility. Achieving and sustaining improvements within communities depends in part on how compelling and feasible these strategies are to those who provide early childhood services. This begins with the clinicians and teachers who have key roles in recognition and response. Provider views about the value and feasibility of improvements are shaped by a number of factors: awareness and attitudes about different ways of providing care, capability and training, available resources, expectations within their professions, quality and accountability provisions, and most importantly the motivation to continually do better. Views about feasibility and value among policymakers (payers, government and public agencies) are also important because these stakeholders shape the expectations, training, and regulations that influence the work of clinicians and teachers.

There is also a *financial* aspect of sustainability. Improvements will spread throughout the county if policymakers make the new approach attractive (valued and easier for all participants) and make the current approach less attractive. Examples of such environmental changes include a streamlined system that makes it easier for providers to deliver high quality care as well as typical incentives and motivations such as increased reimbursement and rewards based on the quality of care provided. These environmental changes are needed to sustain changes and to continue progressing toward an optimal system.

This report describes the systems environment into which the EDSI project has been launched. First the report describes what a more ideal system would look like from the perspective of parents interacting with early childhood professionals regarding development and behavior. This is followed by a description of current roles of a range of sectors and stakeholders that can shape EDSI successes, including current roles related to the systems model, the strategic directions of key organizations, current policy opportunities and constraints, and emerging efforts related to recognition and response. The report focuses largely but not exclusively on public sector programs given their population-based focus. The report concludes with some strategies and specific steps for leveraging these features of the current systems environment to create a more favorable environment for achieving desired results. The report includes

- (1) a vision for an improved system,
- (2) an overview of key features of the policy/systems environment that affect the results sought by EDSI, and
- (3) a summary of opportunities to optimize the EDSI investment by aligning state and local policy efforts and pursuing strategies that will drive the system toward desired results.

A SYSTEM FOR EARLY IDENTIFICATION AND INTERVENTION

It is often said that *“Each system is perfectly designed to achieve the results it gets.”* A system refers to a set of entities that are related to or interact with each other and share a common objective. Improvement is easier when the system is well understood and the levers of change are easily identified. However, there is no single system for early identification and intervention; instead we have a collection of subsystems (such as medical care, early care and education, and family support) that work toward similar although not always identical objectives. Each sector relies upon some form of screening to meet federal and state mandates and/or for accountability to its consumers. This creates interdependency with each sector relying upon the processes of another to get information about the needs of their clients and/or to obtain supports for their clients. As a result, for recognition and response to occur effectively and systematically for all parents and young children, these subsystems will need to function as a virtual early childhood system that has defined and agreed-upon roles, relationships, and outcomes. Continued improvement hinges upon stakeholders in the early childhood outcomes envisioning a system, and the desired properties outcomes of such a system, that we can strive toward.

First we describe several underlying principles for a system of recognition and response. These include the importance of supporting families and a set of principles for effective care. We then present a simplified systems model of functions that can achieve the desired results for young children and families. This is followed by a summary of policy levers that can aid our progress towards a better performing system.

Focus on supporting families

While EDSI focuses largely upon the roles of early childhood professionals, achieving ultimate outcomes depends upon the family as the center of all activities. Early childhood systems produce results by helping parents with their questions, concerns, and needs regarding their young child’s growth and development. Providers who have regular contact with a child and family have the opportunity to observe and to periodically discuss with parents any concerns about a child’s development, behavior or learning. These providers can then provide care and supports directly and link parents with appropriate supports in their community.

Having a shared understanding and plan between providers and parents is an essential part of an effective recognition and response system because without a shared agenda, the chances will be lower that other system functions can work optimally to support early intervention. An important role of pediatric clinicians and ECE providers is to help parents know how to help their child learn and when to seek help. Parents and providers alike hope that children who appear behind on a developmental milestone will catch up on their own. In addition, parents may not identify concerns or act early when they have different expectations from provides about what normal development is, or when they see development as a natural process that they do not directly influence. Norms about child development and family behaviors and practices are a defining feature of culture; within the great cultural diversity of Los Angeles County, parents have different ideas about how children learn and develop. Different parent viewpoints about development can have strengths and protections for children as well as potential limitations when it comes to communicating with early childhood professionals and deciding and acting upon next steps to promote optimal development. The challenge to providers and to the overall system of

care is to build on family strengths and to tailor an approach that is acceptable and effective to the individual family, parent and child, even within fast-paced and standardized care.

Principles underlying effective recognition and response

EDSI activities are based on several principles from the early childhood research, professional and practice literature, which include the following:

- *Parents are the best observers of a child's development, and their observations and concerns are essential for effective care.*

Young children depend on their parents to recognize and address their unique needs. In turn, providers rely upon parent observations and concerns to make good decisions about what to do clinically and educationally to optimize development. Parents should expect to discuss developmental topics and their specific observations of their child with clinicians and ECE providers.

- *Early identification and intervention is most effective within a trusting parent-provider relationship.*

Parents have the largest influence on their child's development and in most instances are the decision-makers about the care and supports that their child will receive. This means that care and supports need to happen on the parental timeline. Because development and behavior evolve in part from parent-child interactions, development is a family process and providing support is an interactive and negotiated process between parents and providers. As a result, care and support of parents with young children is most effective when there is a trusting relationship between parent and provider. A certain level of trust is needed for parents to feel comfortable sharing their concerns or hearing feedback about their child's development, and well as to feel comfortable seeking additional specialized help when recommended to do so. As a result, it makes sense to build a system of recognition and response around the early childhood personnel that parents interact with naturally and trust.

- *A broad range of early childhood professionals can play a role in early identification.*

A systems approach to recognition and response encourages roles for a range of population-based providers, including pediatric clinicians, teachers, and even staff in organizations such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). A range of early childhood professionals can play a role in helping parents at the time that an issue presents itself; ongoing discussions between parents and early childhood personnel in a variety of settings and contexts are important because questions and concerns can arise at any time. Specific roles in the recognition and response functions will vary with by sector and provider depending on their roles, skills and resources. A system of recognition and response is most effective when it is based on continuous discussions with parents about their young child, within scheduled well child visits as well as within daily interactions with early care and education personnel or other early childhood professionals. Having some redundancy in the process of continuous checking-in between parents and professionals is a valuable system property for effective early identification.

- *We have shared responsibility for desired outcomes because no one provider, sector or agency/organization can achieve these outcomes alone.*

The concept of recognition and response emphasizes the importance of action as well as a continued role of teachers and primary care clinicians who are reflecting with the parent

upon child and family needs and next steps. Each provider and agency/organization with a defined early childhood role has responsibility for providing certain care/supports and for facilitating access to care and supports that are provided by others. Pediatric clinicians and ECE personnel are not responsible for providing everything that a child and family may need, but they have a vital role that few others are positioned to play in recognition and in linking parents with appropriate supports. Providers need to be ready, able and willing to (1) address what they can within their own setting, (2) link parents with needed services or supports that are outside their scope of practice, and (3) follow-up with parents on these needs or ensure that another provider or organization is providing this follow-up or coordination (Schor 2007). These roles in direct care can be reinforced at the agency/organizational level; the concept of “no wrong door” refers to an organizational principle that an initial parent/child contact with any part of the system will eventually lead to connection to the appropriate organization and provider.

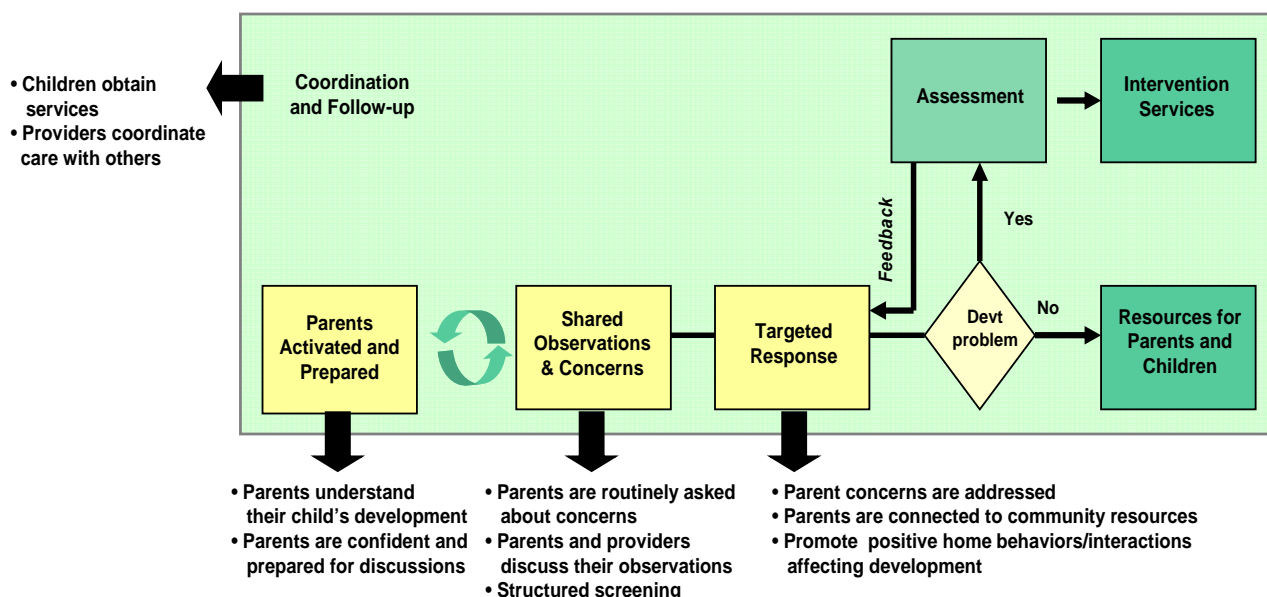
- *Providers (clinicians, ECE providers, and other early childhood professionals) and agencies/organizations are most effective when they act as part of a community system.* Optimal developmental outcomes are a shared responsibility among a range of providers and sectors because so many biological and environmental factors shape children’s development. Since no provider can “do it all” in terms of meeting developmental, behavioral and learning needs of young children, it is vital to know what resources are available in the child’s community and to link parents with the most appropriate resources based on the child and family’s specific needs. Being part of a system also implies working relationships between professionals so that parents are not handed off but stay in contact about the developmental concern with the referring entity, whether a teacher or pediatric clinician. In some cases, local resource such as a family resource center (FRC) or school readiness center can help forge these connections.

A Systems Model

EDSI uses a simple model to depict key functions and desired results of a reliable community approach to early identification and optimizing early childhood outcomes. The model provides a basis for describing the systems environment that can organize care to achieve desired results.

The specific care improvement activities within the EDSI strategic partnership focus largely on achieving better recognition and response. At the same time, improvements to these processes will not achieve desired results if the whole system is not functioning well and if the systems environment is not encouraging improvement throughout the essential functions of the early childhood system. As a result, the system model in **Exhibit 1** depicts a simple model of the whole system of early identification and intervention but distinguishes the features of *population-based recognition and response* (parent activation and preparation, shared observations and concerns between parents and providers, and targeted response to concerns and observations) from the other essential system functions of *community resources and specialized developmental services* (including community resources, assessment, intervention, and coordination and follow-up).

Exhibit 1: System Functions for Early Identification and Promoting Healthy Development



Population-based recognition and response

Activated and prepared parents: Parents are the best observers as well as advocates for their child. Parents can partner in their child's care most effectively when they expect that clinicians and teachers will discuss their child's development with them as a normal part of care. When parents are prepared for these interactions, they increase the chances that early childhood professionals will hear and attend to the parent's concerns and priorities.

Shared observations and concerns between parents and providers: The process of sharing concerns and observations about a child between parents, teachers and clinicians helps parents have meaningful discussions with providers about their child's development and behavior. This includes any concerns and observations on the part of parents, teachers, or clinicians.

Targeted response: Discussions about development are most helpful when teachers and clinicians can respond to questions, informational needs, and concerns. Clinicians and teachers can respond to shared concerns and observations by providing specific information and advice; providing reassurance; adapting activities within an ECE setting to meet the child's developmental and learning needs; and connecting parents with community resources.

Community resources and specialized developmental services

Resources for parents and children: A range of community resources can offer supports for helping parents optimize their young child's learning and development. Such resources may target learning and development specifically or meet other child and family needs, such as early literacy and parent-to-parent support. Community resources include family activities, education, and parent groups as well as basic needs programs.

Assessment: A range of screening and diagnostic assessment processes are the next step for some concerns/observations. These assessments lead to decisions about next steps, such as watchful waiting coupled with specific information or community resources to optimize development; referral to programs or services to meet the child's identified needs; and direct services and interventions.

Intervention services: A range of interventions for development problems may be indicated following assessment. These interventions may focus on the child, the family, or the family and child together.

Coordination and follow-up: Follow-up ensures that concerns/observations are revisited as part of recognition and response and also that referrals lead to a needed service or another strategy for the parent and child. Coordination connects parents with care and supports.

2. ROLES OF EARLY CHILDHOOD PROFESSIONALS

To improve the process of early identification as well as its ultimate outcome, EDSI focuses on roles of key sectors and leveraging opportunities with current initiatives. This section describes current and emerging roles in recognition and response for each of the following providers and entities:

- **early care and education providers,**
- **pediatric clinicians,**
- **WIC** as a population-based health promoting program for young children,
- **specialized programs** for assessment and intervention in health, mental health, family functioning, development and learning, and
- **First 5 investments** for innovation in policy and programs as well as strategic vision.

Exhibit 2 describes major roles of public agencies/program as they related to the early childhood system model. The first four columns list the system functions that are largely carried out within preventive and population-based programs such as primary care, ECE settings, and WIC centers. The last three columns list the system functions that are largely carried out within the specialized medical, developmental, family function, and early intervention subsystems. Some listed public agencies/programs provide or facilitate direct services in both population-based and specialized areas while others largely focus on one or the other.

Given the complexity of early childhood subsystems and programs, several caveats apply. The exhibit displays only public agencies with explicit roles in one or more system model functions as defined in their mission or enabling legislation. This is not intended to minimize the contribution of an array of private, philanthropic, and other programs involved in various functions within the system, but instead to highlight some key sustained roles and responsibilities upon which improvement activities can build, countywide and in any community. The exhibit focuses upon direct parent, child and family services that are provided, paid for, or systematically facilitated by the agency. An example of a facilitating role is assurance that children in foster care receive comprehensive health care, which should include elements of recognition and response. The exhibit does not include agency roles in training, continuing education, or policy planning and development. These latter roles are essential to the systems environment, and some are described in this report.

The exhibit simplifies the roles and responsibilities of the listed organizations. Our goal is to illustrate where public agencies have a significant, ongoing and mandated responsibility for the population of children in Los Angeles County in a specific area of the system model. As a result, not all activities by these agencies are included in the exhibit. For example, the Department of Children and Family Services is involved in a prevention initiative that addresses some recognition and response activities. In addition, the community resources role refers to whether or not the organization systematically offers or links parents with such resources. While many agencies offer or refer to such resources, a smaller number of agencies do this systematically through mandate, such as referral to a follow-up resource from newborn screening programs or referral to an Early Start Family Resource Center. Some but not all of these additional activities are described later in this report. Finally, within the listed missions and responsibilities, there is variability in what specifically is done within a network and across programs.

Exhibit 2: Current Roles of Public Agencies/Population-Based Programs in System Functions

Agencies/Programs		Current services (coverage, direct provision or both) in early childhood system functions						
		Population-based recognition and response				Specialized developmental services		
		Parents activated & prepared	Shared observations & concerns	Targeted response	Community resources for families	Assessment	Intervention	Coordination & follow-up
Health care	Women, Infants and Children (WIC) <i>Nutrition counseling, topical education, food vouchers</i>	Yes			Yes			
	Medi-Cal managed care health plans <i>Medical care for the majority Medi-Cal beneficiaries</i>		Yes	Yes	Yes	Yes		Yes
	Medi-Cal (fee for service) <i>Medical care for non-managed care beneficiaries and supplemental specialized services</i>					Yes	Yes	Yes
	Child Health & Disability Prevention (CHDP) program <i>Health care for uninsured children <200% FPL, largely preventive care and some treatment</i>		Yes	Yes	Yes			Yes
	California Children's Services (CCS) <ul style="list-style-type: none"> • High risk infant follow-up (medical risk) (<i>medical & developmental follow-up for at-risk infants from birth</i>) • CCS (medical program) (<i>care for specified conditions</i>) • Medical therapy units (MTUs) (at schools) (<i>school based therapy units for all medically eligible children</i>) • Newborn hearing screening program (<i>screening & referral at all CCS paneled birth hospitals</i>) 				Yes	Yes	Yes	Yes
ECE	Resource & referral (R&R) agencies <i>Clearinghouse for all types of ECE slots, training for licensed ECE centers/programs, inclusion support</i>				Yes			
	School district/Local education agencies (LEAs) <ul style="list-style-type: none"> • ECE program administration (<i>ECE centers, preschool</i>) • Special education • SELPAs (<i>for low incidence disabilities</i>) 		Yes	Yes	Yes	Yes Yes	Yes Yes	Yes Yes
Targeted programs	Mental health(DMH) <ul style="list-style-type: none"> • Services for severe emotional disturbance (SED) • Intervention for 0-5 at risk due to family mental health 					Yes	Yes	Yes
	Regional Center <ul style="list-style-type: none"> • Early Start (<i>provides Part C early intervention services for at-risk children under age 3 years</i>) • FRCs at Early Starts (<i>family resource centers located at Regional Centers</i>) • Regional Center (<i>provides range of services for eligible diagnoses including autism, CP, epilepsy</i>) 				Yes	Yes	Yes	
	Dept of Children and Family Services (DCFS) <i>(Emergency response, family preservation, foster care)</i>		Yes	Yes	Yes	Yes	Yes	Yes

A role for early care and education providers: Building on existing relationships

Early care and education professionals play a key role in early identification and intervention. At least 60% of California's children age 5 and younger spend a regular part of their day in the care of persons other than their parents or guardians. Teachers and other ECE providers are well-positioned to identify developmental, behavioral and learning concerns given the amount of time they spend with a child and the relationships that they build with families while caring for the child. ECE providers can be involved in various aspects of the early identification process, ranging from prevention (such as through enriching activities within the ECE setting and through talking with parents about ways of helping their young child learn and develop). They also can play an important role in monitoring how children are developing. When there is a concern, ECE providers may be able to help parents prepare for talking with a primary care clinician about the concern. The trusting relationship between parents and teachers creates the opportunity to act early and to provide parents with the support and encouragement that they need when there is a concern.

Although ECE providers are well positioned for an active role in recognition and response, their current role varies substantially across types of settings. Head Start programs are the only ECE settings that have explicit standards with regard to ensuring children in their care receive a developmental screening. Federal Head Start guidelines require that children are screened within a specified time period for any potential health problems or delays.² In Los Angeles, the Ages and Stages Questionnaire (ASQ) was selected for this purpose. Other than Head Start and Early Head Start, ECE programs vary in the extent to which they play any role in early identification. Current child care policy and subsidy programs lack specific guidelines or criteria regarding early identification and follow-up. The most common quality standards for child care, reflected in the Infant/Toddler, Early Childhood, and Family Child Care Environment Rating Scales, focus largely on structural aspects of the setting, curriculum, and safety. California's Desired Results Developmental Profile (DRDP) in use by licensed child care programs and preschools includes teacher evaluation of each child within a range of developmental domains, but the focus of DRDP has been on planning for the educational setting to meet the needs of the population of children rather than on identifying and acting upon the needs of a specific child.

More recently a set of expectations around early identification has evolved for ECE settings. Recent national and local policy developments are regularizing early identification as an ongoing part of early care and education. For example, updated accreditation standards from the National Association for the Education of Young Children (NAEYC) include specific criteria on ensuring that children in child care receive health and developmental screenings. Taken alone, this would improve care for relatively few young children in Los Angeles County since relatively few ECE settings have NAEYC accreditation. A major initiative of the Los Angeles County Office of Child Care has an even broader reach by establishing expectations in several areas that are vital to the EDSI vision through the *Steps to Excellence* program. This program specifies five levels of capability within ECE settings that include not only typical structural measures of quality in ECE settings but also two new areas of capability: (1) identifying and including children with special needs (including developmental and behavioral concerns) within ECE settings, and (2) having ways of fostering positive relationships with parents, building on family strengths, and connecting parents with community resources. In 2007, the *Steps to Excellence* program

launched a bold step toward implementing performance assessment and encouraging improvement by releasing specific expectations for five different levels of quality as well as launching a pilot that ties the five-level rating scale to reimbursement rates. This will not only create incentives for improving screening within ECE settings but also help prepare teachers and other child care providers for transitioning into their new roles. First 5 LA has endorsed this effort with financial support. When the First 5 LA Universal Preschool (LAUP) initiative implements a modified version of this rating scale and ties it to reimbursement in program for 4 year olds, there will be even added incentive for a greater role in early identification with ECE settings in Los Angeles County.

Health Consultation in Early Care and Education Settings

Health consultation to ECE settings helps teachers address health, safety, and developmental issues that they may not feel comfortable addressing. Currently, twenty-five states require the use of a health consultant for some or all licensed child care programs. At a national level, Head Start Performance Standards require mental health consultation in Head Start programs. The national Health Child Care America (HCCA) initiative funded health consultation models, but with the recent end of federal funding, these efforts ceased in California. A number of other states, including Kentucky and Ohio, have also provided funding for health consultants in child care programs, but not all states provide such consultation. Currently in California health consultants are required only as a regular part of sick child care programs. More recently there have been other efforts to incorporate health consultation in child care settings. For example, First 5 California funded the Child Care Health Linkages Project to provide health consultants who helped visit child care programs and improve the health of the children, families, and staff. The Child Health Works Project, funded by First 5 LA, is another local effort to build greater focus on health and development into ECE settings.

A role for pediatric clinicians: Monitoring development in primary care settings

A goal of pediatric medical care is helping parents address their questions, concerns, and needs about their children's growth and development. Many developmental concerns can be addressed with targeted counseling and information within the pediatric practice. In the 1996 Survey of Parents of Young Children sponsored by The Commonwealth Fund, virtually all parents reported wanting and needing information on how to help their child learn and grow (Schuster et al. 2002). Developmental monitoring within well child care includes making informed observations about the child as well as asking the parents about their own observations and about any concerns they may have about their child's development, behavior or learning. For children in low-income household who are covered by Medicaid, the child-specific Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program specifies an expanded benefit of anticipatory guidance and developmental screening (Schor et al. 2007). The revised Bright Futures guidelines encourage clinicians to prioritize among possible topics within well child care, based on the needs and interests of the parent, which can be elicited through screening or monitoring.

In recent years, pediatric clinicians have noted a variety of limitations in how developmental monitoring is practiced. Despite long-standing professional recommendations about screening by the American Academy of Pediatrics (AAP) and a collaborative set of standards for well child care developed by the AAP and the federal Maternal and Child Health Bureau (MCHB) within the Bright Futures initiative (Green et al. 2002; AAP 2002) many developmental problems are not identified by clinicians until school age. Reasons for the continued gap between recommendations and practice include the practice of waiting until a problem is directly

observable by the clinician rather than systematically eliciting developmental concerns from parents at each well child visit, and relying on informal methods of screening rather than using a structured process for all patients (Kuo and Inkelas, 2007; Glascoe and Shapiro, 2006).

Improving Developmental Screening and Monitoring in Pediatric Primary Care

American Academy of Pediatrics Policy Statement on Screening and Surveillance

In 2006, several committees of the American Academy of Pediatrics issued recommendations for developmental screening and surveillance in pediatric primary care (American Academy of Pediatrics, 2006). The policy stated that early identification of developmental disorders is a vital function of pediatric primary care. The policy statement outlined an algorithm as a means of helping pediatric clinicians adopt a systematic process for addressing developmental concerns in children ages birth through 3 years. The committees recommended developmental surveillance at every well-child preventive care visit. Concerns raised through surveillance would then be addressed by a follow-up screening test. The committees also recommended standardized screening at 9, 18, and 30-month well child visits. The 30 month visit is not part of the current recommended well child visit schedule so the policy statement encourages this screening at the 24 month visit for providers who do not use a 30 month visit and/or cannot be reimbursed by payers for such a visit. The policy statement does not recommend specific tools and instead lists a set of validated tools from which pediatric clinicians can choose. The policy statement concludes that these surveillance and screening activities should lead to additional developmental and medical evaluation, diagnosis, and treatment/intervention as appropriate.

Assuring Better Child Health and Development (ABCD) Initiative

The National Academy for State Health Policy (NASHP) and The Commonwealth Fund led two state learning consortia to improve development services to young children in Medicaid. States participating in ABCD I (2000-03) and ABCD II (2003-06) (which included California) have sought state policies, including Medicaid policies, that can (1) improve identification of young children with or at risk for developmental delays through standardized screening tools and (2) improve access to follow-up services including assessment, referral, and care coordination (Kaye et al. 2006). Policy improvements in the ABCD states included the following:

Improving expectations: Clarifying expectations of developmental screening; requiring primary care providers to use a valid structured tool at well child visits; clarifying Part C eligibility to providers

Improving reimbursement: Paying a financial incentive to health plans that increase use of developmental screening and mental health screening tools for children; creating new billing option (CPT 96110) for use of a standardized developmental screening tool in fee-for-service arrangements

Improving performance: Establishing use of common screening tools across systems (Medicaid, mental health, and early intervention); requiring Medicaid health plans to conduct Performance Improvement Projects (PIPs) on topics of referral to follow-up services and coordination of care; unbundling screening from well child care to allow tracking of screening rates over time.

The third phase of ABCD (the Screening Academy) was launched in 2007 to support state efforts to implement the policy options that produced results in earlier ABCD phases.

In 2006, the AAP offered updated recommendations on screening to emphasize the need for monitoring parental concerns at each well child visit and screening at specified visits using validated structured tools (Council on Children with Disabilities et al. 2006). The recommendations suggest use of a structured tool at 9, 18, and either 24 or 30 months of age. While the recommendations do not suggest specific tools, the tools listed as options include several that are appropriate for regular use in primary care settings, including as the Ages and Stages Questionnaire (ASQ) and the Parent Evaluation of Developmental Status (PEDS). While the recommendations and the suggested algorithm for screening and follow-up are an important step forward, several barriers to adopting this recommendation throughout pediatric practices

include increasing pressures of time and patient volume as well as ever-expanding professional recommendations for discussing topics such as safety and injury prevention, nutrition, development, and family issues among others within well child care. Recent federal efforts addressed one of the longstanding barriers by seeking to improve reimbursement for developmental services by creating a new billing (coding) option. While not all payers immediately accepted these codes for reimbursement, their existence and use increases prospects for such reimbursement (and/or adjustment of capitation rates to include the use of structured tools) Along with issuing the revised recommendations, in 2006 the AAP launched the Developmental Surveillance and Screening Policy Implementation Project (D-PIP) to test pragmatic ways that primary care clinicians can implement the revised recommendations.³ D-PIP worked with 17 primary care pediatric practices nationally, including The Children's Clinic in Long Beach, to learn if the algorithm can be effectively implemented into practice and how it can change care.

A role for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): Reaching young children within communities

Sustainable early identification efforts need to focus on where young children and their parents spend time interacting with early childhood providers. Focusing exclusively on clinicians and ECE settings may miss some of the most vulnerable young children, since not all young children receive care in licensed ECE settings or receive all recommended well child visits. While it is a targeted rather than universal program, the WIC program is an essential population-based program for young children in the U.S. from the perspective of the early childhood system model in part because it reaches a large number of young children, many of whom lack an ongoing relationship with a single source of well child care and do not participate in licensed child care or preschool. First developed in the 1970s, WIC has come to be one of the most respected and important programs to support the health and development of children and families in lower-income households. This nutrition program provides food supplements and education/counseling during pregnancy, infancy and early childhood. WIC programs also refer parents who lack a regular source of medical care or need some type of family support to appropriate community resources. WIC has a strong community-level presence with very high participation (about 90%) of eligible mothers and young children. Because WIC centers are in local neighborhoods and are staffed by professionals and paraprofessionals who often live and work in the same neighborhood, they are ideally positioned to give parents important messages about early childhood.

WIC brings a number of attributes that are an excellent support for a system of early childhood recognition and response. Most importantly, WIC requires that participating children have regular access to health professionals, which bolsters access among the young children who are least likely to have an ongoing relationship with a quality medical home. WIC has decades of experience working with families around sensitive topics such as child nutrition and safety. Their parent professional staff is representative of the client community and they can be strong contributors to the educational and messaging components of EDSI. WIC serves about 550,000 women and young children annually in Los Angeles County. Projects such as the First 5 LA Little by Little (LBL) program and the Early Advantage program funded through a federal earmark highlight the capacity of WIC programs for engaging parents around their child's development.⁴ Local WIC agencies including Public Health Foundation Enterprises (PHFE),

L.A. BioMed, and Northeast Valley Health Corporation (which together serve 86 percent of WIC participants in Los Angeles County)⁵ and several smaller WIC programs have long histories of collaboration and innovative approaches to working with families. There is great leveraging potential from professional development among WIC staff around child development and talking with parents about development.⁶ For example, WIC centers can help parents to increase their understanding of childhood growth and development as well as expectations about the developmental content of well child care. Given its population focus in early childhood, WIC programs have the opportunity to play an essential facilitating and reinforcing role for access to recognition and response activities.

Supporting Parents in WIC to Promote Young Children’s Development

Little by Little (LBL) – A Community Development Initiative Funded by First 5 LA

First 5 LA funded the Public Health Foundation Enterprises (PHFE) WIC program to support early literacy and school readiness skills in children served by 5 pilot PHFE-WIC centers. Components of the project include:

A **parent curriculum** to share with parents over the course of several visits, which includes age–appropriate information about child development and activities for parents to do with their children to support development.

A **resource specialist** who models activities with children and handles referrals to special education or Regional Center if there is concern about the child’s development.

A **parent survey** of WIC participants to measure the impact of the program and get a picture of school readiness of their population more generally.

An evaluation showed a positive impact on the home literacy environment for children in the program. Little-by-Little families read more at home and spend more time on other school readiness activities such as learning colors, numbers and shapes. Staff and family acceptance of the materials, and the enhanced skill of PHFE-WIC staff around child development through continued use of the tools, builds on the pre-existing trusting relationship between WIC staff and the families they serve.

The role of specialized programs: Promoting prevention and responding to identified concerns

Subsystems of early childhood services include specialized sectors and programs that offer resources to families once a developmental problem is suspected or identified. In light of these roles, these programs are a vital part of building a sustainable approach to early identification and promoting optimal development. While resources in early intervention are diverse, we focus on publicly funded sectors that have legal mandates in this area, including mental health, Early Start, and school districts. These programs provide assessment/diagnostic services and/or needed supports and services and can help early childhood professionals know when and how to refer parents and young children for services within the sector or in other sectors. Specifically, staff within these programs have specialized training and some amount of infrastructure to support provider outreach/education that can improve identification of eligible children and appropriate referrals. Many of these programs also have developed innovative practices over the last decade to promote inclusion, family-centered care, and awareness of child development. For example, Lanterman Regional Center offered training for pediatric clinicians on aspects of care for children with special health care needs, including tips for sharing bad news and helping parents cope with a diagnosis, through an adapted Touchpoints curriculum funded by First 5 LA.

In addition to specific roles in addressing problems, some of these programs have potential roles in prevention. At the same time, these programs do not have the mandate or resources to promote

optimal development of all children. In light of their respective missions, resources and constraints, each program has an interest in finding ways to make referral paths for their own services more transparent and seamless as well as to help early childhood professionals improve their abilities in recognition and response to developmental concerns.

Building the Capacity of Early Childhood Education Personnel in Early Identification

One of the most promising ways to increase the quality of developmental services in Los Angeles County is through building capacity among ECE providers and clinicians. Examples of programs with staff and specialized skills that contribute to such capacity-building include:

Ready for School (LAUSD)

Supported by funds from First 5 LA and First 5 California, these School Readiness centers combine the services of adult education, Special Education, Health Services, and Early Childhood Education in community outreach sites. Nine sites throughout LAUSD (serving 11,000 children and their families) provide outreach and multidisciplinary services to families including developmental screening, parent leadership and education, and parenting classes. Centers provide services to parents, including parenting, literacy and connections to continuing education. Ready for School also provides outreach and technical assistance to child care providers, including unlicensed providers who care for a substantial number of children ages 0-5 years. The development outreach includes some assessment of the current capacity of the provider site, a gift of toys that support development as well as instruction on involving children with the toys, and when possible, some assessment of the children in the care setting. They also work with providers to use the Parents Evaluation of Developmental Status (PEDS) tool with parents and provide support with scoring at the school readiness site.

Hope Street Family Center

This comprehensive family service center in downtown Los Angeles combines parenting education, preschool, support for local family daycares, and other family supports in one location. Their philosophy of building a trusting and constructive relationship with the parents of their pupils not only helps them provide excellent services for the children, but also helps foster parent leadership in the governance of the organization and in designing and teaching the education sessions. The center promotes knowledge of child development and building family relationships within a community child care network.

EI Sereno Preschool This early childhood education center near downtown Los Angeles, has incubated a program to improve the ability of its staff to provide intermediate interventions to children enrolled in this general education preschool. Working with special education preschool teachers from LAUSD, EI Sereno has been able to develop a tiered approach to preschool intervention, including universal supports for all children, selected supports for children and their families for those children who are not clearly delayed but may need support to reach their full potential, and intensive supports provided by special education specialists for children who require a more intensive intervention. The general education staff participates in trainings and reflective supervision with the specialized program staff. In this way, they can give support to children on an ongoing basis and receive feedback about specific questions or concerns they may have about a child or situation. At the same time, this type of capacity building can help these teachers to promote optimal development in all their children.

Help Group and St. John's Child and Family Center Partnership

This collaboration between a provider of specialized services and primary healthcare providers enhances capacity for working with families around autism spectrum disorder and developmental delays. The program involves community health care educators (*promotoras*) in developmental screening. The project intends to promote early intervention and increase awareness of health care workers of the first signs of autism. The project also includes a special emphasis on outreach to the Spanish-speaking community.

Mental health

The mental health sector plays an important role in early identification through services to young children with socio-emotional concerns and through services to parents with mental health problems whose young children have developmental or behavioral risks as a result. The mental health sector has a number of roles in early identification, including assessment of parents and young children who are referred for public mental health programs, direct services to eligible parents and young children with severe emotional disturbance, consultation to early childhood professionals, and population-level prevention. Mental health consultation has been successfully used in other recent initiatives within Los Angeles County. The mental health consultation model at Head Start Centers is an example of mental health providers assisting ECE providers with early identification of socio-emotional issues. Head Start programs are required to have a mental health professional on-site to allow for effective, early identification of concerns about a child's mental health and for intervention with parents and Head Start staff.

More recently, planning for resources from the Mental Health Services Act has led to planning for additional early childhood supports including prevention. The Los Angeles County Department of Mental Health has launched a countywide planning effort including community-based components through its Infancy, Childhood and Relationship Enrichment (ICARE) Network—which is a collaboration of infant/early childhood mental health and early care/education experts—and Prenatal to Five collaboratives. These collaboratives are encouraging mental health providers to increase their knowledge about child development and ways to better work with young children. These trends are positioning the publicly funded mental health sector as a vital resource not only as the recipient of referred parents and young children but as a professional resource for consultation and prevention.

Early Start

Beginning in 1975, the Individuals with Disabilities Education Act (IDEA) mandated that each state develop a free and inclusive system of educational and developmental services for all children with disabilities. IDEA Part B and Part C programs include special education services for preschool and school-age children and adults provided by the school districts or local education agencies (LEAs) and early intervention services (Early Start) for children younger than three who have a developmental delay or are at risk for delay. In California, the IDEA programs are complemented by the developmental disability services guaranteed under The Lanterman Act (1969), which provides services and supports for people with developmental disabilities through the regional centers. These specialized programs are an essential component of an early identification system. These programs receive referred children, provide comprehensive assessment and diagnosis, and coordinate and/or provide services for eligible children. IDEA also funds many of the family resource centers (FRCs) that have a vital, unique role in sharing information about child development and developmental services and helping parents through the assessment process.⁷

An essential component of the Early Start program in California is the Part C-funded Family Resource Centers that provide family support services to parents and families of children receiving Early Start services. These agencies can be important partners in supporting the EDSI community system model. Their task is to help guide the families through the system, clarifying roles and responsibilities and providing tools and training to help parents get the most out of the

services that are available. FRCs make resource materials available to families about the developmental services system and about specific diagnoses and host support groups around parenting, advocacy and specific diagnoses. They also provide parent-to-parent support by training parents and pairing them with the parents of children who are new to the system. As part of the child find function of Part C, the FRCs are charged with reaching out into the community with information about the Early Start program, and some children entering the Early Start program make their first connection through the FRC associated with a regional center. When children begin to transition out of Early Start, the FRC staff helps the family to connect with local resources that meet the new needs of the child and her family.

The Role of First 5 Investments: Vision, innovation and stewardship

Over the past eight years, First 5 has made major investments in state and local initiatives to improve the health and development of young children statewide. These investments have provided many children ages 0 to 5 and their families with health insurance, quality child care and preschool, and special programs to improve young children's outcomes through supports and services as well as by increasing parent understanding about importance of early child health, education and development.

Several key programs and initiatives established by State Commission and/or the First 5 LA Commission that have special relevance to EDSI goals are described below. The variety and broad scope of programs reflects the First 5 commitment to multi-faceted approaches and the recognition that children and families are in contact with a range of sectors that have specific roles to play.

Healthy Kids provides health insurance coverage for eligible children who would otherwise lack access to health care. This improved access may create the opportunity for improved early identification of developmental concerns. A parent survey in 2006 provides the first information in Los Angeles County about the quality of early childhood health care. About one-quarter (28%) of parents in Healthy Kids report being asked about their concerns during the last 6 months. This relatively low rate is not explained by a lack of health care since 70% had one or more preventive visits during that time period. Importantly, comparison to statewide and national data suggests that quality of these services is similar to care received by other publicly insured children. First 5 LA funding of Healthy Kids creates the opportunity to test and implement strategies and incentives for improving early childhood health care. Developmental screening is one possible priority area for quality improvement within the program.

Los Angeles Universal Preschool (LAUP) was developed to provide high-quality early care and education for four year old children in Los Angeles. In addition to adopting a modified version of the Office of Child Care's five point quality rating scale, LAUP has established inclusion sites across regions throughout Los Angeles County to provide staff support around screening activities and regular parent-provider communications about children's development. These inclusion sites provide an opportunity for encouraging early identification in the ECE sector.

The **School Readiness Initiative** (SRI), a joint effort of the State and 58 County Commissions, seeks to improve children's readiness to enter kindergarten ready to learn through supporting children and parents with a variety of programs and supports. A goal of the 206 funded programs throughout the state was to build community relationships by linking ECE programs to

community resources (First 5 California Children and Families Commission, 2005). For example, a number of LAUSD SRI (“Ready for School”) sites work with child care providers within their service area to increase structured observations and conversations with parents about development. Efforts to improve recognition and response within communities can build upon the infrastructure of such “hubs of innovation” that are not only supporting families directly but also in many cases playing critical roles in relationship-building, expert assistance, and coaching of early childhood professionals in the community.

The *Partnerships for Families* Initiative (PFF) established child maltreatment and abuse prevention activities as well as community-level supports and services for families (First 5 Los Angeles). PFF supports families with substantial support needs who are not part of the formal child welfare system. PFF hopes to create and coordinate a web of local partnerships between new and existing service agencies and groups. PFF is building community capacity through its planning for prevention and coordinating more responsive services and supports for families with identified risks.

The *Prenatal through Three* focus area aims to optimize children’s early development during the most critical of developmental periods from prenatal through three years of age (Prenatal through Three, 2006). Its purpose is “to increase the number of children who achieve appropriate social, emotional, cognitive, language, physical and motor developmental milestones to the best of their potential” (Prenatal through Three, 2006) by building awareness in communities of how to support young children. Creating “hubs” where families can gather to learn from each other offers a natural setting for parents to share observations as well as connect with appropriate and needed supports. The planned Prenatal through Three network provides an unprecedented opportunity for sharing promising practices among early childhood professionals.

Efforts to improve recognition and response at a community level can benefit from knowledge gained through these special projects. Such efforts can also build upon the “hubs of innovation” supported by First 5 LA such as school readiness centers. The planned Prenatal Through Three hubs may be a similar type of investment that creates invaluable partnerships and capacities. EDSI has the opportunity to build on these existing First 5 programs, particularly the relationships with community partners and families, to create a community approach to early identification and promoting optimal development.

TAKING STEPS TOWARD A FAVORABLE POLICY ENVIRONMENT

Creating a favorable environment for recognition and response will help achieve the community approach to early identification and ultimately the desired outcomes for young children. A general improvement approach is to assemble *will*, *ideas*, and *execution*. Leaders can build *will* by recognizing the gap between what works and what is practiced, valuing improvement, believing that change is within reach, and installing rules, regulations and supports that make effective care the easier thing to do while making the status quo more difficult to practice (Langley et al. 1996; Massoud et al. 2006). Improvement also depends upon having viable *ideas* about how to provide better care, and making sure that those ideas permeate the whole system so there is collective movement toward the desired results. Finally improvement depends upon *execution* of these ideas through implementing, supporting, and sustaining change.

This section of the report describes areas of improvement that are essential to achieve and sustain the desired functions and results. Progress in each area will be needed. This section gives examples of current activities in Los Angeles County within each improvement area.

These improvement areas include the following:

1. **Shared vision and engagement** of leaders, provides and consumers for a system that can achieve desired outcomes;
2. **System leadership and collaboration** to enable and sustain a well-functioning system;
3. **Transparent performance measurement** at all levels to provide a picture of current outcomes relative to goals, and to show which changes are effective;
4. **Continuous learning culture** to equip providers with the ability to adapt to the needs of parents and young children and to changes in the resource environment;
5. **Incentives and motivation** to encourage the effective care that providers want to deliver;
6. **Population-based supports** to facilitate prevention, health promotion and care for parents and young children with specific needs; and
7. **Capacity and capability to care for families** so that needs can be met with effective, acceptable services and supports.

Exhibit 3 shows how these improvement areas lead to high performing system functions, which in turn lead to better short term and long term outcomes for young children and families. **Exhibit 4** provides examples of specific strategies and steps that are underway or can be taken within Los Angeles County, within each of these improvement areas.

Exhibit 3: Improvement Areas for Achieving Desired System Functions and Outcomes

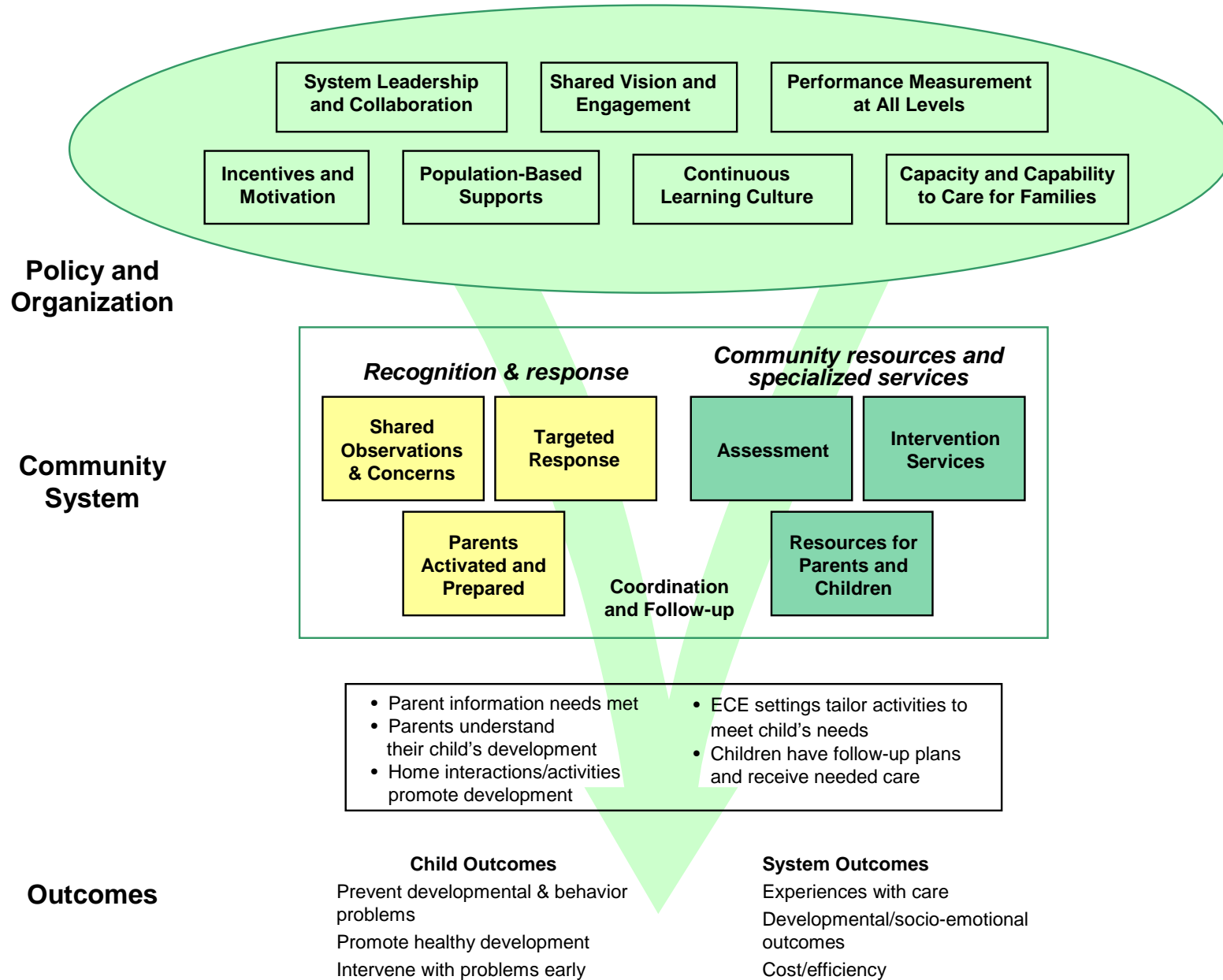


Exhibit 4: Creating a Favorable Environment: Improvement Areas, Types of Strategies, and Current Leveraging Opportunities

Improvement Areas	Types of Strategies	Specific Steps and Current Leveraging Opportunities
Shared Vision and Engagement	<p>Increase awareness about early childhood</p> <p>Achieve consensus on desired results</p> <p>Increase parent expectations for care</p> <p>Make it normal for parents to discuss their child's development with clinicians and teachers</p>	<ul style="list-style-type: none"> • Population-based messaging and networking (e.g., Early Identification and Intervention (EII) Collaborative) • Normalize discussions of development between parents and providers • Parent-provider interaction skills/tools (e.g., CPC Community Building Institute, WIC sessions for parents)
System Leadership and Collaboration	<p>Help payers, government, providers, advocates see the value of investing in early identification</p> <p>Align the mission of relevant agencies</p> <p>Align the requirements of relevant agencies (e.g., screening expectations and tools)</p>	<ul style="list-style-type: none"> • Stewardship on early identification vision and policy issues by First 5 LA • Collaboration around early identification in Service Integration Branch//IOG • Children's Planning Council (CPC), including SPA/AIC Councils and Community Building Institute involving stakeholders and parents • Master plan for early childhood recognition and response
Performance Measurement	<p>Develop process and outcome measures of early identification</p> <p>Achieve consensus on standard definitions</p> <p>Publish measures by a trusted organization</p>	<ul style="list-style-type: none"> • Test/adapt outcomes, indicators, and measures for a diverse population • Include early identification measures in population surveys and indicator reports (e.g., Children's Score Card, United Way, LA County Health Survey) • Implement similar indicators at system and service delivery levels
Continuous Learning Culture	<p>Make available evidence-based tools, resources, and processes of care</p> <p>Develop improvement networks that help providers put change into practice</p> <p>Provide effective coaching and consultation</p> <p>Enable peer-to-peer communication and support</p>	<ul style="list-style-type: none"> • Quality improvement (QI) support for local providers and training programs • Multi-sector learning and coaching • Sharing of national and local evidence base • Make better use of existing tools/mandates for QI in medical care and early care and education, such as CHDP and DRDP
Incentives and Motivation	<p>Ensure that resources match expectations</p> <p>Link reimbursement to quality of care provided</p> <p>Make linkages between providers and programs easier to understand and to navigate</p> <p>Increase accountability</p>	<ul style="list-style-type: none"> • Reconcile expectations with mandates and financing (e.g., California ABCD Screening Academy) • Pay-for-performance/pay-for-quality (e.g., Medi-Cal, Steps to Excellence Program Quality Rating System) • Clarify responsibility for services across public programs
Population-Based Supports	<p>Increase outreach to parents</p> <p>Provide supports to help parents navigate the system of services</p>	<ul style="list-style-type: none"> • Consultation to clinicians and ECEs (e.g., Special Needs Advisory Project) • Connection to community resources (e.g., 211/Infoline, family resource centers, nurse advice lines, First 5 LA Prenatal through Three investments) • System navigation (e.g., First 5 California TLC, Westside Infant Network)
Capacity and Capability to Care for Families	<p>Increase critical knowledge and skills within the early childhood workforce</p> <p>Create shared provider-family care plans</p> <p>Facilitate and manage referral processes</p> <p>Information technology support of desired care</p> <p>Increase access to primary care, early care and education, and specialized services</p>	<ul style="list-style-type: none"> • Expand capable workforce (primary care, ECE, specialized care) through consultation, continuing education, content of training programs • Cross-sector learning, coaching, consultation • Relationships between providers & community agencies • Parent input in design/strategies • Population coverage of prevention, health promotion, secondary, tertiary care • Appropriate use of specialized care

1. Achieving a Shared Vision of a System for Early Identification and Intervention

A shared vision is an essential first step for adopting a set of outcomes and specific steps to improvement. The EDSI vision is an early childhood system that efficiently organizes services and supports to promote child and family assets for optimal child development and to identify and address developmental issues as early as possible. While early childhood agencies and programs have varying responsibility for recognition and response, each bears some burden of ineffective care, in the form of poorer outcomes for their clients, poorer experiences with care for their clients, and/or greater costs of care to the agency/program to address population needs. Part of achieving a shared vision for improvement involves all key participants recognizing the gap and having shared expectations and desired results for the larger system. A clear, shared vision at the macro system (policy and organization) level reduces the level of effort required on the part of providers in the micro system (service delivery system) to provide care that is consistent with that vision. Making it easier to provide effective care at the practice level increases chances of success.

Changing the operating rules of a system requires a vision that is meaningful and acceptable to parents, providers, payers, and other stakeholders. Just as action without vision leads to confusion, having a vision without specific desired results can lead to false starts and wasted effort. As a result, a consensus on desired results and explicit commitment to improvement to achieve these results are part of creating the shared vision. Achieving consensus among the necessary leadership requires an engagement process. In an era of cost control, accountability, and limited resources, the private sector in particular may require a business case.

There is already considerable effort within all public agencies involved in the early childhood system to encourage timely and effective care. Several strategies for bolstering a shared vision of an early childhood system for Los Angeles County are described below.

- *Strategic communication about the value of early identification and intervention may contribute to greater investment and more organized approaches.*

Having a clear, compelling vision of a future system that is within reach could accelerate the effective use of screening within a well-functioning system. Universal and effective recognition and response is more likely if the different entities involved see the mutual benefit of collaboration. There is a need for clear messages about the desired outcomes. It is also important to be able to describe how the results from an improved system could be different than the status quo.

First 5 LA is well positioned to communicate this vision throughout the county given its major investments in early childhood and its unique systems viewpoint. Unlike some other early childhood organizations, First 5 can focus on the ultimate outcome since it is not tied to specific diagnoses, services, providers or sectors. Putting forth messages about the need and strategies for recognition and response can be part of not only funded initiatives and programs but also the public outreach and advocacy roles of First 5.

- *Use parent expectations and greater preparedness for discussions to build change*

Parents have a vital advocacy role for their own children and for the needs of children generally. The Community Building Institute of the Children's Planning Council is one community-based example of engaging parents in advocating improvement across the different geographical areas of Los Angeles. Efforts such as this tap into the potential of parents to express their needs and to partner with agencies and organizations to make sure that the needs of children are met. For individual parents, efforts such as the Special Needs Advisory Project (SNAP) family advocacy training and the PHFE WIC educational session on preparing to talk with the doctor about development help to prepare parents as partners in their child's care and as the most important advocate for their child. FRCs also support parents in their advocacy roles although often at a later stage than initial recognition and response as many parents accessing Early Start FRCs have already identified a potential developmental need.

Although parents vary considerably in their expectations for care and their advocacy and partnering skills, building the capacity of all parents to act effectively on their young child's behalf involves several strategies. It is important for parents to view discussions about a child's development as a normal process for all children. To the extent that a parent views development as an unfolding process that they do not influence, messages about development-promoting activities from clinicians and teachers are less likely to have an impact. If parents expect to discuss development with clinicians and teachers and also have the confidence and skills to share concerns and discussion observations, the efforts of clinicians and teachers towards recognition and response will be much more effective.

- *Articulating a shared vision for a community approach to early identification can unite several distinct but related efforts and increase success of each.*

A range of initiatives are strategizing around developmental screening. Recognizing the common philosophy underlying these efforts might leverage the range of activities into a more cohesive and effective shared set of strategies. Within an increasingly complex delivery system, it can be difficult to leverage investments with those of other organizations.

Regarding the process of developmental screening, greater awareness of related efforts and needs for developmental information could lead to greater efficiencies; this might occur through shared information, use of common screening tools, and other such strategies. Similarly clearer expectations among the different federal, state and local mandates and protocols for screening could create synergies among the various efforts. Examples of developmental screening within publicly-funded well child care include the Child Health and Disability Prevention (CHDP) program billing/guidelines form and the Medi-Cal managed care "Staying Healthy" form that outlines expectations for counseling topics. Licensed early care and education providers are required to complete the DRDP annually, which requires detailed observations in multiple developmental domains for each young child in the setting. The DRDP and parent-child conferences within subsidized early care and education settings also detail specific activities for identifying developmental issues. Child Abuse Prevention and Treatment Act (CAPTA) provisions require referral of young children entering foster care at risk for developmental problems to the Early Start (Part C early intervention) program, and IDEA 2004 provisions require states to refer for Part C early intervention services any child ages birth to 3 involved in

substantiated child abuse/neglect, or identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure (NECTAC 2007). In addition to responsibilities for screening relating to these provisions, the Department of Children and Family Services administers assessments through Multidisciplinary Assessment Teams.

There are a number of ongoing improvement efforts in the area of screening as popular attention to screening continues to increase. State and county First 5 Commissions have developmental screening and special needs on their agendas and have invested in demonstration programs, including the Los Angeles-based TLC program. A partnership between the California Department of Mental Health (DMH) and the Department of Health Services Medi-Cal Managed Care Division (MMCD) has developed a matrix of responsibility for socioemotional, developmental, and mental health services; facilitated screening pilots within several health plans; and studied the roles of different state programs in this complicated system. The Early Identification and Prevention focus area in the Mental Health Services Act planning process includes some priorities benefiting young children. At the parent/consumer level, the Children's Planning Council (CPC) Community Building Institute has engaged parents in each Service Planning Council (SPA) to prioritize population health concerns and activate other parents and the broader community in addressing those concerns. Early childhood is part of the prioritized population in several of the SPAs.

The Early Identification and Intervention (EII) Collaborative is a unique resource in Los Angeles County that serves a networking and information sharing function. Staff from a number of key early childhood agencies and community organizations attend regular meetings and share detailed information about agency perspectives, regulations and processes. This is a valuable process for staff and community partners to better understand eligibility as well as the current challenges that each agency encounters in terms of promoting developmental screening and other functions within the early childhood system.

- *Consensus on desired results enables leaders to invest in and track progress toward a common aim.*

As different organizations and initiatives reflect on how they can invest more in the process of early identification, having explicit shared outcomes will be vital. Agreement on desired ultimate outcomes (such as preventing developmental problems, identifying problems as early as possible, and optimizing healthy development) as well as intermediate outcomes (parental information needs are met, concerns and observations are routinely shared between parents and providers) enables leaders to set aims and track progress toward common goals. Without explicit outcomes and valid, accepted measures of these outcomes, the engagement of leadership as well as most improvement strategies will have less chance of success.

Specific Steps to Achieving a Common Vision

Outcomes of recognition and response in strategic plans and child-well being indicator sets will elevate the status of these outcomes throughout Los Angeles County.

Having outcome measures relating to recognition and response within public agency strategic plans and child indicator sets (such as United Way and the Children's Planning Council Children's Scorecard) would provide greatly needed goals and performance information.

Another specific step toward a unified vision is a common language for early identification. When each sector uses unique disciplinary and professional language, it is more difficult to see that they are actually working towards a common goal. It is important not only for each stakeholder to be clear about what they mean by their terms but also to understand how other stakeholders react to those terms. The process of adopting a common language and approach creates a shared understanding of how specific services such as “screening” fit with system goals such as meeting parent informational needs.

First 5 LA stewardship can promote a shared vision of a more optimal system of early identification.

First 5 LA has the credibility and capacity to convene stakeholders around a set of improvement goals. The First 5 LA strategic plan articulates desired outcomes for children and families as well as for the early childhood system. Aspects of a shared vision of a system that identifies problems early and optimizes healthy development include greater partnering of professionals with parents to understand their needs and concerns; greater availability and access to services and supports related to parenting; more effective partnering among providers; and continued improvement efforts towards a system that values recognition and response. Using a results based accountability framework (RBA), promoting a shared vision will be most effective by including community capacities as well as processes of care that the evidence suggests will lead to desired outcomes.

First 5 LA can work toward a shared vision through its convening functions (such as the Joint Planning Committee and special policy forums) and through its initiatives. For example, the Prenatal through Three focus area intends to intervene on a broad range of developmental determinants by articulating what needs to change in community environments to support young children. Such efforts may be more successful if EDSI (and other programs) can improve the ability of clinicians and ECE providers to share information with parents and other providers about children's development, and to recognize and act upon developmental concerns. The Prenatal through Three focus area is based in part on the principle that it is not always more services but instead greater centralization of resources and family-centeredness that leads to better early childhood outcomes. Coordination between the Prenatal through Three focus area, EDSI and other initiatives enables sharing of mutual knowledge about evidence-based practice, sustainability plans, and best practices.

A number of county departments have launched major prevention-focused initiatives that share a common vision.

Both the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) are launching major efforts focused on principles of prevention, health promotion and early identification. These initiatives are intended to achieve better outcomes for children and to reduce the need for intensive intervention for preventable problems. To communicate its vision, DMH Prenatal to Five Subcommittee recently put forward a positive vision for early childhood socio-emotional health that focuses on prevention and identifies priority populations of young children at risk. The CPC Community Building Institute, which engages parents at the grassroots level and complements the system improvement goals, also focuses on prevention and family support. These concurrent efforts provide an opportunity to

mobilize interest in prevention and therefore in early identification activities that take a strengths-based improvement approach.

2. System Leadership and Collaboration

Leadership is essential for improving shared outcomes of a complicated multi-level system. Leadership can create consistent pressure towards achieving the vision. They can make the case within their systems or organizations that the organization's values and mission demand change and that change will lead to better experiences and outcomes of care. Leaders are best positioned to make the business case for change, which may require evidence of cost reduction, greater efficiency, or both. The business case for the private sector roles in early childhood is especially important since early investments improve outcomes and costs over a long time horizon and yield cross-sector benefits that are not always fully captured by the investing organization. Leaders can create an environment that encourages reflection on current processes and outcomes. This includes working on feasible short term gains as well as changes that will lead to the longer term goal, and minimizing the risks of change that staff and providers within a network may see. Leaders of organizations providing care and supports for young children need to make it easier for administrators and providers to provide effective care and more difficult to provide ineffective care.

Substantial progress in developing effective systems of care for children has already been achieved through the exceptional leadership capacity in Los Angeles County. The Los Angeles County Services Integration Branch (SIB) Intergovernmental Operations Group (IOG) and the Children's Planning Council are key countywide organizations for creating vision, establishing shared outcomes, and leveraging public resources. Specifically, the IOG membership of public agencies that provide services and supports to children and families works toward service integration. As the official planning and advisory entity for child and family services in Los Angeles CPC is a unique and highly capable asset in Los Angeles County for promoting a shared vision. Leadership is essential at multiple levels— the IOG and CPC, public early childhood programs, health care organizations, organizations such as the local Interagency Coordination Council (ICC) that advises the state government on early intervention, professional organizations, and advocacy groups.

- *A coordinated approach for improving a system of recognition and response can help to organize the range of strategies and the multiple levels at which change needs to occur within Los Angeles County.*

The IOG and CPC not only focus on service integration but have launched prevention-oriented approaches to child and family services. The CPC is now involving parents in priority setting for systems change. Creating a Master Plan across agencies with the shared goal of effective recognition and response may be a necessary mechanism for achieving systems change. The master plan concept reflects the fact that no sector has complete responsibility or authority to pull the key levers that influence the early identification processes. A range of contributing factors, such as resources, training, financing for providers and readiness for parents, must be addressed concurrently. Few organizations are well positioned to develop a master plan for a shared goal such as effective recognition and response because they have expertise or purview in only a particular part of the system. An integrated plan would be particularly valuable for outlining opportunities for greater efficiency in use of limited resources.

The master plan concept can build on recent scans of cross-cutting goals. For example, the Infant Preschool Family Mental Health Initiative (IPFMHI) provides lessons learned and a vision of what is required to create programs that include early developmental screening and engaging parents in the process (Knapp 2006). Formation of a coordinated plan in Los Angeles County could benefit from resources developed by IPFMHI, such as the strategies for financing mental health screening and services and the compendium of screening tools for social and emotional development.

- *Promoting relationships across agencies can lead to more efficient use of limited resources.*

Given the ever-present constraint of limited resources, making more efficient use of the various screening activities that now take place is a promising although largely untested improvement strategy. These include screening at the universal level (i.e., in well child care and in ECE parent-teacher conferences) and for children already identified with risks (e.g., in the child welfare system). Shared knowledge of what is currently in place and an assessment of how these efforts meet the need—such as, if screening/assessments include socio-emotional considerations in addition to other developmental domains, how the information is used, if the screening is done as a partnership with the family—could lead to greater efficiencies. There are likely opportunities to reduce redundant costly assessments by sharing information and by adding socio-emotional and developmental content to current screening efforts. For example, MAT assessments within child welfare are important for setting children’s care priorities yet underemphasize mental health due to funding restrictions.

Greater collaboration can lead to better experiences with care, better health and developmental outcomes, and more efficient use of limited resources. For example, collaborative population-based planning for early identification can promote consistent messaging about child development for parents and across agencies, reduce unnecessary assessments (by using common tools and sharing assessment information), and encourage shared responsibility for desired outcomes. For instance, local education agencies can coordinate with Early Start and other relevant agencies in the use of screening and assessment materials and other best practice approaches to “child find” and community outreach. Greater transparency in the roles and responsibilities in referral and follow-up can decrease delays in referral, assessment and ultimately intervention. At the service delivery level, examples of how coordinated planning could lead to more efficient use of limited resources includes information sharing about the clients they have in common and reducing unnecessary duplicative assessments. Given limited resources, consensus on tools and coordination of the assessment process among agencies such as DCFS, Regional Center, and DMH could reduce the burden on the child and family as well as use limited resources more efficiently.

- *A system culture of shared rather than transferred responsibility is a more family-centered and effective approach.*

A more effective approach to meeting the developmental services needs of families is a climate of shared, rather than transferred, responsibility. A philosophy of shared rather than transferred responsibility encourages relationships between primary care providers, early care and education providers, and community resources.

Specific Steps to Promote Leadership and Collaboration

First 5 LA stewardship toward an improved system, in partnership with leaders and stakeholders, can help to promote the will, ideas, and implementation to achieve desired results.

First 5 LA has the standing and resources to play a stewardship role in addition to the essential, explicit focus on improving early childhood systems and outcomes. Vital current roles include setting the vision and convening many of the leaders who need to much of the detailed work to promote a better functioning system. Working in partnership with the SIB/IOG and the CPC can lead to a concrete improvement plan and a consensus-based, long term strategy for system improvement. Over the long term, stewardship may include convening and consensus-building, advocacy, dissemination of evidence-based policy and practice among leadership, strategic investment, and continued pressure for improvement.

First 5 LA initiatives and focus areas each have strategies for capacity-building that can further EDSI goals.

Although specific activities and approaches vary among First 5 LA investments, they share a commitment to goals within the First 5 LA strategic outcomes framework. As a result, these investments are complementary and can be synergistic. EDSI uses a quality improvement approach while First 5 LA investments focus on creating community infrastructure as well as family-centered policy (such as the Prenatal Through Three focus area); workforce enhancements (e.g., School Readiness, Child Health Works); and working with parents as advocates for their children, informed observers, and consumers of health care (e.g., First 5 LA funding of the Children's Planning Council, A Place of Our Own/Los Niños en Su Casa). There can be great synergy from developing common outcomes and using consistent policy messages and strategies across programs. Advantages include reduced complexity from funded programs about the results they should achieve, more systematic information on First 5 LA outcomes, and ultimately less complexity within the service system. There is great potential to build on recent First 5 LA advances in this area including a new evaluation strategy and the cross-cutting initiatives effort.

3. Performance Measurement at All Levels

Building upon the relatively limited available information about the performance of the system will strengthen the business case for change. Performance measurement that is available at the countywide level for policymakers, providers and consumers will show changes to policy and practice are moving the system toward shared goals. Having consensus on shared outcomes to work towards is necessary but not sufficient for continued improvement. Both macro and micro systems need indicators (how we define outcomes) and measures (numerators and denominators for the indicators) so that we can reliably gauge current performance and measure our progress towards desired performance targets. The national ABCD Screening Academy has detailed a number of these measurement considerations for policy and practice (Reuland et al. 2006).

First, improvement depends upon appropriate and effective measures of desired outcomes. For primary care pediatric clinicians, the Promoting Healthy Development (PHD) parent survey offers validated measures of quality of preventive care in clinical settings. Health plans use the

Health Plan Employer Data and Information Set (HEDIS) and additional health plan measures for accountability or pay-for-performance. For medical providers a challenge has been the availability of valid measures of recognition and response, as well as the availability of any performance data at the provider level. Health plan level measures often tell providers little about the processes and outcomes of their own individual practice. Health plans are increasingly able to provide detailed information to practices that profiles the medical group and individual clinicians but are limited by what is available in administrative data and what is collected in periodic audits. For example, the annual Consumer Assessment of Health Plan Satisfaction (CAHPS) produces plan-level but not provider-level information about qualitative aspects of care (such as effective communication, understanding the child's needs, etc.). Moreover there are virtually no health plan or provider level data on recognition and response processes such as elicitation of parent concerns, and timely referral. The First 5 LA Healthy Kids client survey provided the first data in Los Angeles County using such measures from the PHD. For early care and education settings, annual DRDP observations and parent surveys are aggregated and returned to licensed ECEs annually, although there is some variability in the extent to which teachers find this information actionable.

Second, adoption of measures across organizations is more likely when there has been cooperation on standardization of definitions. Examples of national standardization processes include NAEYC certification expectations and HEDIS measures for health plan accreditation and performance comparisons. Within California, MMCD and health plans have done this collaboratively for performance improvement projects. Beyond the PHD (for clinicians) and the DRDP (for ECE settings), this standardization process has not yet been undertaken for an early childhood system, or for outcomes of well-functioning recognition and response. A consensus based process helps ensure that shared outcomes are operationalized so that leaders, providers, and parents agree that the measures represent priority goals to be achieved and thus can inform improvement efforts.

Having a trusted body to assemble and disseminate measures is also important for credibility. Currently the CPC gathers existing measures for the Children's Scorecard and disseminates the results countywide. The Los Angeles County Health Survey generates and analyzes countywide data through biannual population-based surveys of priority public health topics for Los Angeles County. Health plan indicators and DRDP reporting by the CDE are examples of currently available trusted results. Public agencies also produce some level of information (such as total clients served, average age of children at the time of referral to the Early Start program) although relatively few meaningful data on recognition and response are available currently. Chances of initial and continued engagement will be higher if we have trusted sources of the data as well as trusted sources of compiled information and effective distribution.

Specific Steps to Promote Leadership and Collaboration

A consensus-based approach to agreeing on indicators, operationalizing measures, testing/adapting them for diverse populations in Los Angeles County, and implementing them at the system and service delivery levels will provide the information needed to guide improvement.

A consensus based approach on measurement that considers indicators that are available currently as well as those that are not collected currently will be needed so that leaders of multiple sectors see shared responsibility in driving toward those measures. Substantial work has already been done nationally on domains of measurement as well as on specific indicators for clinical care. Testing and adaptation needs largely involve additional systems measures as well as a validation process of some parental survey measures with diverse populations in Los Angeles County to ensure that results reflect the quality of care provided. Relevant content might be collected through population surveys such as the Los Angeles County Health Survey and WIC Data Mining Project, and indicator reports (e.g., CPC Children's Score Card, United Way,)

4. Continuous Learning Culture

Encouraging a continuous learning culture throughout the early childhood system equips administrators and providers to test continually possible improvements to how care is provided. This enables organizations and providers to adapt to the needs of parents and young children as well as to changes in promising practices and the broader resource environment. A number of strategies have been identified for improving a culture of continuous learning within practice. For example, recertification of physicians now requires demonstrated skills in and implementation of periodic QI cycles. Organizations and providers share the responsibility to improve care so there are roles at multiple levels of the system. Currently QI roles of organizations such as health plans and local education agencies generally include measurement through analysis of administrative data and/or client surveys and feedback.

Sharing evidence-based tools, resources, and care patterns occurs not only through professional standards within disciplines but also within local service systems. Some innovation comes from testing changes within a practice. For other improvements it is inefficient to discover innovation on a practice-by-practice basis. Peer-to-peer communication and support is a well accepted method for spreading evidence-based practice throughout physician networks. Traditional methods of continuing education are known not to be as effective as other learning techniques, yet they are often used for clinicians as well as teachers for reasons of convenience and apparent cost-effectiveness. Increasingly, building quality improvement skills for providers as part of medical training pipeline has been recognized as a strategy to equip clinicians with these vital skills. In a diverse region such as Los Angeles County, training future providers to reflect and adapt their practice to the realities of young children and families is essential to effective care and to achieving desired results for the early childhood system.

- *While most organizations and providers do some type of quality improvement, a culture of continuous learning includes an explicit appreciation of testing and learning throughout all levels of an organization, which includes a support process for those involved in planning, testing, and acting upon what is learned.*

A key feature of a continuous learning culture is effective support of change at the provider level. Measurement and feedback to providers at the service delivery level without effective coaching and consultation often prevents the translation of what we know to work into how care is provided. A particular need given the multiple functions and sectors within the early childhood system is to facilitate cross-sector learning and coaching. Cross sector training enables different

providers in the system—such as clinicians and ECE personnel—to understand each other’s perspectives, roles and challenges and a result to work more effectively as part of a community system.

Improvement networks that enable providers to test and share effective strategies with each other can take many forms. Current quality improvement efforts for clinicians within Los Angeles County, outside of health plan efforts, include the Community Clinic Association of Los Angeles (CCALA) QI initiatives as well as those of LA Net, which is a not-for-profit entity with the goal of encouraging improvement in care among local clinicians, with a particular emphasis on community clinics.

Specific Steps to Promote a Continuous Learning Culture

- *Because clinicians and ECE providers are providing care within a complex and ever-changing service environment, identifying and testing changes should be supported as a regular part of practice.*

Those providing care to children and families continually encounter new challenges and different types of complex family need. As a result, an important characteristic of a well functioning early childhood system is continual reflection on how care is provided, with a view toward continually improving capacity, efficiency and desired results. There is a need for infrastructure in Los Angeles County that can support the improvement efforts of clinicians and teachers through consultation and coaching. Given the range of continuing education and improvement activities involving clinicians and early care and education providers, mapping these activities and finding ways of supporting effective continuous learning is a priority to equip providers with the skills to respond to client needs.

- *Since teachers and clinicians have limited time and resources for recognition and response activities, supporting more optimal use of all assessment activities can mutually benefit clinicians and teachers..*

While tools such as the DRDP can facilitate continuous improvement, part of a learning culture implies having the skills and tools to interpret and then act upon data that are collected about a practice or setting. For example, licensed ECE settings use the DRDP annually to gather detailed information about how each individual child in the setting is functioning within multiple developmental domains. While ECE settings use the results to craft tailored activity plans, the individual information is not used because the DRDP was not intended to be an individual measure. There is potential to make better use of this information for recognition and response, particularly for underserved children who may have limited access to other professionals in terms of developmental monitoring.

5. Strengthening Incentives and Motivation for Effective Care and Supports

Incentive and motivation strategies can make effective care easier than the status quo. An early step towards improvement is identifying how current incentives shape the results that we see and how different incentives can produce more optimal results. Using incentives effectively usually means changing not just one process within the system, but instead working on different parts of the system concurrently: parents encouraging the sharing of observations and concerns through expectations and discussions, efficient ways of eliciting developmental information within well

child care, having a standardized process within clinicians and ECEs for addressing the most common developmental/socioemotional issues that come up for young children in the setting, having linkages with community resources, and ideally having community resources that can support the follow-up process. A question facing leaders within the system is what would make it easier for clinicians and ECE settings to play optimal roles in early identification?

Specific types of incentives that can work include enhanced reimbursement for those practicing effective care and a range of pay-for-performance approaches for specific capacities and services. Rewarding effective care with financial incentives is an important strategy when a viable reward system can be crafted with valid and feasible measures and reporting. Professional development incentives such as obtaining continuing education or course credits can encourage professionals to enhance their skills, although among clinicians, the traditional continuing education model has not always produced behavior change particularly in processes of care that involve multiple staff roles and office flow. Other types of motivations include removing current disincentives to early identification. For example, a more logical and seamless organization of publicly-funded services encourages providers to refer by reducing the effort required. Mounting paperwork in pediatric practices reduces the time that clinicians have for talking with parents about their own priorities. Peer and consumer recognition of quality, and greater professional satisfaction in providing more effective care, can also encourage change.

Several ways of strengthening incentives and enabling early childhood professionals to provide more effective care are described below.

- *Reconciling expectations, mandates, and funding with the realities of practice are needed within public and commercial medical insurance programs and health plans to encourage more effective care by clinicians in their networks.*

Providers perceive a number of current disincentives—such as burdensome paperwork that takes time away from clinical care, and daily requirements for the number of patients that practices must see—that detract from the time available in practice to provide effective health promotion and developmental care. For public medical programs in particular, there are basic tensions between the productivity expectations for providers (i.e., daily patient volume), the standardization of care (including mandated forms and processes in which specific guidance topics are addressed with all patients), and professional recommendations that call for prioritization of topics based on the patient’s needs and preferences, and eliciting and addressing parental concerns. Modest changes in financial incentives are unlikely to resolve this tension. If providers bear all of the burden for putting mandates into practice, progress towards system outcomes will fall short of what is possible.

- *More explicit expectations through regulations and professional recommendations may increase interest in and use of more structured screening tools.*

Defining expectations for care and accountability of organizations and providers to meeting those expectations are an essential part of assuring effective care in practice. Revisions to the Child Health and Disability Prevention (CHDP) program recommendations on developmental screening may encourage greater use of structured tools. Head Start programs in Los Angeles are beginning to use the Ages and Stages Questionnaire with children. Pragmatic strategies to help

Head Start and other ECE settings as well as clinicians to meet professional expectations within the current realities of practices are greatly needed.

- *Community infrastructure to support of early identification can encourage clinicians to identify socio-emotional concerns in young children.*

Clinicians often express concern that identifying more socio-emotional concerns will not actually improve outcomes due to the dearth of helpful services or supports to families. Examples of reasons for these gaps include restrictive eligibility for public programs and a general shortage of accessible mental health assessment and treatment for young children. The consultative mental health services approach of Project ABC, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), seeks to address this gap. The service network established by Project ABC, in collaboration with Children's Hospital Los Angeles, addresses this concern and reduces these disincentives of early identification. Outcomes of this project may stimulate greater use of this type of consultation and streamlined linkage to specialists. A range of examples from other states provide options for California. The Help Me Grow program in Connecticut showed positive results in increased identification and successful referrals by making system navigators available to practices. Part C is one funding option for community-based coordination and follow-up.

- *Inclusion of screening activities and regular parent-provider communications about children's development in the Quality Rating Scales adopted by LAUP and the Los Angeles County Office of Child Care promotes early identification activities in ECE settings.*

The Quality Rating Scale developed by the Office of Child Care for the Steps to Excellence Program describes five levels of quality in the routine use of validated tools and effective response to identified developmental needs. Effective referral and coordination of services with appropriate support services and agencies is also part of planned activities. Including these criteria promotes the idea that early identification activities should be happening in high-quality ECE programs. The version of the Quality Rating Scale adopted for the Steps to Excellence pilot includes domains of developmental screening, and connection to community resources to support families. At this time, LAUP has not adopted these two domains for use of the Quality Rating Scale among funded preschool settings

- *Recent needs assessments and pilots in California describe challenges as well as specific policy options for addressing socio-emotional issues in young children.*

The experience of the State DPH MMCD and DMH "BEST-PCP" project previews both the opportunities and limitations to clarifying roles and responsibilities of different public agencies for standardized early childhood screening and services in socio-emotional health. The first phase of the project developed a matrix of responsibility for mental, emotional and developmental needs of children and also outlined legal considerations for sharing information between providers, thereby reducing lack of clarity at the provider and agency level that might preclude information sharing for fear of sanction. The California Blue Ribbon Task Force on Autism recently offered a set of recommendations, which led to proposed legislation requiring developmental screening within pediatric primary care visits for children ages 0-5 years. California and more than 20 other states are supported currently by The Commonwealth Fund in partnership with the National Academy for State Health Policy (NASHP) ABCD Screening

Academy to work toward adopting policies that promote developmental screening, spread screening to pediatric practices, and engage statewide leadership for guidance on sustainability and policy development.

Specific Steps to Build Incentives and Motivation

Steps to reconcile mandates with desired processes, outcomes, and feasible patterns of care for providers can accelerate improvement.

Mandates/requirements can pose a barrier to systematic improvement when they hinder effective care or when providers do not adopt them because they are not perceived as feasible. There is a need to offer providers viable strategies for fitting mandates of public organizations (e.g., expectations for screening, CHDP and Staying Healthy, DRDP) as well as professional standards (e.g., AAP preventive care and screening guidelines) into local practice. Practical discussions are needed to reconcile expectations and practice. Health plans and medical groups/independent practice associations have a vital leadership role in reconciling accountability provisions (e.g., patient volume, use of standardized forms) with desired processes and outcomes of recognizing and responding to developmental and behavioral issues. This will involve participation of medical directors in multiple commercial and public health plans as well as state agencies (such as MMCD and CHDP) that set administrative policies. Such discussions could ultimately help professionals and programs focus on achieving desired outcomes rather than meeting specific mandates.

Health plans have the opportunity to invest in quality improvement efforts focused on improved developmental services within primary care practice.

Commercial and public managed care plans can play a leadership role in reconciling accountability provisions and goals of pediatric well child care with the desired outcomes of recognizing and responding to developmental and behavioral issues, helping practices self-assess performance in this area, and finding effective ways of improving quality of care. Achieving agreement on valid measurement approaches is a precursor to increasing recognition and response as a priority for quality measurement particularly within the emerging Medi-Cal managed care pay-for-performance program. Having reliable, acceptable quality measures and a clear business case can increase the chances of many health plans making this investment.

Strategies are needed to help ECE settings move towards benchmarks in the Quality Rating Scale adopted by LAUP and the Los Angeles County Office of Child Care.

The Quality Rating Scale provides the first critical step toward improvement. Showing ECE settings each performance level creates a basis for continued quality improvement. There is a need to support ECE settings not only in becoming eligible for enhanced reimbursement, or for participation in LAUP, but in moving from one level to the next. The pilot Steps to Excellence program, EDSI, and other current efforts may provide useful lessons for what types of supports are effective. Helping ECE settings make better use of the DRDP for improving center-wide and individualized approaches to young children is another way of building capacity. Extending the use of these quality rating tools, along with support for change, can ensure that improvement extend to children in all types of early care and education settings.

6. Population-Based Supports

From the vantage point of those involved in recognition and response, population-based supports include specialized services for developmental/socioemotional problems—such as mental health, Early Start, Regional Center, and special education assessment and services. An ongoing challenge is ensuring that there are adequate community resources for parents when problems or prevention/health promotion opportunities are identified. Each community faces the challenge of assembling the resources necessary to recognize and respond to developmental and behavioral issues, including referral and follow up with children and families who need specialized supports. For example, the diagnostic assessment process for many developmental concerns is complex and inadequately resourced and financed in the current system. Each community shares common resource limitations but also has unique unmet service priorities based on the promotion, prevention and clinical service needs of their population.

Population-based supports also include a range of possible community-based resources that support effective recognition and response. Such resources range from parent-focused strategies to help them partner with clinicians and teachers (such as through the WIC session on skills for talking to the doctor) to community-based referral and follow-up capacities. These types of community resources can reduce the effort required of clinicians and teachers to identify concerns as well as to act on concerns and observations about development.

It is clear that greater volume of specialized services would not completely close the gap in need even if they became available. Having community infrastructure to help parents connect with useful resources and ensure that they ultimately linked with the appropriate resource is a feature of a high-functioning system to promote optimal development. For example, Connecticut's *Help Me Grow* care coordination infrastructure helps with the resource-intensive process of linking parents and young children with programs that meet their developmental/socioemotional needs.

First 5 LA has made key investments in community infrastructure. The TLC program at Westside Children's Center and several First 5 funded school readiness programs have experimented with this role and have promising results. These programs provide models for building the capacity of providers to identify children and follow-up with special needs. These programs also encourage effective early identification among clinicians and early care and education settings because they provide options for helping families when a problem is identified. An important lesson from these investments is that it is not only the availability of support, but the trusting relationships established between the programs and the clinicians and early care and education settings within the community served, that makes these community approaches effective. As these initiatives progress, sustainability becomes a vital question. The current question is not whether these efforts can work but instead how they can be sustained as hubs of innovation and support, as well as replicated and financed throughout Los Angeles County.

- *DMH planning and demonstration efforts are seeking to improve abilities to address mental health concerns as well as the availability of mental health providers.*

The Prenatal to Five Collaboratives in each Service Planning Area in Los Angeles County helping to coordinate local mental health services. Project ABC in partnership with DMH is

working to enhance the capacity and skills of providers in infant and early childhood mental health, as well as early childhood professionals, through sponsored events.

- *The DCFS hubs provide greater capacity for monitoring the well-being of children in foster care as well as other children who are involved with DCFS but are not placed out of the home.*

The foster care hubs are now operational in all areas of the county and will implement a standardized mental health screening tool (CIMH). DCFS expects to move toward more consistent use of a common set of developmental monitoring tools in 2007 or 2008. These steps may also be accompanied by promotion of networks of pediatricians and family practice physicians who are linked to their regional hub. Benefits of being in this network include training in child welfare issues as well as in screening and assessment. In addition, current planning by DCFS for families referred to DCFS with risks that do not reach the level of formal involvement creates another point of connection. For these families, there could be value in follow-up by someone with a relationship with the parent, and/or by someone with a greater knowledge/skills base in helping parents with the kinds of risks identified by DCFS.

7. Capacity and Capability to Care for Families

Having the capacity and capability to provide quality care for young children and families involves skill enhancement among clinicians and teachers, as well as increasing the availability and efficiency of community resources for parents when problems or prevention/health promotion opportunities are identified.

There is a need for training and skill-building among clinicians and teachers in communicating with parents and in addressing or referring for concerns. Clinicians and early care and education personnel are the early childhood professionals most likely to interact regularly with parents and young children so it is important to take advantage of their informed observations and trusting relationships with parents. Yet numerous reports show that pediatric clinicians receive limited training in community practice as it relates to early identification and connections with community resources. Some young children receive primary care from general practice clinicians who have less experience than pediatricians and family medicine physicians in child development. Similarly while ECE providers have regular contact with many young children, relatively few receive specific training on early identification and connecting families to community resources. Finally, few clinicians and teachers get help making improvements in busy work routines so that good ideas may fail to be put into practice systemically. Several ways of investing in knowledge and skills within the early childhood workforce are described below.

- *A coordinated effort among educational programs for clinicians and ECE personnel—including medical schools, health plans, and resource and referral agencies, among others—could extend continuing education resources to a larger proportion of the current workforce.*

A sustainable workforce strategy for both groups requires effective continuing education for those currently providing care and services in Los Angeles County. While physicians and nurses have continuing medical education (CME) requirements to maintain licensure, not all continuing education programs use the most effective learning approaches for clinicians. Similarly educational efforts for ECE settings may focus on using a tool but not adapting the system within

the setting to make optimal use of that information. The fact that early identification has not been a major focus of clinical quality of care measures or a major driver of reimbursement makes it even more important to strive for change through accessible and practical continuing education.

A critical long-term strategy is shaping the “pipeline” of early childhood professionals. This includes training programs such as residency programs for pediatricians and family medicine physicians in Los Angeles, based at UCLA and USC and with their community partners. The UCLA Community Health and Advocacy Training (CHAT) program is an example of enhancing preparation in community practice by enabling pediatric residents to take part in planning and advocacy activities in a specific community in addition to working clinically with interdisciplinary and innovative community partners. Another example of preparation among other types of professionals is the Childrens Hospital Los Angeles Center for Excellence in Developmental Disabilities. Ideally such pipeline efforts would emphasize not only developmental content and working effectively within a community system, but also the processes of self-assessment and quality improvement.

- *The Steps to Excellence initiative is creating professional growth opportunities and quality expectations in developmental screening.*

The Office of Child Care has developed a Quality Rating Scale that is ground-breaking in setting specific expectations for both developmental screening and connecting families with community resources. The Steps to Excellence pilot program in 2007 will link enhanced reimbursement to achieving benchmarks. The program sets expectations at five levels of performance so that all ECE settings from family day care to large centers understand what is involved in moving from one level to the next. Tying this rating scale to reimbursement levels through Steps to Excellence and the First 5 LA LAUP will provide new incentives for greater roles in early identification.

- *Resource and referral agencies have key supportive and connecting role for early care and education programs.*

Resource and referral agencies (R&Rs) provide a range of services and resources for the ECE community and as a result have key roles in sustaining and encouraging early identification activities within ECE settings. R&Rs are positioned to have an ongoing formal role in capacity building among ECE providers. Examples of efforts to build upon include support of child care programs in the use and application of the DRDP, and inclusion supports for children with special needs. While future funding is not assured, SNAP resources based at Pathways have strengthened inclusion consultation throughout Los Angeles County.

- *Child care workforce capacity efforts including First 5 LA efforts can expand to promote quality and improved provider-parent communication and early identification and screening.*

A major focus of child care investments by First 5 LA focus on increasing the number of child care openings given supply constraints within the county. The next stage of investment may be promoting quality within ECE settings. Focusing efforts on continuing education for current providers, with financial incentives such as additional teacher stipends for those participating in SNAP curriculum classes offered by Pathways, may be another avenue to increase early identification in the early childhood education sector. The AB212 initiative “Investing in Early Educators” through the Office of Child Care is another leveraging opportunity.

- *Consultation is an efficient way of supporting front-line providers and making efficient use of limited specialized early childhood professionals.*

Because there has always been a shortage of early childhood personnel in areas such as mental health and speech therapy, clinicians and teachers have often been on their own in deciding how to address developmental and behavioral concerns. In particular, private child care centers, family day care, and independent physician practices have few resources within their own organizations to draw from. Consultation to clinicians and ECE personnel to prevent problems from requiring specialty intervention is an efficient use of such limited resources. A consultation model works especially well when the needs and capacities of individual providers vary. It is also a promising approach to address a provider's reluctance to explore potential problems when they feel they lack the skills, time or resources to address them.

Early experience with the Pathways consultation and inclusion supports in Los Angeles, the use of nurse consultation in the national Healthy Child Care America initiative, and California's Child Care Health Linkages Project shows that consultation to ECE settings can be effective.⁸ The SNAP program operated by Pathways uses consultation to help ECE settings address developmental concerns by sharing strategies for working with children and communicating with their parents. While the Health Linkages program has lost much of its funding, some individual counties have found ways to continue supporting this program with local funding. LAUSD has also successfully upgraded skills of ECE providers through strategic use of special education teachers in their collaborative classroom model. Additionally, a number of models such as reflective supervision, tiered services structures, multidisciplinary settings, and creative mentoring programs can promote the sharing of specialized knowledge.

On-the-job training is also important for clinicians and ECE personnel. Early identification that is preventive in nature is not only a better outcome for the child and family but also reduces the strain on these limited resources. Specialized programs might also embrace a potential role in building capacity of clinicians and early care and education professionals. Programs such as Early Start and special education have an opportunity to build the capacity among first-contact providers and families to work more effectively with children who may show signs of delay but do not yet qualify for services. While these programs work with providers for individual clients, and outreach to providers on eligibility rules, there is an additional more subtle role in helping these providers with situations when eligibility is less clear.

Specific Steps to Build Capacity in the Workforce

Improving training in the pipeline of new professionals as well as offering effective continuing education for clinicians in practice are critical responsibilities of local medical training programs and health plans.

Because national accreditation drives the main curriculum of training programs, finding local ways of supplementing the training so that pediatric clinicians are better prepared for effective community practice in recognition and referral is an issue for local medical training programs. Local philanthropies may be able to encourage effective training in community practice—and particularly in the non-clinical aspects of partnership and interdisciplinary work—through fellowships and other types of supports. Examples of training models include

leadership fellowships from The California Endowment, the Robert Wood Johnson Foundation Clinical Scholars Program, and the First 5 LA Fellows program.

Sustaining the health consultation and inclusion infrastructure established by SNAP is a policy priority for supporting ECE settings in early identification.

SNAP has demonstrated success in building relationships between ECE providers and parents, increasing the chances that ECE providers will try to address developmental and behavioral concerns among children in their care, and reducing the problem of children moving between multiple child care arrangements due to their special needs. State funding of SNAP has not been assured from year to year. Extending this funding will enable SNAP to continue offering this support to ECE settings throughout Los Angeles County.

Helping early childhood professionals better understand public program eligibility and referral processes can help direct families to the appropriate agency or program.

Clinicians are often unclear about eligibility and referral processes for key programs such as Early Start/Regional Center, school districts, and mental health. Efforts to inform clinicians might be more effective if offered in a comprehensive program rather than by each separate program. A general strategy is to coordinate outreach and continuing education activities with clinicians so that clinicians understand the spectrum of supports and how they relate to each other. Separate training efforts for each program encourage providers to learn the specific referral pathways to each program rather than achieving a more complete grasp of how to know which program to begin with, leading to potential false starts and wasted time.

CONCLUSION

EDSI is a strategic investment by First 5 LA to develop the capacity of communities to monitor, evaluate and support young children's optimal development. This effort requires envisioning a system that is focused on desired outcomes. This is a complex challenge since unlike most other industrialized nations, the U.S. lacks a universal system of health promotion for children. There is a need for local solutions particularly for parents and young children with needs who are ineligible for clinical, early intervention, or other specialized services. Because responsibility does not rest with a specific provider, it is important to prepare several types of venues with a high probability of reaching and working with each parent and child: clinicians as well as early care and education providers have a vital role in establishing comfortable and constructive relationships with families. A vital strategy for accelerating improvement is infusing key principles for effective early identification and intervention into public policies and planning efforts.

Achieving and sustaining desired results of recognition and response include the following general strategies:

1. **Shared vision and engagement** of leaders, providers and consumers for a system that can achieve desired outcomes;
2. **System leadership and collaboration** to enable and sustain a well-functioning system;
3. **Transparent performance measurement** at all levels to provide a picture of current outcomes relative to goals, and to show which changes are effective;

4. **Continuous learning culture** to equip providers with the ability to adapt to the needs of parents and young children and to changes in the resource environment;
5. **Incentives and motivation** to encourage the effective care that providers want to deliver;
6. **Population-based supports** to facilitate prevention, health promotion and care for parents and young children with specific needs; and
7. **Capacity and capability to care for families** so that needs can be met with effective, acceptable services and supports.

This report describes many of the opportunities in Los Angeles County for achieving these desired results. The EDSI strategic partnership will convene policy summits in 2008 and 2010 as part of this strategic partnership to focus on these and other leveraging opportunities. Priority leveraging opportunities for the short term may include the following:

- Achieving consensus on the types and relative importance of a set of improvement strategies for the early childhood system;
- Engaging leadership from multiple sectors in the desired results of an early childhood system;
- Coordinating EDSI improvement efforts within ECE settings with the *Steps to Excellence* tiered reimbursement pilot in Santa Monica, as well as inclusion and consultation efforts related to SNAP and the DRDP;
- Examining how expectations of CHDP and the Medi-Cal Managed Care Division regarding developmental screening and identification of children with special needs can be incorporated into pediatric practice, and how progress towards these goals might be measured;
- Assessing ways of spreading change throughout pediatric practices and ECE settings in the county;

In summary, this policy scan shows that EDSI can build upon a variety of current efforts. If the demonstration projects and efforts outlined in this report can be sustained, there will be an opportunity to tackle some of the key state and federal issues regarding scope of services, eligibility, training, and financing/reimbursement that currently pose barriers to more optimal systems of early identification and intervention.

Bibliography

- American Academy of Pediatrics, Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118 :405 –420
- American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. Guidelines for Health Supervision III. Elk Grove Village, IL: American Academy of Pediatrics; 1997 (updated 2002).
- Brazelton TB. (1994). Touchpoints: Your child's emotional and behavioral development. De Capo Press.
- Coleman, M. R., Buysse, V., & Neitzel, J. (2006). Recognition and response: An early intervening system for young children at risk for learning disabilities. Full report. Chapel Hill: The University of North Carolina at Chapel Hill, FPG Child Development Institute.
- Dworkin, PH (2004). 2003 C. Anderson Aldrich Award Lecture: Enhancing developmental services in child health supervision—an idea whose time has truly arrived. *Pediatrics*, 114, 827–831.
- First 5 California Children and Families Commission. (2005). *Annual Report 2004-2005*. Retrieved 2006/08/04, from <http://www.cafc.ca.gov/fiscal.htm>, http://www.cafc.ca.gov/PDF/Research/F5AR_FY2004-05.pdf?pg=28.
- First 5 Los Angeles. Partnerships for Families Initiative (PFI). Retrieved 2006/04/20, from <http://www.w58674.w1.com/ourprojects/PartnershipsforFamiliesInitiative.php4>.
- Glascoe FP, Dworkin PH. (1993). Obstacles to effective developmental surveillance: errors in clinical reasoning. *J Dev Behav Pediatr*. Oct;14(5):344-9.
- Green M, Palfrey JS, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev.) Arlington, VA: National Center for Education in Maternal and Child Health; 2002.
- Hall DMB, Elliman D. Health for All Children. 4th ed. Oxford, England: Oxford University Press; 2003.
- Kaye N, May J, Abrams M. 2006. State policy options to improve delivery of child development services: Strategies from the eight ABCD states. National Academy for State Health Policy. December.
- Kaye, N. (April 2006). Improving the Delivery of Health Care that Supports Young Children's Healthy Mental Development: Early Accomplishments and Lessons Learned from a Five-State Consortium. National Academy for State Health Policy.
- Knapp, P. (February 27, 2006). The California Infant Preschool Family Mental Health Initiative Brief Executive Summary. Retrieved March 2006, from http://www.dmh.cahwnet.gov/CFPP/infant_preschool.asp.
- Kuo AA, Inkelas M. (January 2007). The changing roles of pediatric well-child care. Zero to Three. 27(3):5-11.

- Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin C. (2006). A Framework for Spread: From Local Improvements to System-Wide Change. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement.
- National Early Childhood Technical Assistance Center. Accessed September 18, 2007. <http://www.nectac.org/topics/earlyid/capta.asp>
- Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. (1996). The Improvement Guide. San Francisco, California, USA: Jossey-Bass Publishers, Inc.
- Oberklaid F. (2000). Is development assessment worthwhile? *Aust Fam Physician*. 29:731–734
- Prenatal through Three. (2006). The ABC's of First 5 LA's Baby Zones (Memorandum from Evelyn Martinez to First 5 LA Board of Commissioners): First 5 Los Angeles.
- Reuland CP, Bethell C, and the Child and Adolescent Health Measurement Initiative (CAHMI). (2006.) Measuring and evaluating developmental services: strategies and lessons from the ABCD II Consortium States. The Commonwealth Fund. December.
- Schor, EL. (2007). Redefining well-child care. Transforming Well Child Care Seminar, First 5 LA. June 6. Los Angeles, CA.
- Schor, EL. (2004). Rethinking well-child care. *Pediatrics*. 114(1), 210-216.
- Schor EL, Abrams M, Shea K. (2007). Medicaid: health promotion and disease prevention for school readiness. *Health Aff*. Mar-Apr;26(2):420-9.
- Schuster M, Duan N, Regalado M, et al. (2002). Anticipatory guidance: What information do parents receive? What information do they want? *Arch Pediatr Adolesc Med*. 154:1191-98.
- Steps to Excellence Program Implementation Plan: Launching a Child Care Quality Rating System in Los Angeles County. Prepared by the Los Angeles County Roundtable for Child Care. Submitted to the Board of Supervisors October 12, 2006. <http://cao.lacounty.gov/ccp/step.htm>

¹ Recognition and Response is the term applied to an early intervening system developed for young children ages 3 to 5 years. It is described by its authors as an emerging early childhood practice with the intent of helping parents and teachers respond to learning difficulties in young children. This approach is described in Coleman, M. R., Buysse, V., & Neitzel, J. (2006). Recognition and response: An early intervening system for young children at risk for learning disabilities. Full report. Chapel Hill: The University of North Carolina at Chapel Hill, FPG Child Development Institute.

² Developmental screenings as a specific practice are required by law to take place in Head Start programs. Developmental screenings are not required for any other state or federally funded child care programs. Neither funding nor licensing conditions require screenings. It is, however, a requirement for those seeking accreditation by the National Association for the Education of Young Children (NAEYC).

³ Details about the D-PIP are available at <http://www.medicalhomeinfo.org/screening/DPIP.html>

⁴ Early Advantage is a program of the Los Angeles County Office of Education focused on promoting parent awareness of child development. The Living and Learning program, for instance, makes available information about early learning and parent involvement to parents of new infants in a variety of sites including WIC sites. The School Readiness Training Program is a series of classes on either toddler or infant development that is available to parents as well as caregivers, ECE staff and other professionals. The Early Advantage at WIC and Health Care Sites Initiative brought activities, trainings, resource materials and community networking support to WIC sites throughout Los Angeles County. PHFE-WIC, LA BioMed-WIC and Northeast Valley WIC are all strategic partners in the project. As of April 2006, over 90,000 children and caregivers had access to these activities at WIC sites. (LACOE Fact Sheet, 2006)

⁵ Learning about local families in need: The 2005 Los Angeles County WIC Survey. First 5 LA. Research Brief, Report 1.

⁶ A 2001 review of educational and counseling approaches appropriate for WIC sites noted that the Touchpoints model is very relevant for WIC encounters (Craypo, et al, 2001). The Touchpoints model “positions the parent as the authority on their child...[and] recognizes the uniqueness of each child through the creative, rather than generic, solutions to each situation.” (Ibid, 6) WIC staff have received Touchpoints training in a number of sites in California and nationally. For instance, in Napa County WIC sites staff received training and consultation from the local health department around use of the Brazelton Touchpoints approach (Whaley and True, 2000) Where WIC sites are co-located with medical services or in a hospital, the interaction with Touchpoints trained personnel is enhanced, as is the case with Sonoma County WIC and Parents and Communities Together Program (PACT). In this project, over 800 health providers were trained over two years, including public health nurses who provide services in or adjacent to WIC sites (Shenkman, 2001).

In Vermont, Touchpoints is promoted through public messaging and provider trainings in medical, social service and other settings, including WIC, to create a statewide language for understanding child development (Hornstein and Dougherty, 2001; Curtis, 2002). Beginning in 2001, the trainers from the Brazelton Touchpoints Center in Boston worked with four interdisciplinary teams that included a WIC professional who in turn have trained over 200 health providers, including physicians, WIC nutritionists and others to incorporate the Touchpoints approach into their interactions. In the WIC setting, WIC staff use a standard checklist in their one-on-one sessions with families and then ask about more individual concerns. The staff respond to these concerns by making a referral or providing anticipatory guidance materials (Hartline and Henchy, 2002).

⁷ There are 13 Early Start FRCs in Los Angeles County, and they are linked through the Family Resource Centers in Los Angeles County network (FRCnLAC), an organization that promotes shared learning and personnel development at the family-run centers. Some receive extra funding from other sources and serve clients beyond the Early Start community. Westside FRC, for instance, has received funding from the California Department of Education as a Family Empowerment Center so that it provides information and training of issues related to special education training to a more general population FRCs are able to supplement or improve training around these services depending on their individual resources.

There are also three *Family Empowerment Centers* (FECs) in Los Angeles and Orange County, which receive California Department of Education (CDE) funding to support children ages 3-22 receiving special education services and their families. Family Focus Empowerment Center in Northridge and TASK (Team of Advocates for Special Kids) in Anaheim also participate in the FRCnLAC network. The FECs are a growing movement, supported by the California Association of Family Empowerment Centers, to support family education and training beyond the Early Start years. The table below outlines many of the publicly funded family resource centers that serve children with special needs and their families. In general, these programs have a decade of experience training parents to work with other parents around development and accessing services, and their collaboration with EDSI is a significant opportunity.

California Family Resource Centers

Center Type	Source of Funds	Purpose
Family Resource Center (FRC)	IDEA, Part C SB1085 (1998)	Early Start family support
Family Empowerment Center (FEC)	CDE SB511 (2001)	Support for families with children over 3
Family Voices	MCHB, national organization	Support and advocacy for all families
Community Partnership Resource Centers	IDEA, Part D	Promote participation by particular communities
Parent Training and Information (PTI)	IDEA/Office of Special Education	Support for parents
Parent Information and Resource Center (PIRC)	CDE (2000)	Support for parents
Resource and Referral (R&R)	Child Care Block Grant	Resources, community inclusion, family training and engagement

⁸ Healthy Child Care America was a national campaign, supported until 2005 with federal funds from the Maternal and Child Health Bureau and Child Care Bureau aimed toward improving the health and safety of children in child care. In California, it financed the establishment of the California Training Institute for Child Care Health Consultants. The health consultants were funded in 20 counties in California through First 5 California. More information about Healthy Child Care America can be found on <http://www.healthychildcare.org/>.