SOLICITATION, OFFER, AND AWARD

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2. Contract Number	3. Solicitation Number	4. Type of Solicitation	5. Date Issued	6. Type of Market
	DCHC-2010-R-0088	[ ] Sealed Bid (IFB) [X] Sealed Proposals (RFP) [ ] Sole Source [ ] Emergency	4/6/2010	[x] Open [ ] Set Aside [ ] Open Market with Set-Aside SBE Designated Category:

7. Issued By:	8. Address Offer to:
Office of Contracting and Procurement 441 4th Street, NW, Suite 700 South Washington, D.C. 20001	

NOTE: In sealed bid solicitations "offer" and offeror" means "bid" and "bidder"

SOLICITATION

9. Sealed offers in original and 4 copies for furnishing the supplies or services in the Schedule will be received at the place specified in Item 8, or if hand carried to the bid counter located at 441 4th Street, NW Suite 703 South until 2:00 p.m. (Hour) local time 20-Apr-10 (Date)

CAUTION: Late Submissions, Modifications and Withdrawals: See 27 DCMR chapters 15 & 16 as applicable. All offers are subject to all terms & conditions contained in this solicitation.

10. For Information Contact	A. Name	B. Telephone (Area Code)	(Number)	(Ext)	C. E-mail Address
	Denise Burton-Johnson- Pushase Agent	202	724-4755		denise.burton@dc.gov

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OFFER

12. In compliance with the above, the undersigned agrees, if this offer is accepted within 10 calendar days from the date for receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified herein.

13. Discount for Prompt Payment	10 Calendar days %	20 Calendar days %	30 Calendar days %	____ Calendar days %

14. Acknowledgement of Amendments (The offeror acknowledges receipt of amendments to the SOLICITATION):	Amendment Number	Date	Amendment Number	Date

15A. Name and Address of Offeror	16. Name and Title of Person Authorized to Sign Offer/Contract

15B. Telephone (Area Code)	(Number)	(Ext)	15 C. Check if remittance address is different from above - Refer to Section G	17. Signature	18. Offer Date
			[ ]		

AWARD (TO BE COMPLETED BY GOVERNMENT)

19. Accepted as to Items Numbered	20. Amount	21. Accounting and Appropriation

22. Name of Contracting Officer (Type or Print)	23. Signature of Contracting Officer (District of Columbia)	24. Award Date

Government of the District of Columbia — Office of Contracting & Procurement

DC OCP-209(11-2004)

REQUEST FOR PROPOSALS (RFP)
FOR SUPPLIES AND SERVICES
TEMPLATE

Use the Uniform Contract Format Solicitation/Offer/Award form for the cover page, Section A.

You must use the RFP Guidelines in conjunction with the RFP Template.

After complying with each bold, italicized instruction, remove all bold, italicized language.

SECTION B: CONTRACT TYPE, SUPPLIES OR SERVICES AND PRICE/COST

B.1 The District of Columbia (DC) Department of Health (DOH) Community Health Administration (CHA) seeks to enter into a contract (1 base year with 4 option years) with a Contractor to develop an evaluation plan for the Substance Abuse and Mental Health Services Administration (SAMHSA) Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), funded grant. The evaluation plan shall outline how all the design and implementation of DC Project LAUNCH programs shall be comprehensively evaluated. The proposed evaluation plan shall include three major components: process, outcome and cost evaluations. The evaluation plan shall also outline how DC's Project LAUNCH initiative shall participate in SAMHSA's Project LAUNCH national cross-site evaluation

B.2 The District contemplates award of a fixed price contract.

B.3 PRICE SCHEDULE COST SCHEDULE

B.3.1 Base Year (Date of award through One Year)

#	Description/Services	Total Price
1	**Develop an Evaluation Plan**	

B.3.2 Option Year 1

#	Description/Services	Total Price
1	**Develop an Evaluation Plan**	

B.3.3 Option Year 2

#	Description/Services	Total Price
1	**Develop an Evaluation Plan**	

B.3.4 Option 3

#	Description/Services	Total Price
1	**Develop an Evaluation Plan**	

B.3.5 Option4

#	Description/Services	Total Price
1	**Develop an Evaluation Plan**	

B.4 If an offeror intends to subcontract under this solicitation, it must subcontract at least 35% of the dollar volume of this contract in accordance with the provisions of section M.5.1. The prime contractor responding to this solicitation shall be required to submit with its proposal, a notarized statement detailing its subcontracting plan. Proposals responding to this RFP shall be deemed nonresponsive and shall be rejected if the offeror intends to subcontract in accordance with the provisions of section M.5.1, but fails to submit a subcontracting plan with its proposal.

SECTION C: SPECIFICATIONS/WORK STATEMENT

C.1 SCOPE: The District of Columbia (DC) Department of Health (DOH) Community Health Administration (CHA) seeks to enter into a contract (1 base year with 4 option years) with a Contractor to develop an evaluation plan for the Substance Abuse and Mental Health Services Administration (SAMHSA) Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), funded grant. The evaluation plan shall outline how all the design and implementation of DC Project LAUNCH programs shall be comprehensively evaluated. The proposed evaluation plan shall include three major components: process, outcome and cost evaluations. The evaluation plan shall also outline how DC's Project LAUNCH initiative shall participate in SAMHSA's Project LAUNCH national cross-site evaluation.

C.2 APPLICABLE DOCUMENTS

The following documents are applicable to this procurement and are hereby incorporated by this reference:

Item No.	Title	Date	Location
1	ECCS Resource Map	June 2007	825 N. Capitol St, NE 3rd Floor Washington DC 20002
2	ECCS Strategic Plan	June 2007	825 N. Capitol St, NE 3rd Floor Washington DC 20002
3	Project LAUNCH RFP	May 2009	http://www.samhsa.gov/Grants/2008/sm_08_011.pdf
4	Project LAUNCH Environmental Scan Guidance	Most Recent	http://projectlaunch.promoteprevent.org/html/resources.htm
5	Project LAUNCH Strategic Plan Guidance	Most Recent	http://projectlaunch.promoteprevent.org/html/resources.htm
6	Project LAUNCH Grant	Most Recent	Electronic PDF. copy

C.3 DEFINITIONS

These terms when used in this RFP have the following meanings:

C.3.1 Cross-site Evaluation – Is the systematic collection of context, product, and process and impact information across Project LAUNCH sites. The data will inform SAMHSA regarding the magnitude, importance, reach and effectiveness of Project LAUNCH activities.

C.3.2 Early Childhood Comprehensive Systems (ECCS) – The purpose of ECCS is to Support States and communities in their efforts to build and integrate early childhood Services systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education and family support.

C.3.3 Environmental Scan - The environmental scan is a tool that can be utilized to collect data to design health programs uniquely tailored to the needs of communities.

C.3.4 Outcomes – Represent the results of program implementation. They can be expressed in terms of changes in knowledge, skills, behavior, attitudes, values, and status or life condition and often begin with words such as *decrease, increase,* or *reduce.* Outcomes can be short term, intermediate, or long term. Short-term and intermediate outcomes focus on the immediate effect(s) the program has on the children and families served. Long-term results are the systemic changes the program may influence for children, families, or other organizations over time, including lasting changes in attitudes, behaviors, achievement, policies, or capacity.

C.4 BACKGROUND

C.4.1 Through the Project LAUNCH grant, the DC DOH proposes to create a system of connected programs that will increase and improve service delivery to children ages 0-8 and their families in the city's poorest neighborhoods. The goal is to promote the wellness of young children so they can thrive in safe, supportive environments and enter school ready to learn.

C.4.2 The early years of a child's development are a critical stage in establishing a foundation for the social, emotional, intellectual and academic skills needed for success in school and beyond into adulthood. Project LAUNCH aims to bring local child-serving agencies together to coordinate and streamline policies and practices for families and children most in need, and to fill service gaps where they exist. The project will incorporate five basic services:

a. Developmental assessments in a range of child-serving settings
b. Integration of behavioral health programs and practices into primary care
c. Home visiting programs
d. Mental health consultations
e. Family strengthening and parent skills training

C.4.3 The target population for this project shall be children residing in Wards 7 and 8 -- areas that demonstrate alarming health and economic disparities and who suffer disproportionately from elevated levels of the indicators of ill health. Unemployment is high in the target Wards, drug use and violence are prevalent in the community, and per capita income is lowest of anywhere in DC. Children living in these communities are largely poor, African-American and living in single-parent households, and they have limited access to primary and mental health services when compared to their counterparts throughout the city.

C.4.4 To focus this child-centered work on a common set of goals, Project LAUNCH will establish the DC Council on Young Child Wellness (DCCYCW), which will oversee all Project LAUNCH activities and develop a comprehensive strategy for both infrastructure and programmatic work. During Year One, Project LAUNCH will offer a variety of evidence-based programs, each with a specific target audience: (1)Incredible Years (children 2-8 years and parents/caregivers); (2) Primary Project (children 5-8 years); (3) Ages and Stages Questionnaire/ASQ:SE (children 6 months-5 years); (4) Parents as Teachers: Born to Learn (prenatal-2 years and parents); and (5) Strengthening Families (children 3-8 years and parents).

C.5 REQUIREMENTS

The Contractor shall perform the required services in accordance with the Project LAUNCH evaluation plan. The Contractor's requirements include the following:

C.5.1 Work Plan

The Contractor shall demonstrate experience developing and submitting a work plan. The Contractor shall develop and submit a work plan that includes a clearly defined approach toward the execution of the work; timelines and deliverable dates; and shall include, or address at a minimum, the following:

a. The completion of deliverables within the due date specified;
b. Partner with Project LAUNCH program personnel, including the local evaluator, to develop ongoing process evaluation activities that can regularly inform program improvement strategies;
c. Development of policy-relevant questions;
d. Development of Project LAUNCH evaluation plan;
e. Development of sampling procedures and drawing of the evaluation sample;
f. Provision of guidance on the collection and analysis of data;
g. Development of evaluation instruments;
h. Provision of technical assistance in the development of the environmental scan and needs assessment;
i. Design of data collection protocols;
j. Design of process evaluation tool including protocols and a template that will summarize lessons learned during program implementation;
k. Development and submission of Project LAUNCH evaluation reports; and a timeline that includes C.5.1.1. -- C.5.1(k) above and allows time for interaction with Project LAUNCH personnel including the Young Child

Wellness Expert (Program Coordinator), the Local Child Wellness Coordinator, the local Evaluator, and the DCCYCW.

C.5.2 The Contractor shall demonstrate experience developing and submitting an evaluation plan. The Contractor shall develop and submit an evaluation plan under the guidance of the local Evaluator that shall include the following:

C.5.2.1 Process Evaluation – The Contractor shall demonstrate experience designing process evaluation tool(s) and protocols for data collection that shall examine staffing, training, fidelity of implementation, collaboration, program capacity building, and sustainability. The process evaluation shall assess the implementation of the project, including the fidelity to chosen practices and programs. The process evaluation should also include mechanisms for using data to make program improvements.

C.5.2.2 Outcome Evaluation Plan – The Contractor shall demonstrate experience including an assessment of the overall collaborative system and independent assessment of the individual program effectiveness of each of the evidenced based models adapted by DC's Project LAUNCH project to be implemented in Wards 7 and 8 of the District. Evidence based models being implemented by Project LAUNCH include; *The Incredible Year (IY), Parents as Teachers, Born to Learn Program (PAT), Ages and Stages Questionnaire (ASQ), Primary Project, and the Strengthening Families Program (SFP)*. The outcomes component of the evaluation shall aim to demonstrate potential linkages between project activities and improved outcomes, as identified in the LAUNCH logic models.

C.5.2.3 Cost Evaluation Pan – The Contractor shall demonstrate experience developing a plan that will estimate the economic impact of child develop development. Cost evaluation shall include, at a minimum, costs of implementing the program (and individual program components) and cost per person served.

C. 5.3 The Contractor shall demonstrate experience developing and submitting evaluation instruments. The Contractor shall develop and submit the evaluation instruments for Project LAUNCH. The focus shall be on data needed to present a detailed picture of the children 0 – 8 years and their families (including primary data collection needed to fill gaps in services to this population. The evaluation instrument shall include:

a. Development of sampling procedures and drawing of the evaluation sample;
b. Design of data collection instruments and protocols, including policy relevant evaluation questions;
c. Piloting of all DOH approved data collection instruments and protocols and provide feedback to Project LAUNCH leadership staff;
e .Design of a process evaluation tool and protocols and a template that shall summarize lessons learned during program implementation; and
f. Development of Project LAUNCH Evaluation reports.

C.5.4 The Contractor shall provide data for the national cross-site evaluation.

C5.5 The Contractor shall demonstrate experience collaborating with others to develop an environmental scan and needs assessment. The Contractor shall work with the Project LAUNCH personnel and other contractors in the development of an environmental scan and needs assessment. Activities will include, but not be limited to, the following:

a. The Contractor shall demonstrate experience providing guidance in the development of the tool(s) to be used to conduct the environmental scan.
b. The Contractor shall demonstrate experience providing guidance in the analysis of data collected from the environmental scan.
c. The Contractor shall demonstrate experience providing guidance in the development of the strategic plan.
d. The Contractor shall provide periodic updates on interim findings through reports, meetings and presentations as requested by Project LAUNCH staff.

SECTION D: PACKAGING AND MARKING

D.1 The packaging and marking requirements for this contract shall be governed by clause number (2), Shipping Instructions-Consignment, of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated March 2007. (Attachment J.1)

SECTION E: INSPECTION AND ACCEPTANCE

E.1 The inspection and acceptance requirements for this contract shall be governed by clause number ***clause number six (6), Inspection of Services***of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated March 2007. (Attachment J.1)

SECTION F: PERIOD OF PERFORMANCE AND DELIVERABLES

F.1 TERM OF CONTRACT

The term of the contract shall be for a base period of 12 month, from date of award specified on the cover page of the contract, with (4) option.

F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT

F.2.1 The District may extend the term of this contract for a period of**, four(4)** option periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the District will give the Contractor preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the District to an extension. The exercise of this option is subject to the availability of funds at the time of the exercise of this option. The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

F.2.2 If the District exercises this option, the extended contract shall be considered to include this option provision.

F.2.3 The price for the option period shall be as specified in the Section B of the contract.

F.2.4 The total duration of this contract, including the exercise of any options under this clause, shall not exceed ***five (5) years***.

F.3 DELIVERABLES

The Contractor shall perform the activities required to successfully complete the District's requirements and submit each deliverable to the COTR identified in section G.9 in accordance with the following:

Clin #	Deliverable	Format & Delivery Method	Due Date
C5.1	Work plan	Electronic copy in Microsoft Word format	10 days from date of award.
C.5.2	Evaluation Plan	Electronic copy in Microsoft Word format	21 days from date of award.
C.5.3	Evaluation Instruments	Electronic copy in Microsoft Word format	21 days from date of award.
C.5.4	Cross site evaluation data	TBA	September 1, 2010
C.5.5	Develop Project Launch Evaluation Reports	Electronic copy in Microsoft Word format	Quarterly
C.5.5	Provide periodic updates in interim findings through meetings, presentation as requested	Electronic copy in Microsoft Word format	On-going

F.3.1 The Contractor shall submit to the District, as a deliverable, the report described in section H.5.5 that is required by the 51% District Residents New Hires Requirements and First Source Employment Agreement. If the Contractor does not submit the report as part of the deliverables, final payment to the Contractor shall not be paid pursuant to section G.3.2.

SECTION G: CONTRACT ADMINISTRATION

G.1 INVOICE PAYMENT

G.1.1 The District will make payments to the Contractor, upon the submission of proper invoices, at the prices stipulated in this contract, for supplies delivered and accepted or services performed and accepted, less any discounts, allowances or adjustments provided for in this contract.

G.1.2 The District will pay the Contractor on or before the 30th day after receiving a proper invoice from the Contractor.

G.2 INVOICE SUBMITTAL

G.2.1 The Contractor shall submit proper invoices on a monthly basis or as otherwise specified in Section G.4. Invoices shall be prepared in duplicate and submitted to the agency Chief Financial

Officer with concurrent copies to the Contracting Officer's Technical Representative (COTR) specified in Section G.9 below. The address of the CFO is:

Office of the Chief Financial Officer
Agency Department of Health
Address 825 North Capitol Street, NW 5th floor, Suite 5100
Washington D.C. 20002
Telephone 202) 442-9069

G.2.2 To constitute a proper invoice, the Contractor shall submit the following information on the invoice:

G.2.2.1 Contractor's name, federal tax ID and invoice date (date invoices as of the date of mailing or transmittal);

G.2.2.2 Contract number and invoice number;

G.2.2.3 Description, price, quantity and the date(s) that the supplies or services were delivered or performed;

G.2.2.4 Other supporting documentation or information, as required by the Contracting Officer;

G.2.2.5 Name, title, telephone number and complete mailing address of the responsible official to whom payment is to be sent;

G.2.2.6 Name, title, phone number of person preparing the invoice;

G.2.2.7 Name, title, phone number and mailing address of person (if different from the person identified in G.2.2.6 above) to be notified in the event of a defective invoice; and

G.2.2.8 Authorized signature.

G.3 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

G.3.1 For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the report or a waiver of compliance discussed in section H.5.5.

G.3.2 No final payment shall be made to the Contractor until the agency CFO has received the Contracting Officer's final determination or approval of waiver of the Contractor's compliance with 51% District Residents New Hires Requirements and First Source Employment Agreement requirements.

G.4 PAYMENT

The District will pay the Contractor monthly in accordance with the price Schedule contained section B. upon presentation of a presentation of a properly executed invoice and authorization by COTR contractor will be payment one 12 of the total cost per month.

G.5 ASSIGNMENT OF CONTRACT PAYMENTS

G.5.1 In accordance with 27 DCMR 3250, the Contractor may assign to a bank, trust company, or other financing institution funds due or to become due as a result of the performance of this contract.

G.5.2 Any assignment shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party.

G.5.3 Notwithstanding an assignment of contract payments, the Contractor, not the assignee, is required to prepare invoices. Where such an assignment has been made, the original copy of the invoice must refer to the assignment and must show that payment of the invoice is to be made directly to the assignee as follows:

"Pursuant to the instrument of assignment dated _____, make payment of this invoice to (name and address of assignee)."

G.6 THE QUICK PAYMENT CLAUSE

G.6.1 Interest Penalties to Contractors

G.6.1.1 The District will pay interest penalties on amounts due to the Contractor under the Quick Payment Act, D.C. Official Code §2-221.01 *et seq*., for the period beginning on the day after the required payment date and ending on the date on which payment of the amount is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid if payment for the completed delivery of the item of property or service is made on or before:

a) the 3rd day after the required payment date for meat or a meat product;
b) the 5th day after the required payment date for an agricultural commodity; or
c) the 15th day after the required payment date for any other item.

G.6.1.2 Any amount of an interest penalty which remains unpaid at the end of any 30-day period shall be added to the principal amount of the debt and thereafter interest penalties shall accrue on the added amount.

G.6.2 Payments to Subcontractors

G.6.2.1 The Contractor must take one of the following actions within seven (7) days of receipt of any amount paid to the Contractor by the District for work performed by any subcontractor under this contract:

a) Pay the subcontractor for the proportionate share of the total payment received from the District that is attributable to the subcontractor for work performed under the contract; or

b) Notify the District and the subcontractor, in writing, of the Contractor's intention to withhold all or part of the subcontractor's payment and state the reason for the nonpayment.

G.6.2.2 The Contractor must pay any subcontractor or supplier interest penalties on amounts due to the subcontractor or supplier beginning on the day after the payment is due and ending on the date on which the payment is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid on the following if payment for the completed delivery of the item of property or service is made on or before:

a) the 3rd day after the required payment date for meat or a meat product;
b) the 5th day after the required payment date for an agricultural commodity; or
c) the 15th day after the required payment date for any other item.

G.6.2.3 Any amount of an interest penalty which remains unpaid by the Contractor at the end of any 30-day period shall be added to the principal amount of the debt to the subcontractor and thereafter interest penalties shall accrue on the added amount.

G.6.2.4 A dispute between the Contractor and subcontractor relating to the amounts or entitlement of a subcontractor to a payment or a late payment interest penalty under the Quick Payment Act does not constitute a dispute to which the District of Columbia is a party. The District of Columbia may not be interpleaded in any judicial or administrative proceeding involving such a dispute.

G.6.3 Subcontract requirements

G.6.3.1 The Contractor shall include in each subcontract under this contract a provision requiring the subcontractor to include in its contract with any lower-tier subcontractor or supplier the payment and interest clauses required under paragraphs (1) and (2) of D.C. Official Code §2-221.02(d).

G.7 CONTRACTING OFFICER (CO)

Contracts will be entered into and signed on behalf of the District only by contracting officers. The contact information for the Contracting Officer is:

Jim Marshall
Office of Contracting and Procurement
Address 441 4 Street N.W. Suite 700South
Washington D.C. 20001
Telephone 202-724-4197
Fax
E-mail address jim.marshall@dc.gov

G.8 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER

G.8.1 The CO is the only person authorized to approve changes in any of the requirements of this contract.

G.8.2 The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this contract, unless issued in writing and signed by the CO.

G.8.3 In the event the Contractor effects any change at the instruction or request of any person other than the CO, the change will be considered to have been made without authority and no adjustment will be made in the contract price to cover any cost increase incurred as a result thereof.

G.9 CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR)

G.9.1 The COTR is responsible for general administration of the contract and advising the CO as to the Contractor's compliance or noncompliance with the contract**.** The COTR has the responsibility of ensuring the work conforms to the requirements of the contract and such other responsibilities and authorities as may be specified in the contract. These include:

G.9.1.1 Keeping the CO fully informed of any technical or contractual difficulties encountered during the performance period and advising the CO of any potential problem areas under the contract;

G.9.1.2 Coordinating site entry for Contractor personnel, if applicable;

G.9.1.3 Reviewing invoices for completed work and recommending approval by the CO if the Contractor's costs are consistent with the negotiated amounts and progress is satisfactory and commensurate with the rate of expenditure;

G.9.1.4 Reviewing and approving invoices for deliverables to ensure receipt of goods and services. This includes the timely processing of invoices and vouchers in accordance with the District's payment provisions; and

G.9.1.5 Maintaining a file that includes all contract correspondence, modifications, records of inspections (site, data, equipment) and invoice or vouchers.

G.9.2 The address and telephone number of the COTR is:

Name: Twana Dinnall, MHS
Title: Program Coordinator
Agency: Department of Health (DOH) Community Health Administration
Address: 825 North Capitol Street, NE; 3rd Floor
Washington DC, 20002
Telephone: (202) 724-7667 **Facsimile No.** : (202) 442-4947
E-mail address: twana.dinnall@dc.gov

G.9.3 The COTR shall NOT have the authority to:

1. Award, agree to, or sign any contract, delivery order or task order. Only the CO shall make contractual agreements, commitments or modifications;
2. Grant deviations from or waive any of the terms and conditions of the contract;
3. Increase the dollar limit of the contract or authorize work beyond the dollar limit of the contract,
4. Authorize the expenditure of funds by the Contractor;
5. Change the period of performance; or
6. Authorize the use of District property, except as specified under the contract.

G.9.4 The Contractor will be fully responsible for any changes not authorized in advance, in writing, by the CO; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

SECTION H: SPECIAL CONTRACT REQUIREMENTS

H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

H.1.1 For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the Contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

H.1.1.1 At least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.

H.1.2 The Contractor shall negotiate an Employment Agreement with the Department of Employment Services ("DOES") for jobs created as a result of this contract. The DOES shall be the Contractor's first source of referral for qualified apprentices and trainees in the implementation of employment goals contained in this clause.

H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The Contractor shall be bound by the Wage Determination No. 8 /26/2009 ***Determination as of the date of the issuance of this RFP,*** dated 5/26/2009, issued by the U.S. Department of Labor in accordance with the Service Contract Act, 41 U.S.C. §351 *et seq*., and incorporated herein as Section J.2. The Contractor shall be bound by the wage rates for the term of the contract subject to revision as stated herein and in accordance with Section 24 of the SCP. If an option is exercised, the Contractor shall be bound by the applicable wage rates at the time of the option. If the option is exercised and the CO obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

H.3 PUBLICITY

The Contractor shall at all times obtain the prior written approval from the CO before it, any of its officers, agents, employees or subcontractors, either during or after expiration or termination of the contract, make any statement, or issue any material, for publication through any medium of communication, bearing on the work performed or data collected under this contract.

H.4 FREEDOM OF INFORMATION ACT

The District of Columbia Freedom of Information Act, at D.C. Official Code §2-532 (a-3), requires the District to make available for inspection and copying any record produced or collected pursuant to a District contract with a private contractor to perform a public function, to the same extent as if the record were maintained by the agency on whose behalf the contract is made. If the Contractor receives a request for such information, the Contractor shall immediately send the request to the COTR who will provide the request to the FOIA Officer for the agency with programmatic responsibility in accordance with the D.C. Freedom of Information Act. If the agency with programmatic responsibility receives a request for a record maintained by the Contractor pursuant to the contract, the COTR will forward a copy to the Contractor. In either event, the Contractor is required by law to provide all responsive records

to the COTR within the timeframe designated by the COTR. The FOIA Officer for the agency with programmatic responsibility will determine the releasability of the records. The District will reimburse the Contractor for the costs of searching and copying the records in accordance with D.C. Official Code §2-532 and Chapter 4 of Title 1 of the *D.C. Municipal Regulations*.

H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT

H.5.1 The Contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code §2-219.01 *et seq*. ("First Source Act").

H.5.2 The Contractor shall enter into and maintain, during the term of the contract, a First Source Employment Agreement, (Section J.4) in which the Contractor shall agree that:

(1) The first source for finding employees to fill all jobs created in order to perform this contract shall be the DOES; and

(2) The first source for finding employees to fill any vacancy occurring in all jobs covered by the First Source Employment Agreement shall be the First Source Register.

H.5.3 The Contractor shall submit to DOES, no later than the 10th of each month following execution of the contract, a First Source Agreement Contract Compliance Report ("contract compliance report") to verify its compliance with the First Source Agreement for the preceding month. The contract compliance report for the contract shall include the:

(1) Number of employees needed;

(2) Number of current employees transferred;
(3) Number of new job openings created;
(4) Number of job openings listed with DOES;
(5) Total number of all District residents hired for the reporting period and the cumulative total number of District residents hired; and
(6) Total number of all employees hired for the reporting period and the cumulative total number of employees hired, including:
(a) Name;
(b) Social security number;
(c) Job title;
(d) Hire date;
(e) Residence; and
(f) Referral source for all new hires.

H.5.4 If the contract amount is equal to or greater than $100,000, the Contractor agrees that 51% of the new employees hired for the contract shall be District residents.

H.5.5 With the submission of the Contractor's final request for payment from the District, the Contractor shall:

(1) Document in a report to the CO its compliance with section H.5.4 of this clause; or
(2) Submit a request to the CO for a waiver of compliance with section H.5.4 and include the following documentation:

(a) Material supporting a good faith effort to comply;
(b) Referrals provided by DOES and other referral sources;
(c) Advertisement of job openings listed with DOES and other referral sources; and
(d) Any documentation supporting the waiver request pursuant to section H.5.6.

H.5.6 The CO may waive the provisions of section H.5.4 if the CO finds that:

(1) A good faith effort to comply is demonstrated by the Contractor;
(2) The Contractor is located outside the Washington Standard Metropolitan Statistical Area and none of the contract work is performed inside the Washington Standard Metropolitan Statistical Area which includes the District of Columbia; the Virginia Cities of Alexandria, Falls Church, Manassas, Manassas Park, Fairfax, and Fredericksburg, the Virginia Counties of Fairfax, Arlington, Prince William, Loudoun, Stafford, Clarke, Warren, Fauquier, Culpeper, Spotsylvania, and King George; the Maryland Counties of Montgomery, Prince Georges, Charles, Frederick, and Calvert; and the West Virginia Counties of Berkeley and Jefferson.
(3) The Contractor enters into a special workforce development training or placement arrangement with DOES; or
(4) DOES certifies that there are insufficient numbers of District residents in the labor market possessing the skills required by the positions created as a result of the contract.

H.5.7 Upon receipt of the contractor's final payment request and related documentation pursuant to sections H.5.5 and H.5.6, the CO shall determine whether the Contractor is in compliance with

section H.5.4 or whether a waiver of compliance pursuant to section H.5.6 is justified. If the CO determines that the Contractor is in compliance, or that a waiver of compliance is justified, the CO shall, within two business days of making the determination forward a copy of the determination to the agency Chief Financial Officer and the COTR.

H.5.8 Willful breach of the First Source Employment Agreement, or failure to submit the report pursuant to section H.5.5, or deliberate submission of falsified data, may be enforced by the CO through imposition of penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract. The Contractor shall make payment to DOES. The Contractor may appeal to the D.C. Contract Appeals Board as provided in this contract any decision of the CO pursuant to this section H.5.8.

H.5.9 The provisions of sections H.5.4 through H.5.8 do not apply to nonprofit organizations.

H.6 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

During the performance of the contract, the Contractor and any of its subcontractors shall comply with Section 504 of the Rehabilitation Act of l973, as amended. This Act prohibits discrimination against disabled people in federally funded programs and activities. See 29 U.S.C. § 794 *et seq*.

H.7 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

During the performance of this contract, the Contractor and any of its subcontractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. See 42 U.S.C. §12101 *et seq*.

H.8 WAY TO WORK AMENDMENT ACT OF 2006

H.8.1 Except as described in H.8.8 below, the Contractor shall comply with Title I of the Way to Work Amendment Act of 2006, effective June 8, 2006 (D.C. Law 16-118, D.C. Official Code §2-220.01 *et seq*.) ("Living Wage Act of 2006"), for contracts for services in the amount of $100,000 or more in a 12-month period.

H.8.2 The Contractor shall pay its employees and subcontractors who perform services under the contract no less than the current living wage published on the OCP website at www.ocp.dc.gov.

H.8.3 The Contractor shall include in any subcontract for $15,000 or more a provision requiring the subcontractor to pay its employees who perform services under the contract no less than the current living wage rate.

H.8.4 The DOES may adjust the living wage annually and the OCP will publish the current living wage rate on its website at www.ocp.dc.gov.

H.8.5 The Contractor shall provide a copy of the Fact Sheet attached as J.6 to each employee and subcontractor who performs services under the contract. The Contractor shall also post the Notice attached as J.5 in a conspicuous place in its place of business. The Contractor shall include in any subcontract for $15,000 or more a provision requiring the subcontractor to post the Notice in a conspicuous place in its place of business.

H.8.6 The Contractor shall maintain its payroll records under the contract in the regular course of business for a period of at least three (3) years from the payroll date, and shall include this requirement in its subcontracts for $15,000 or more under the contract.

H.8.7 The payment of wages required under the Living Wage Act of 2006 shall be consistent with and subject to the provisions of D.C. Official Code §32-1301 *et seq*.

H.8.8 The requirements of the Living Wage Act of 2006 do not apply to:

(1) Contracts or other agreements that are subject to higher wage level determinations required by federal law;
(2) Existing and future collective bargaining agreements, provided, that the future collective bargaining agreement results in the employee being paid no less than the established living wage;
(3) Contracts for electricity, telephone, water, sewer or other services provided by a regulated utility;
(4) Contracts for services needed immediately to prevent or respond to a disaster or eminent threat to public health or safety declared by the Mayor;
(5) Contracts or other agreements that provide trainees with additional services including, but not limited to, case management and job readiness services; provided that the trainees do not replace employees subject to the Living Wage Act of 2006;
(6) An employee under 22 years of age employed during a school vacation period, or enrolled as a full-time student, as defined by the respective institution, who is in high school or at an accredited institution of higher education and who works less than 25 hours per week; provided that he or she does not replace employees subject to the Living Wage Act of 2006;
(7) Tenants or retail establishments that occupy property constructed or improved by receipt of government assistance from the District of Columbia; provided, that the tenant or retail establishment did not receive direct government assistance from the District;
(8) Employees of nonprofit organizations that employ not more than 50 individuals and qualify for taxation exemption pursuant to section 501(c)(3) of the Internal Revenue Code of 1954, approved August 16, 1954 (68A Stat. 163; 26 U.S.C. § 501(c)(3);
(9) Medicaid provider agreements for direct care services to Medicaid recipients, provided, that the direct care service is not provided through a home care agency, a community residence facility, or a group home for mentally retarded persons as those terms are defined in section 2 of the Health-Care and Community Residence
Facility, Hospice, and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501); and
(10) Contracts or other agreements between managed care organizations and the Health Care Safety Net Administration or the Medicaid Assistance Administration to provide health services.

H.8.9 The Mayor may exempt a contractor from the requirements of the Living Wage Act of 2006, subject to the approval of Council, in accordance with the provisions of Section 109 of the Living Wage Act of 2006.

H.9 SUBCONTRACTING PLAN COMPLIANCE

H.9.1 Reporting. If the Contractor has an approved subcontracting plan under this contract, the Contractor shall submit to the CO and the Director of DSLBD, no later than the 21st of each month following execution of the contract, a Subcontracting Plan Compliance Report to verify its compliance with the subcontracting requirements for the preceding month. The monthly subcontracting plan compliance report shall include the following information:

H.9.1.1 The dollar amount of the contract or procurement;

H.9.1.2 A brief description of the goods procured or the services contracted for;

H.9.1.3 The name of the business enterprise from which the goods were procured or services contracted;

H.9.1.4 Whether the subcontractors to the contract are currently certified business enterprises;

H.9.1.5 The dollar percentage of the contract awarded to SBEs, or if insufficient SBEs, to other certified business enterprises;

H.9.1.6 A description of the activities the Contractor engaged in, in order to achieve the subcontracting requirements set forth in its plan; and

H.9.1.7 A description of any changes to the activities the Contractor intends to make by the next month to achieve the requirements set forth in its plan.

H.9.2 Enforcement and Penalties for Breach of Subcontracting Plan

H.9.2.1 If during the performance of this contract, the Contractor fails to comply with its approved subcontracting plan, and the contracting officer determines the Contractor's failure to be a material breach of the contract, the contracting officer shall have cause to terminate the contract under the default clause of the Standard Contract Provisions.

H.9.2.2 In addition, the willful breach by the Contractor of an approved subcontracting plan for utilization of certified business enterprises, the failure to submit a subcontracting plan compliance report, or the deliberate submission of falsified data may be enforced by DSLBD through the imposition of penalties, including monetary fines of $15,000 or 5% of the total amount of the work that the Contractor was to subcontract to certified business enterprises, whichever is greater, for each such breach, failure, or falsified submission.

SECTION I: CONTRACT CLAUSES

I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated March 2007 ("SCP") are incorporated as part of the contract. To

obtain a copy of the SCP go to www.ocp.dc.gov, click on OCP Policies under the heading "Information", then click on "Standard Contract Provisions – Supplies and Services Contracts".

I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

I.3 CONFIDENTIALITY OF INFORMATION

The Contractor shall keep all information relating to any employee or customer of the District in absolute confidence and shall not use the information in connection with any other matters; nor shall it disclose any such information to any other person, firm or corporation, in accordance with the District and federal laws governing the confidentiality of records.

I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

I.5 RIGHTS IN DATA

I.5.1 "Data," as used herein, means recorded information, regardless of form or the media on which it may be recorded. The term includes technical data and computer software. The term does not include information incidental to contract administration, such as financial, administrative, cost or pricing, or management information.

I.5.2 The term "Technical Data", as used herein, means recorded information, regardless of form or characteristic, of a scientific or technical nature. It may, for example, document research, experimental, developmental or engineering work, or be usable or used to define a design or process or to procure, produce, support, maintain, or operate material. The data may be graphic or pictorial delineations in media such as drawings or photographs, text in specifications or related performance or design type documents or computer printouts. Examples of technical data include research and engineering data, engineering drawings and associated lists, specifications, standards, process sheets, manuals, technical reports, catalog item identifications, and related information, and computer software documentation. Technical data does not include computer software or financial, administrative, cost and pricing, and management data or other information incidental to contract administration.

I.5.3 The term "Computer Software", as used herein means computer programs and computer databases. "Computer Programs", as used herein means a series of instructions or statements in a form acceptable to a computer, designed to cause the computer to execute an operation or operations. "Computer Programs" include operating systems, assemblers, compilers, interpreters, data management systems, utility programs, sort merge programs, and automated data processing equipment maintenance diagnostic programs, as well as applications programs such as payroll, inventory control and engineering analysis programs. Computer programs may be

either machine-dependent or machine-independent, and may be general purpose in nature or designed to satisfy the requirements of a particular user.

I.5.4 The term "computer databases", as used herein, means a collection of data in a form capable of being processed and operated on by a computer.

I.5.5 All data first produced in the performance of this Contract shall be the sole property of the District. The Contractor hereby acknowledges that all data, including, without limitation, computer program codes, produced by Contractor for the District under this Contract, are works made for hire and are the sole property of the District; but, to the extent any such data may not, by operation of law, be works made for hire, Contractor hereby transfers and assigns to the District the ownership of copyright in such works, whether published or unpublished. The Contractor agrees to give the District all assistance reasonably necessary to perfect such rights including, but not limited to, the works and supporting documentation and the execution of any instrument required to register copyrights. The Contractor agrees not to assert any rights in common law or in equity in such data. The Contractor shall not publish or reproduce such data in whole or in part or in any manner or form, or authorize others to do so, without written consent of the District until such time as the District may have released such data to the public.

I.5.6 The District will have restricted rights in data, including computer software and all accompanying documentation, manuals and instructional materials, listed or described in a license or agreement made a part of this contract, which the parties have agreed will be furnished with restricted rights, provided however, notwithstanding any contrary provision in any such license or agreement, such restricted rights shall include, as a minimum the right to:

I.5.6.1 Use the computer software and all accompanying documentation and manuals or instructional materials with the computer for which or with which it was acquired, including use at any District installation to which the computer may be transferred by the District;

I.5.6.2 Use the computer software and all accompanying documentation and manuals or instructional materials with a backup computer if the computer for which or with which it was acquired is inoperative;

I.5.6.3 Copy computer programs for safekeeping (archives) or backup purposes; and modify the computer software and all accompanying documentation and manuals or instructional materials, or combine it with other software, subject to the provision that the modified portions shall remain subject to these restrictions.

I.5.7 The restricted rights set forth in section I.5.6 are of no effect unless

(i) the data is marked by the Contractor with the following legend:

RESTRICTED RIGHTS LEGEND

Use, duplication, or disclosure is subject to restrictions stated in Contract No._____with (Contractor's Name); and

(ii) If the data is computer software, the related computer software documentation includes a prominent statement of the restrictions applicable to the computer software. The Contractor may not place any legend on the computer software indicating restrictions on the District's rights in such software unless the restrictions are set forth in a license or agreement made a part of the contract prior to the delivery date of the software. Failure of the Contractor to apply a restricted rights legend to such computer software shall relieve the District of liability with respect to such unmarked software.

I.5.8 In addition to the rights granted in Section I.5.6 above, the Contractor hereby grants to the District a nonexclusive, paid-up license throughout the world, of the same scope as restricted rights set forth in Section I.5.6 above, under any copyright owned by the Contractor, in any work of authorship prepared for or acquired by the District under this contract. Unless written approval of the Contracting Officer is obtained, the Contractor shall not include in technical data or computer software prepared for or acquired by the District under this contract any works of authorship in which copyright is not owned by the Contractor without acquiring for the District any rights necessary to perfect a copyright license of the scope specified in the first sentence of this paragraph.

I.5.9 Whenever any data, including computer software, are to be obtained from a subcontractor under this contract, the Contractor shall use this clause, I.5, Rights in Data, in the subcontract, without alteration, and no other clause shall be used to enlarge or diminish the District's or the Contractor's rights in that subcontractor data or computer software which is required for the District.

I.5.10 For all computer software furnished to the District with the rights specified in Section I.5.5, the Contractor shall furnish to the District, a copy of the source code with such rights of the scope specified in Section I.5.5. For all computer software furnished to the District with the restricted rights specified in Section I.5.6, the District, if the Contractor, either directly or through a successor or affiliate shall cease to provide the maintenance or warranty services provided the District under this contract or any paid-up maintenance agreement, or if Contractor should be declared bankrupt or insolvent by a court of competent jurisdiction, shall have the right to obtain, for its own and sole use only, a single copy of the then current version of the source code supplied under this contract, and a single copy of the documentation associated therewith, upon payment to the person in control of the source code the reasonable cost of making each copy.

I.5.11 The Contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.

I.5.12 Nothing contained in this clause shall imply a license to the District under any patent, or be construed as affecting the scope of any license or other right otherwise granted to the District under any patent.

I.5.13 Paragraphs I.5.6, I.5.7, I.5.8, I.5.11 and I.5.12 above are not applicable to material furnished to the Contractor by the District and incorporated in the work furnished under contract, provided that such incorporated material is identified by the Contractor at the time of delivery of such work.

I.6 OTHER CONTRACTORS

The Contractor shall not commit or permit any act that will interfere with the performance of work by another District contractor or by any District employee.

I.7 SUBCONTRACTS

The Contractor hereunder shall not subcontract any of the Contractor's work or services to any subcontractor without the prior written consent of the CO. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the Contractor. Any such subcontract shall specify that the Contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the Contractor shall remain liable to the District for all Contractor's work and services required hereunder.

I.8 RESERVED

I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.3. An award cannot be made to any offeror who has not satisfied the equal employment requirements.

I.10 ORDER OF PRECEDENCE

The contract awarded as a result of this RFP will contain the following clause:

ORDER OF PRECEDENCE

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the contract by reference and made a part of the contract in the following order of precedence:

(1) An applicable Court Order, if any
(2) Contract document
(3) Standard Contract Provisions
(4) Contract attachments other than the Standard Contract Provisions

(5) RFP, as amended
(6) BAFOs (in order of most recent to earliest)
(7) Proposal

I.11 CONTRACTS IN EXCESS OF ONE MILLION DOLLARS

Any contract in excess of $l,000,000 shall not be binding or give rise to any claim or demand against the District until approved by the Council of the District of Columbia and signed by the CO.

I.12 GOVERNING LAW

This contract, and any disputes arising out of or related to this contract, shall be governed by, and construed in accordance with, the laws of the District of Columbia.

SECTION J: ATTACHMENTS

The following list of attachments is incorporated into the solicitation by reference

Attachment Number	Document
J.1	Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (March 2007) available at www.ocp.dc.gov click on "Solicitation Attachments"
J.2	U.S. Department of Labor Wage Determination ***[insert current Determination No. and Date]***
J.3	Office of Local Business Development Equal Employment Opportunity Information Report and Mayor's Order 85-85 available at www.ocp.dc.gov click on "Solicitation Attachments"
J.4	Department of Employment Services First Source Employment Agreement available at www.ocp.dc.gov click on "Solicitation Attachments"
J.5	Way to Work Amendment Act of 2006 - Living Wage Notice
J.6	Way to Work Amendment Act of 2006 - Living Wage Fact Sheet
J.7	Tax Certification Affidavit
J.8	Cost/Price Certification and Data Package available at www.ocp.dc.gov click on "Solicitation Attachments"
J.10	**ECCS Resource Map date June2007** available at 825 N. capitol St., 3rd floor Washington D.C. 20002 ATTACHED
J.11	ECCS Strategic Plan date June 2007 available at 825 N. capitol St., 3rd floor Washington D.C. 20002 ATTACHED
J.12	Project LAUNCH RFP available at http://www.samhsa.gov/Grants/2008/sm_08_011.pdf
J.13	Project LAUNCH Environmental Scan Guidance available at http://projectlaunch.promoteprevent.org/html/resources.htm
J.12	Project LAUNCH Grant – Most recent ATTACHED

SECTION K: REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

K.1 AUTHORIZED NEGOTIATORS

The offeror represents that the following persons are authorized to negotiate on its behalf with the District in connection with this request for proposals: (list names, titles, and telephone numbers of the authorized negotiators).

_____
_____
_____

K.2 TYPE OF BUSINESS ORGANIZATION

K.2.1 The offeror, by checking the applicable box, represents that:

(a) It operates as:

__ a corporation incorporated under the laws of the state of: _____
__ an individual,
__ a partnership,
__ a nonprofit organization, or
__ a joint venture.

(b) If the offeror is a foreign entity, it operates as:

__ an individual,
__ a joint venture, or
__ a corporation registered for business in _____
(Country)

K.3 CERTIFICATION AS TO COMPLIANCE WITH EQUAL OPPORTUNITY OBLIGATIONS

Mayor's Order 85-85, "Compliance with Equal Opportunity Obligations in Contracts", dated June 10, 1985 and the Office of Human Rights' regulations, Chapter 11, "Equal Employment Opportunity Requirements in Contracts", promulgated August 15, 1986 (4 DCMR Chapter 11, 33 DCR 4952) are included as a part of this solicitation and require the following certification for contracts subject to the order. Failure to complete the certification may result in rejection of the offeror for a contract subject to the order. I hereby certify that I am fully aware of the content of the Mayor's Order 85-85 and the Office of Human Rights' regulations, Chapter 11, and agree to comply with them in performance of this contract.

Offeror_____Date_____

Name_____Title_____

Signature_____

Offeror ____has ____has not participated in a previous contract or subcontract subject to the Mayor's Order 85-85. Offeror____has ____has not filed all required compliance reports, and representations indicating submission of required reports signed by proposed subofferors. (The above representations need not be submitted in connection with contracts or subcontracts which are exempt from the Mayor's Order.)

K.4 BUY AMERICAN CERTIFICATION

The offeror hereby certifies that each end product, except the end products listed below, is a domestic end product (See Clause 23 of the SCP, "Buy American Act"), and that components of unknown origin are considered to have been mined, produced, or manufactured outside the United States.

_____EXCLUDED END PRODUCTS
_____COUNTRY OF ORIGIN

K.5 DISTRICT EMPLOYEES NOT TO BENEFIT CERTIFICATION

Each offeror shall check one of the following:

____ No person listed in Clause 13 of the SCP (Attachment J.1), "District Employees Not To Benefit" will benefit from this contract.

____ The following person(s) listed in Clause 13 of the SCP (Attachment J.1), "District Employees Not To Benefit" may benefit from this contract. For each person listed, attach the affidavit required by Clause13.

_____
_____

K.6 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

(a) Each signature of the offeror is considered to be a certification by the signatory that:

1) The prices in this contract have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any offeror or competitor relating to:

(i) those prices,
(ii) the intention to submit a contract, or
(iii) the methods or factors used to calculate the prices in the contract.

2) The prices in this contract have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before contract opening unless otherwise required by law; and

3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit a contract for the purpose of restricting competition.

(b) Each signature of the offeror is considered to be a certification by the signatory that the signatory:

1) Is the person in the offeror's organization responsible for determining the prices being offered in this contract, and that the signatory has not participated and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above; or

2) Has been authorized, in writing, to act as agent for the following principals in certifying that those principals have not participated, and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above:

_____

(*insert full name of person(s) in the organization responsible for determining the prices offered in this contract and the title of his or her position in the offeror's organization);*

(i) As an authorized agent, does certify that the principals named in subdivision (b)(2) have not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above; and

(ii) As an agent, has not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above.

(c) If the offeror deletes or modifies subparagraph (a)(2) above, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure.

K.7 TAX CERTIFICATION

Each offeror must submit with its offer, a sworn Tax Certification Affidavit, incorporated herein as Attachment J.7.

K.8 CERTIFICATION OF ELIGIBILITY

The offeror's signature shall be considered a certification by the signatory that the offeror, or any person associated therewith in the capacity of owner, partner, director, officer, principal, or any position involving the administration of funds:

A. is not currently under suspension, debarment, voluntary exclusion, or determination of ineligibility under any federal, District or state statutes;

A. has not been suspended, debarred, voluntarily excluded or determined ineligible by any federal, District or state agency within the past three (3) years;

B. does not have a proposed debarment pending; and

C. has not been indicted, convicted, or had a civil judgment rendered against it or them by a court of competent jurisdiction in any matter involving fraud or official misconduct within the past three (3) years.

Indicate below any exception to your certification of eligibility and to whom it applies, their position in the offeror's organization, the initiating agency, and dates of action. Exceptions will not necessarily result in denial of award, but will be considered in determining responsibility of the offeror. Providing false information may result in criminal prosecution or administrative sanctions.

_____
_____
_____
_____

SECTION L: INSTRUCTIONS, CONDITIONS AND NOTICES TO OFFERORS

L.1 CONTRACT AWARD

L.1.1 Most Advantageous to the District

The District intends to award ***single*** contract resulting from this solicitation to the responsible offeror whose offer conforming to the solicitation will be most advantageous to the District, cost or price, technical and other factors, specified elsewhere in this solicitation considered.

L.1.2 Initial Offers

The District may award a contract on the basis of initial offers received, without discussion. Therefore, each initial offer should contain the offeror's best terms from a standpoint of cost or price, technical and other factors.

L.2 PROPOSAL FORM, ORGANIZATION AND CONTENT

One original and 3 copies of the written proposals shall be submitted in two parts, titled "Technical Proposal" and "Price Proposal". Proposals shall be typewritten in 12 point font size on 8.5" by 11" bond paper. Telephonic, telegraphic, and facsimile proposals will not be accepted. Each proposal shall be submitted in a sealed envelope conspicuously marked: "Proposal in Response to Solicitation No. **DCHC-2010-R-0088**

L.2.1 Technical Approach

a. The Offeror shall provide a written narrative to describe the Offeror's understanding of the District's requirements and an awareness of the scope and complexity of services to be provided; [C.5.1-e]

b. The Offeror shall provide a written narrative to describe the Offeror's methodologies and approaches to be used to accomplish the technical components of the requirements in C.3. The Offeror's proposed methodologies and approaches shall comprehensively cover all technical requirements; [C.5.1-e]

c. The Offeror shall provide a written narrative to demonstrate the Offeror's knowledge of and a comprehensive understanding of developing evaluation instruments including, but not limited to: (1) development of sampling procedures and drawing of the evaluation sample; (2) design of data collection instruments and protocols, including policy –relevant evaluation questions; and (3) design of a process evaluation tool and protocols and a template that shall summarize lessons learned during program implementation; [C.5.3]

d. The Offeror shall provide a written narrative to demonstrate the Offeror's ability to analyze and summarize qualitative and quantitative information from a variety of stakeholders and sources. [C.5.3]

L.2.1.2 Technical Expertise

a. The Offeror shall provide a narrative describing the qualifications of the Offeror's staff, including the team leader or principal to perform the services required in C.3. The narrative shall provide details of the Offeror's lessons learned and the resulting actions that led to improved and the successful completion of contract requirements similar in size and scope as the requirements described in Section C.5; [C.5.1-e]

b. Describe the offeror's proposed staffing mix and the relevant experience of the proposed staff to successfully complete the required services described in C.5; [C.5.1-e]

c. Demonstrate evidence that staff possess the necessary epidemiological expertise and demonstrates the capacity to conduct data analysis and interpretation of data to successfully complete the required services described in C.5; [C.5.1 - e] .

d. The Offeror shall provide a narrative to describe the Offeror's quality assurance plan and system to ensure timely completion of required deliverables. [C.5.1]

Section L.2.1.3

Past Performance

a. The Offeror shall describe its experience with performing the same or similar functions as those described in Section C.

b. The Offeror shall provide three (3) references who are able to verify the Offeror's capability to perform the services specified in this RFP, within the last five (5) years.

c. Offeror shall submit at a minimum two completed (2) Past Performance Evaluation Forms provided as Attachment J.X from the list of contracts identified in L.2.1.3 b above

L.3 PROPOSAL SUBMISSION DATE AND TIME, AND LATE SUBMISSIONS, LATE MODIFICATIONS, WITHDRAWAL OR MODIFICATION OF PROPOSALS AND LATE PROPOSALS

L.3.1 Proposal Submission

Proposals must be submitted no later than April 20,, 2010 2:00p.m.. Proposals, modifications to proposals, or requests for withdrawals that are received in the designated District office after the exact

local time specified above, are "late" and shall be considered only if they are received before the award is made and one (1) or more of the following circumstances apply:

(a) The proposal or modification was sent by registered or certified mail not later than the fifth (5th) day before the date specified for receipt of offers;

(b) The proposal or modification was sent by mail and it is determined by the CO that the late receipt at the location specified in the solicitation was caused by mishandling by the District, or

(c) The proposal is the only proposal received.

L.3.2 Withdrawal or Modification of Proposals

An offeror may modify or withdraw its proposal upon written, telegraphic notice, or facsimile transmission if received at the location designated in the solicitation for submission of proposals, but not later than the closing date and time for receipt of proposals.

L.3.3 Postmarks

The only acceptable evidence to establish the date of a late proposal, late modification or late withdrawal sent either by registered or certified mail shall be a U.S. or Canadian Postal Service postmark on the wrapper or on the original receipt from the U.S. or Canadian Postal Service. If neither postmark shows a legible date, the proposal, modification or request for withdrawal shall be deemed to have been mailed late. When the postmark shows the date but not the hour, the time is presumed to be the last minute of the date shown. If no date is shown on the postmark, the proposal shall be considered late unless the offeror can furnish evidence from the postal authorities of timely mailing.

L.3.4 Late Modifications

A late modification of a successful proposal, which makes its terms more favorable to the District, shall be considered at any time it is received and may be accepted.

L.3.5 Late Proposals

A late proposal, late modification or late request for withdrawal of a proposal that is not considered shall be held unopened, unless opened for identification, until after award and then retained with unsuccessful proposals resulting from this solicitation.

L.4 EXPLANATION TO PROSPECTIVE OFFERORS

If a prospective offeror has any questions relating to this solicitation, the prospective offeror shall submit the question in writing to the contact person, identified on page one. The prospective offeror shall submit questions no later than **April 12, 2010** days prior to the closing date and time indicated for this solicitation. The District will not consider any questions received less than 5 days before the date set for submission of proposals. The District will

furnish responses promptly to all prospective offerors. An amendment to the solicitation will be issued if the CO decides that information is necessary in submitting offers, or if the lack of it would be prejudicial to any prospective offeror. Oral explanations or instructions given by District officials before the award of the contract will not be binding.

LP L.5 FAILURE TO SUBMIT OFFERS

Recipients of this solicitation not responding with an offer should not return this solicitation. Instead, they should advise the CO, Jim Marshall 441 4th Street N.W. Suite 700 Washington D.C. 20001, 202- 724-4197, by letter or postcard whether they want to receive future solicitations for similar requirements. It is also requested that such recipients advise the CO of the reason for not submitting a proposal in response to this solicitation. If a recipient does not submit an offer and does not notify the CO that future solicitations are desired, the recipient's name may be removed from the applicable mailing list.

L.6 RESTRICTION ON DISCLOSURE AND USE OF DATA

L.6.1 Offerors who include in their proposal data that they do not want disclosed to the public or used by the District except for use in the procurement process shall mark the title page with the following legend:

"This proposal includes data that shall not be disclosed outside the District and shall not be duplicated, used or disclosed in whole or in part for any purpose except for use in the procurement process.

If, however, a contract is awarded to this offeror as a result of or in connection with the submission of this data, the District will have the right to duplicate, use, or disclose the data to the extent consistent with the District's needs in the procurement process. This restriction does not limit the District's rights to use, without restriction, information contained in this proposal if it is obtained from another source. The data subject to this restriction are contained in sheets (insert page numbers or other identification of sheets)."

L.6.2 Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this proposal."

L.7 PROPOSALS WITH OPTION YEARS

The offeror shall include option year prices in its price/cost proposal. An offer may be determined to be unacceptable if it fails to include pricing for the option year(s).

L.8 PROPOSAL PROTESTS

Any actual or prospective offeror or contractor who is aggrieved in connection with the solicitation or award of a contract, must file with the D.C. Contract Appeals Board (Board) a protest no later than ten (10) business days after the basis of protest is known or should have been known, whichever is earlier. A protest based on alleged improprieties in a solicitation which are apparent at the time set for receipt of initial proposals shall be filed with the Board prior to the time set for receipt of initial proposals. In procurements in which proposals are

requested, alleged improprieties which do not exist in the initial solicitation, but which are subsequently incorporated into the solicitation, must be protested no later than the next closing time for receipt of proposals following the incorporation. The protest shall be filed in writing, with the Contract Appeals Board, 717 14th Street, N.W., Suite 430, Washington, D.C. 20004. The aggrieved person shall also mail a copy of the protest to the Contracting Officer for the solicitation.

L.9 SIGNING OF OFFERS

The offeror shall sign the offer and print or type its name on the Solicitation, Offer and Award form of this solicitation. Offers signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the Contracting Officer.

L.10 UNNECESSARILY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor desired.

L.11 RETENTION OF PROPOSALS

All proposal documents will be the property of the District and retained by the District, and therefore will not be returned to the offerors.

L.12 PROPOSAL COSTS

The District is not liable for any costs incurred by the offerors in submitting proposals in response to this solicitation.

L.13 ELECTRONIC COPY OF PROPOSALS FOR FREEDOM OF INFORMATION ACT REQUESTS

In addition to other proposal submission requirements, the offeror must submit an electronic copy of its proposal, redacted in accordance with any applicable exemptions from disclosure in D.C. Official Code §2-534, in order for the District to comply with §2-536(b) that requires the District to make available electronically copies of records that must be made public. The District’s policy is to release documents relating to District proposals following award of the contract, subject to applicable FOIA exemption under §2-534(a)(1).

L.14 CERTIFICATES OF INSURANCE

Prior to commencing work, the Contractor shall have its insurance broker or insurance company submit certificates of insurance giving evidence of the required coverages as specified in Section I.8 to:

Name of Contracting Officer Jim Marshall

Office of Contracting and Procurement
Address 441 4 Street N.W. Suite 700South
Washington D.C. 20001
Telephone 202-724-4197
Fax 202-727-0245
E-mail address jim.marshall@dc.gov

L.15 ACKNOWLEDGMENT OF AMENDMENTS

The offeror shall acknowledge receipt of any amendment to this solicitation (a) by signing and returning the amendment; (b) by identifying the amendment number and date in the space provided for this purpose in Section A, Solicitation, Offer and Award form; or (c) by letter, telegram or e-mail from an authorized negotiator. The District must receive the acknowledgment by the date and time specified for receipt of proposals. An offeror's failure to acknowledge an amendment may result in rejection of its offer.

L.16 BEST AND FINAL OFFERS

If, subsequent to receiving original proposals, negotiations are conducted, all offerors within the competitive range will be so notified and will be provided an opportunity to submit written best and final offers at the designated date and time. Best and final offers will be subject to the Late Submissions, Late Modifications and Late Withdrawals of Proposals provisions of the solicitation. After receipt of best and final offers, no discussions will be reopened unless the CO determines that it is clearly in the District's best interest to do so, e.g., it is clear that information available at that time is inadequate to reasonably justify contractor selection and award based on the best and final offers received. If discussions are reopened, the CO shall issue an additional request for best and final offers to all offerors still within the competitive range.

L.17 LEGAL STATUS OF OFFEROR

Each proposal must provide the following information:

L.17.1 Name, address, telephone number and federal tax identification number of offeror;

L.17.2 A copy of each District of Columbia license, registration or certification that the offeror is required by law to obtain. This mandate also requires the offeror to provide a copy of the executed "Clean Hands Certification" that is referenced in D.C. Official Code §47-2862, if the offeror is required by law to make such certification. If the offeror is a corporation or partnership and does not provide a copy of its license, registration or certification to transact business in the District of Columbia, the offer shall certify its intent to obtain the necessary license, registration or certification prior to contract award or its exemption from such requirements; and

L.17.3 If the offeror is a partnership or joint venture, the names and addresses of the general partners or individual members of the joint venture, and copies of any joint venture or teaming agreements.

L.18 FAMILIARIZATION WITH CONDITIONS

Offerors shall thoroughly familiarize themselves with the terms and conditions of this solicitation, acquainting themselves with all available information regarding difficulties which may be encountered, and the conditions under which the work is to be accomplished. Contractors will not be relieved from assuming all responsibility for properly estimating the difficulties and the cost of performing the services required herein due to their failure to investigate the conditions or to become acquainted with all information, schedules and liability concerning the services to be performed.

L.19 GENERAL STANDARDS OF RESPONSIBILITY

The prospective contractor must demonstrate to the satisfaction of the District its capability in all respects to perform fully the contract requirements; therefore, the prospective contractor must submit the documentation listed below, within five (5) days of the request by the District.

L.19.1 Evidence of adequate financial resources, credit or the ability to obtain such resources as required during the performance of the contract.

L.19.2 Evidence of the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing commercial and governmental business commitments.

L.19.3 Evidence of the necessary organization, experience, accounting and operational control, technical skills or the ability to obtain them.

L.19.4 Evidence of compliance with the applicable District licensing and tax laws and regulations.

L.19.5 Evidence of a satisfactory performance record, record of integrity and business ethics.

L.19.6 Evidence of the necessary production, construction and technical equipment and facilities or the ability to obtain them.

L.19.7 Evidence of other qualifications and eligibility criteria necessary to receive an award under applicable laws and regulations.

L.19.8 If the prospective contractor fails to supply the information requested, the CO shall make the determination of responsibility or nonresponsibility based upon available information. If the available information is insufficient to make a determination of responsibility, the CO shall determine the prospective contractor to be nonresponsible.

SECTION M - EVALUATION FACTORS

M.1 EVALUATION FOR AWARD

The contract will be awarded to the responsible offeror whose offer is most advantageous to the District, based upon the evaluation criteria specified below. Thus, while the points in the evaluation criteria indicate their relative importance, the total scores will not necessarily be determinative of the award. Rather, the total scores will guide the District in making an intelligent award decision based upon the evaluation criteria.

M.2 TECHNICAL RATING

M.2.1 The Technical Rating Scale is as follows:

Numeric Rating	Adjective	Description
0	Unacceptable	Fails to meet minimum requirements; e.g., no demonstrated capacity, major deficiencies which are not correctable; offeror did not address the factor.
1	Poor	Marginally meets minimum requirements; major deficiencies which may be correctable.
2	Minimally Acceptable	Marginally meets minimum requirements; minor deficiencies which may be correctable.
3	Acceptable	Meets requirements; no deficiencies.
4	Good	Meets requirements and exceeds some requirements; no deficiencies.
5	Excellent	Exceeds most, if not all requirements; no deficiencies.

M.2.2 The technical rating is a weighting mechanism that will be applied to the point value for each evaluation factor to determine the offeror's score for each factor. The offeror's total technical score will be determined by adding the offeror's score in each evaluation factor. For example, if an evaluation factor has a point value range of zero (0) to forty (40) points, using the Technical Rating Scale above, if the District evaluates the offeror's response as "Good," then the score for that evaluation factor is 4/5 of 40 or 32.

If subfactors are applied, the offeror's total technical score will be determined by adding the offeror's score for each subfactor. For example, if an evaluation factor has a point value range of zero (0) to forty (40) points, with two subfactors of twenty (20) points each, using the Technical Rating Scale above, if the District evaluates the offeror's response as "Good" for the first subfactor and "Poor" for the second subfactor, then the total score for that evaluation factor is 4/5 of 20 or 16 for the first subfactor plus 1/5 of 20 or 4 for the second subfactor, for a total of 20 for the entire factor.

M.3 EVALUATION CRITERIA

Proposals will be evaluated based on the following evaluation factors in the manner described below:

M.3.1

Proposal Evaluation

M.3.1 The technical evaluation criteria set forth below has been developed by agency technical personnel and has been tailored to the requirements of this particular solicitation. The offeror is informed that the criteria (1) serve as the standard against which all proposals will be evaluated and (2) serve to identify the significant matters which the offeror should specifically address in complying with the requirements of this solicitation.

M.3.2 The Offerors' technical proposal and price proposal shall be evaluated separately. Offers are advised that the technical and price proposals will be evaluated by the District based on the criteria outlined below.

M.3.3 Proposals will be evaluated based on the following technical evaluation factors listed in descending order of importance**.**

Technical approach	35- points
Technical expertise	25- points
Past performance	20- points
Price	20- points

M.4.1 TECHNICAL CRITERIA (35 Points Maximum)

Technical Approach

The offeror 's has proposed an acceptable methodology and plan that demonstrates the offeror "understands the objectives, scope and deliverables and can successfully execute the program of services required in this RFP. OF SECTION C.

M.3.1 TECHNICAL CRITERIA (25 Points Maximum)

Factor 2: Technical Expertise

The offeror's has demonstrated its experience and qualifications to performe the required in the RFPs. In addition, the offeror has demonstrated expertise in. technical components, environmental scans and developing strategic plan.

Past Performance (10 points Maximum)

The offeror ‘s has demonstrated successful operation of projects similar to those in this RFP.

M.3.2 PRICE CRITERION (10Points Maximum)

The price evaluation will be objective. The offeror with the lowest price will receive the maximum price points. All other proposals will receive a proportionately lower total score. The following formula will be used to determine each offeror's evaluated price score:

Lowest price proposal
---------- x weight = Evaluated price score
Price of proposal being evaluated

M.3.3 PREFERENCE POINTS AWARDED PURSUANT TO SECTION M.5.2 (12 Points Maximum)

M.3.4 TOTAL POINTS (100 Points Maximum)

Total points shall be the cumulative total of the offeror’s technical criteria points, price criterion points and preference points, if any.

M.4 EVALUATION OF OPTION YEARS

The District will evaluate offers for award purposes by evaluating the total price for all options as well as the base year. Evaluation of options shall not obligate the District to exercise them. The total District’s requirements may change during the option years. Quantities to be awarded will be determined at the time each option is exercised.

M.5 PREFERENCES FOR CERTIFIED BUSINESS ENTERPRISES (CBE)

Under the provisions of the “Small, Local, and Disadvantaged Business Enterprise Development and Assistance Act of 2005”, as amended, D.C. Official Code § 2-218.01 *et seq.* (the Act), the District shall apply preferences in evaluating proposals from businesses that are small, local, disadvantaged, resident-owned, longtime resident, or local with a principal office located in an enterprise zone of the District of Columbia.

M.5.1 Subcontracting Requirements

If the prime contractor subcontracts any portion of the work under this contract, the prime contractor shall meet the following subcontracting requirements:

M.5.1.1 At least 35% of the dollar volume shall be subcontracted to certified small business enterprises; provided, however, that the costs of materials, goods and supplies shall not be counted towards the 35% subcontracting requirement unless such materials, goods and supplies are purchased from certified small business enterprises; or

M.5.1.2 If there are insufficient qualified small business enterprises to completely fulfill the requirement of paragraph M.5.1.1, then the subcontracting may be satisfied by subcontracting 35% of the dollar volume to any certified business enterprises; provided, however, that all reasonable efforts shall be made to ensure that qualified small business enterprises are significant participants in the overall subcontracting work.

M.5.2 Application of Preferences

For evaluation purposes, the allowable preferences under the Act for this procurement shall be applicable to prime contractors as follows:

M.5.2.1 Any prime contractor that is a small business enterprise (SBE) certified by the Department of Small and Local Business Development (DSLBD) will receive the addition of three points on a 100-point scale added to the overall score for proposals submitted by the SBE in response to this Request for Proposals (RFP).

M.5.2.2 Any prime contractor that is a resident-owned business (ROB) certified by DSLBD will receive the addition of five points on a 100-point scale added to the overall score for proposals submitted by the ROB in response to this RFP.

M.5.2.3 Any prime contractor that is a longtime resident business (LRB) certified by DSLBD will receive the addition of ten points on a 100-point scale added to the overall score for proposals submitted by the LRB in response to this RFP.

M.5.2.4 Any prime contractor that is a local business enterprise (LBE) certified by DSLBD will receive the addition of two points on a 100-point scale added to the overall score for proposals submitted by the LBE in response to this RFP.

M.5.2.5 Any prime contractor that is a local business enterprise with its principal offices locates in an enterprise zone (DZE) certified by DSLBD will receive the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DZE in response to this RFP.

M.5.2.6 Any prime contractor that is a disadvantaged business enterprise (DBE) certified by DSLBD will receive the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DBE in response to this RFP.

M.5.3 Maximum Preference Awarded

Notwithstanding the availability of the preceding preferences, the maximum total preference to which a certified business enterprise is entitled under the Act for this procurement is the equivalent of twelve (12) points on a 100-point scale for proposals submitted in response to this RFP. There will be no preference awarded for subcontracting by the prime contractor with certified business enterprises.

M.5.4 Preferences for Certified Joint Ventures

When DSLBD certifies a joint venture, the certified joint venture will receive preferences as a prime contractor for categories in which the joint venture and the certified joint venture partner are certified, subject to the maximum preference limitation set forth in the preceding paragraph.

M.5.5 Verification of Offeror's Certification as a Certified Business Enterprise

M.5.5.1 Any vendor seeking to receive preferences on this solicitation must be certified at the time of submission of its proposal. The contracting officer will verify the offeror's certification with DSLBD, and the offeror should not submit with its proposal any documentation regarding its certification as a certified business enterprise.

M.5.5.2 Any vendor seeking certification or provisional certification in order to receive preferences under this solicitation should contact the:

Department of Small and Local Business Development
ATTN: CBE Certification Program
441 Fourth Street, NW, Suite 970N
Washington DC 20001

M.5.5.3 All vendors are encouraged to contact DSLBD at (202) 727-3900 if additional information is required on certification procedures and requirements.

M.5.6 Subcontracting Plan

If the prime contractor intends to subcontract under this contract, it must subcontract at least 35% of the dollar volume of this contract in accordance with the provisions of section M.5.1. The prime contractor responding to this solicitation which intends to subcontract shall be required to submit with its proposal, a notarized statement detailing its subcontracting plan. Proposals responding to this RFP shall be deemed nonresponsive and shall be rejected if the offeror intends to subcontract in accordance with the provisions of section M.5.1, but fails to submit a subcontracting plan with its proposal. Once the plan is approved by the CO, changes to the plan will only occur with the prior written approval of the CO and the Director of DSLBD. Each subcontracting plan shall include the following:

M.5.6.1 A description of the goods and services to be provided by SBEs or, if insufficient qualified SBEs are available, by any certified business enterprises;

M.5.6.2 A statement of the dollar value of the proposal that pertains to the subcontracts to be performed by the SBEs or, if insufficient qualified SBEs are available, by any certified business enterprises;

M.5.6.3 The names and addresses of all proposed subcontractors who are SBEs or, if insufficient SBEs are available, who are certified business enterprises;

M.5.6.4 The name of the individual employed by the prime contractor who will administer the subcontracting plan, and a description of the duties of the individual;

M.5.6.5 A description of the efforts the prime contractor will make to ensure that SBEs, or, if insufficient SBEs are available, that certified business enterprises will have an equitable opportunity to compete for subcontracts;

M.5.6.6 In all subcontracts that offer further subcontracting opportunities, assurances that the prime contractor will include a statement, approved by the CO, that the subcontractor will adopt a subcontracting plan similar to the subcontracting plan required by the contract;

M.5.6.7 Assurances that the prime contractor will cooperate in any studies or surveys that may be required by the CO, and submit periodic reports, as requested by the CO, to allow the District to determine the extent of compliance by the prime contractor with the subcontracting plan;

M.5.6.8 A list of the type of records the prime contractor will maintain to demonstrate procedures adopted to comply with the requirements set forth in the subcontracting plan, and assurances that the prime contractor will make such records available for review upon the District's request; and

M.5.6.9 A description of the prime contractor's recent effort to locate SBEs or, if insufficient SBEs are available, certified business enterprises and to award subcontracts to them.

M.5.7 Compliance Reports

By the 21st of every month following the execution of the contract, the prime contractor shall submit to the contracting officer and the Director of DSLBD a compliance report detailing the contractor's compliance, for the preceding month, with the subcontracting requirements of the contract. The monthly compliance report shall include the following information:

M.5.7.1 The dollar amount of the contract or procurement;

M.5.7.2 A brief description of the goods procured or the services contracted for;

M.5.7.3 The name and address of the business enterprise from which the goods were procured or services contracted;

M.5.7.4 Whether the subcontractors to the contract are currently certified business enterprises;

M.5.7.5 The dollar percentage of the contract awarded to SBEs, or if insufficient SBEs, to other certified business enterprises;

M.5.7.6 A description of the activities the contractor engaged in, in order to achieve the subcontracting requirements set forth in section M.5.1; and

M.5.7.7 A description of any changes to the activities the contractor intends to make by the next month to achieve the requirements set forth in section M.5.1.

M.5.8 Enforcement and Penalties for Breach of Subcontracting Plan

M.5.8.1 If during the performance of this contract, the contractor fails to comply with the subcontracting plan submitted in accordance with the requirements of this contract, and as approved by the contracting officer and the Director of DSLBD, and the CO determines the contractor's failure to be a material breach of the contract, the CO shall have cause to terminate the contract under the default clause of the Standard Contract Provisions.

M.5.8.2 In addition, the willful breach by a contractor of a subcontracting plan for utilization of certified business enterprises in the performance of a contract, the failure to submit any required subcontracting plan monitoring or compliance report, or the deliberate submission of falsified data may be enforced by DSLBD through the imposition of penalties, including monetary fines of $15,000 or 5% of the total amount of the work that the contractor was to subcontract to certified business enterprises, whichever is greater, for each such breach, failure, or falsified submission.

M.6 EVALUATION OF PROMPT PAYMENT DISCOUNT

M.6.1 Prompt payment discounts shall not be considered in the evaluation of offers. However, any discount offered will form a part of the award and will be taken by the District if payment is made within the discount period specified by the offeror.

M.6.2 In connection with any discount offered, time will be computed from the date of delivery of the supplies to carrier when delivery and acceptance are at point of origin, or from date of delivery at destination when delivery, installation and acceptance are at that, or from the date correct invoice or voucher is received in the office specified by the District, if the latter date is later than date of delivery. Payment is deemed to be made for the purpose of earning the discount on the date of mailing of the District check.

Project LAUNCH—Environmental Scan Guidance
January 2009

In response to a growing recognition of the need to promote wellness among children from birth to age eight, the Substance Abuse Mental Health Services Administration (SAMHSA) has created Project LAUNCH—Linking Actions for Unmet Needs in Children's Health. Through LAUNCH cooperative agreements, a group of states and tribes will develop state, tribal, and local networks for the coordination of key child-serving systems and the enhancement and improvement of practices, programs, and services for young children and their families. Given the importance of careful and thoughtful program planning for successful implementation and meaningful evaluation, LAUNCH grantees will conduct a comprehensive strategic planning process that will result in the creation of tools, including a strategic plan and logic model, to guide their work. To ensure that their strategic plans reflect and build upon the programs, services, and resources that are already in place to serve young children, LAUNCH grantees will conduct an environmental scan to develop a more comprehensive picture of the early childhood-serving environment in their state, tribe, and communities.

Through this document, SAMHSA provides detailed guidance on how Project LAUNCH grantees can approach the environmental scan process. As noted in the Request for Applications, grantees (each state, tribe, and community) must conduct an environmental scan in the first six months of the grant to map out the systems and programs (including those funded through federal and private grants) that serve children from birth to eight years of age and their families. The scan should identify the systems, programs, and services that existed *prior* to Project LAUNCH, not those that LAUNCH will add at the state, tribe, or community level. (Please note that tribes combining the tribal and local levels only need to create one environmental scan.)

In the pages that follow, we offer guiding questions and a template for collecting Project LAUNCH environmental scan information. Grantees are not required to use the questions or the template; rather, this guidance is offered to help grantees in thinking about how to approach the environmental scan, and grantees may take from it what they wish. Furthermore, there is no single required format for the environmental scan. Therefore, there may be variations among the products that grantees create. We offer this guidance to support grantees in conducting thorough, well-conceived scans at both the state/tribal and community levels that will serve the project well as it moves forward.

We encourage grantees to build from existing scans, such as work conducted for Early Childhood Comprehensive Systems (ECCS) grants or similar efforts. SAMHSA and the Project LAUNCH Technical Assistance Team will customize and provide technical assistance regarding the environmental scan and comprehensive strategic plan to each grantee as needed and requested.

In addition to mapping out the systems and programs in place *prior* to Project LAUNCH, the environmental scan also should include a financial map of the funding streams that support programs to address the physical, emotional, social, cognitive, and behavioral health of children birth to age eight. *Spending Smarter: A Funding Guide for Policymakers and Advocates to*

Promote Social and Emotional Health and School Readiness, developed by Project Thrive at the National Center for Children in Poverty, provides a process used by many states and communities to map their financial environment. Tribes should contact their technical assistance specialist to adapt this approach to their tribal systems. The *Spending Smarter* document can be found at http://www.nccp.org/publications/pdf/text_634.pdf and may help with the financial mapping component of the scan. Additionally, grantees may find it helpful to draw from the financial inventory completed with Abt Associates' cross-site evaluation liaisons for completing the financial scan.

SAMHSA recognizes that grantees may not have the opportunity to complete a thorough environmental scan within the first six months of grant award. However, grantees should be prepared to document at six months the steps they have taken to begin the scanning process, including the methods they have chosen for engaging partners in the process and for data collection. In addition, grantees should share a summary of findings to date, and if the scanning process is not complete, grantees should describe what future steps will be taken to complete the scan and provide a timeline for completion.

Further, while no single format for reporting on the environmental scan is required, grantees are encouraged to include the following elements in their environmental scan summary document to be submitted to SAMHSA:

- A description of who participated in the scanning process and how stakeholders were engaged and diverse perspectives ensured
- A description of the methods used for gathering scan data (e.g., extant data, focus groups, surveys, etc.)
- A sample of data that demonstrates the instrument(s) used for capturing data, such as the templates provided in this document
- Reflections on the successes and challenges that arose in the process of conducting the environmental scan (e.g., lessons learned)
- A summary of findings from the scan; that is, not a summary of data but conclusions that could be drawn from the scan that are key to helping the project move to the next phase, to serve as the foundation for the strategic plan (for more description, please see page 16).

This guidance is organized into four sections:

- **Part 1: Framing the Environmental Scan and Comprehensive Strategic Plan** gives the vision behind these major cornerstones of the Project LAUNCH initiative.
- **Part 2: Documenting the Environmental Scan** offers principles to have in mind as grantees plan and execute the scan.
- **Part 3: Scanning the Environment** lists questions to inform a thorough scan process and offers a chart template to organize information gathered.
- **Part 4: Analyzing the Scan and Drawing Conclusions** provides suggestions on how to sort through the information collected and how best to understand the findings. Also called "strategic analysis," this section can guide Project LAUNCH grantees in forming an optimal strategic direction for moving forward over the next five years.

Part 1: Framing the Environmental Scan and Comprehensive Strategic Plan

We encourage grantees to develop environmental scans that include but are not limited to an inventory of services available for children and families. While it is critical to have a complete picture of the landscape of systems, programs, and other resources currently available to address challenges facing children, birth to eight years, and their families, the process of scanning should also stimulate thoughtful analysis of gaps in programming, duplication of efforts, and challenges related to access to or quality of services. The scans are "living documents" that may expand in scope over the course of the project to reflect changes in the community, as well as changes in systems and supports that address the well-being of children and families. Both scans (the state/tribal and community) should be updated over the life of the project.

The state/tribal and local-level (community) environmental scans are critical components of the Project LAUNCH comprehensive strategic planning process. Each scan will build on the needs assessment completed as a part of the application process and serve as the foundation for the comprehensive strategic plan. Using a comprehensive strategic plan will build on and improve current services and coordinate between the many systems that serve young children. Developing broad-based environmental scans that map out these systems in sufficient detail to guide thinking and decision-making will be central to the success of grantees' strategic plans. The diagram below shows the relationship between the needs assessment, the environmental scan, and the strategic plan, and illustrates that relationship with some examples.

Needs Assessment

Timeframe: Conducted as part of grant application process.

- What problems exist in my area?

Local Example

- High number of babies born to teenage mothers.
- Elevated rate of child abuse and neglect.
- High number of children in day care with social/emotional/ behavioral problems.
- Poor nutrition among children birth to eight.

State Example

- Behavioral health integration with primary care is not currently addressed at the state level
- Access to behavioral health programs is lacking in many areas of the state
- Primary care systems have expressed the need for more information and support related to mental health

Tribal Example

- Families are not participating in parenting programs in the chosen community and across the tribal area
- Service providers report that parents and caregivers are indifferent or adversarial to services
- Curriculums used in services system don't seem to fit well with the population served

Environmental Scan

Timeframe: Conducted during first 6 months

- What programs, services, supports and other resources exist that serve children birth to eight and their families?
- What is the current status of these programs (i.e., have they been effective)?
- Who runs them?
- Where are the gaps in programming? Are there duplicative efforts that can be merged or otherwise coordinated?

Local Example

- Women, Infants and Children (WIC) nutritional program in place since 1990; run through county health dept.; not all families in need receiving the service.
- Community Org X holds parenting classes at local high school. Instructor training is inconsistent.
- Community Org X is ideally positioned to expand curriculum to include classes on nutrition but funding has not been available.

State Example

- Some localities are creating programs to integrate behavioral health services into primary care settings
- There are no interagency relationships supporting behavioral health primary care integration
- There are no state policies to address behavioral health primary care integration

Tribal Example

- There is no family representation on the health workgroup of the Tribal Council
- There are no formal paths to receive feedback from families about program or policy choices
- Families have not been consulted during program design, implementation, or evaluation

Comprehensive Strategic Plan

Timeframe: Developed during first 6 months

- Engage partners and stakeholders
- Gather and analyze information (including scan)
- Review and refine vision, values, goals and objectives
- Develop outcomes and indicators
- Develop and refine strategies

Local Example

- County health dept. reps will lead local LAUNCH council's effort to address WIC program access issues by implementing a nutrition initiative.
- Workforce development initiative will be developed/implemented to train child care providers in healthy social, emotional, and behavioral development of young children.
- Community Org X will partner with health dept. to focus on nutrition and other issues and work with other LAUNCH council members to coordinate with other services, and leverage community resources.

State Example

- Identify partners from appropriate agencies (mental health, MCH, Medicaid, Public Health) and create behavioral health primary care integration workgroup on LAUNCH council
- Charge workgroup with identifying regulatory, practice and policy reforms that would support behavioral health primary care integration
- Begin a review of current policies and practices that affect behavioral health primary care integration
- Survey other localities and use behavioral health primary care integration efforts in chosen LAUNCH locality as pilot to examine issues and barriers in current policies and practices

Tribal Example

- Survey parents and caregivers about current and planned programs
- Include family representative on LAUNCH council and coordinate work with health workgroup
- Direct evaluator and program managers to create formal feedback mechanisms that incorporate parent concerns
- Direct staff to develop a family engagement strategy

Part 2: Documenting the Environmental Scan

The environmental scan process is as much about dialogue and consensus-building as it is about information gathering. Each step in the planning process should be conducted in a collaborative manner involving a range of stakeholders. Grantees should consider actively engaging their Councils on Young Child Wellness in scanning activities, as well as using this process as an opportunity to form alliances with a wide variety of individuals at the state/tribal or community level. Soliciting input from a range of stakeholders, including current and potential program participants, will help ensure that services are responsive to the needs of the community and will build support for the initiative as a whole. Grantees are encouraged to gather community input in a variety of ways (e.g., formal meetings, key informant interviews, focus groups, surveys, etc.). Further, as states/tribes and local communities develop their individual environmental scans, it is important that they communicate with each other about what is being learned. Local communities' findings may help inform policy and decision-making at the state/tribal level, and state/tribal findings may help to inform local communities about ways in which their needs, resources, and practices compare to those in other jurisdictions.

Part 3: Scanning the Environment

We developed Part 3 as a guide and not a list of requirements for grantees to follow. We have divided the section into five general topic areas that grantees will likely include in their environmental scan for Project LAUNCH:

1. **Family Support and Parenting Education**
2. **Mental Health and Social and Emotional Wellness**
3. **Early Care and Education**
4. **Primary Care**
5. **Systems Development**

For each topic area, we have provided a series of guiding questions followed by a chart template (including examples) that grantees can use to organize and document the systems, programs, and other resources that currently exist at the state/tribal, and community levels. We offer the questions to trigger thinking about all the possible systems, programs, and other resources that grantees might include in the scan. We have adapted several of these questions from the Health Resources and Services Administration's (HRSA) guidance to ECCS coordinators for the scan process.

Similarly, we provide the tables as a possible template for grantees to use to record the information gathered through the environmental scan. The tables are structured to document information about the service provided, the organization delivering the service, the type of activities offered by the organization (i.e., promotion, prevention, intervention), the population served, the targeted outcomes, the funding amount and source, and how the service interfaces with Project LAUNCH activities.

1. Family Support and Parenting Education

When scanning the early childhood environment related to *family support and parenting education*, consider the following questions:

- What is in place to ensure the use of evidence-based practices in family strengthening to enhance child wellness?
- How are families being connected to culturally relevant parenting education and supports, including traditional spiritual activities?
- What is in place to ensure that all families (inclusive of mothers, fathers, grandparents, and other family members) have access to culturally sensitive and appropriate family-strengthening programs and services to foster child wellness?
- What is being done to help families become effective advocates for their children starting before their birth and through their early years?
- What is being done to ensure that family support and parenting education efforts are culturally-sensitive?
- What is in place to create linkages across family-serving organizations and related groups that enable family involvement?
- What is being done to further support the development of knowledge and skills that families need to be meaningfully involved in policy and program planning, implementation, and quality assurance to support young child wellness?
- What is being done to create parenting education programs that are family-led and family-centered and enable caregivers to know where to go when they need parenting assistance or information?
- Are families supporting each other in parenting and accessing supports and other community-based services? What is being done to support these activities?
- What is being done to ensure that parents have the health-related knowledge to engage professionals around their children's wellness?
- What is being done to ensure that child-serving providers offer family-centered care?

Use the following table to provide information about *family support* and *parenting education* programs available in the community. When completing the table at the state/tribal level, be sure to include programs that span the entire state/tribe or large areas of the state/tribe. The first entries, in *italics*, are offered as examples.

Sample Table for Family Support and Parenting Education

Service Provided	Organization Delivering the Service	Activity Type, i.e., Promotion? Prevention? Intervention?	Population Served	Targeted Outcomes	Funding Amount and Source	Involvement in Project LAUNCH
Parenting Wisely: Parent training program	*Valley Community Action Program*	*Promotion and prevention*	*4 groups of 100 families per year until Dec. 2009* *Services targeted at families with multiple risk factors*	*Decreased use of physical discipline methods*	*$250,000/year for 3 years, from United Way*	*Program coordinator serves on local child wellness council*
Use of relational world view to evaluate effectiveness of family talking circles	*Tribal council's subcommittee on family involvement*	*Promotion and prevention*	*Families with children birth to five*	*More traditional holistic view of parenting*	*Grant from tribal college*	*Project director meets with subcommittee*

2. Mental Health and Social and Emotional Wellness

When scanning the early childhood environment related to *mental health and social and emotional wellness*, consider the following questions:

- What types of therapeutic interventions are currently being offered for children aged birth to three? Three to five? Five to eight? And their families?
- How is mental health consultation currently being provided in the state/tribe and community?
- What other services are being offered that promote social and emotional wellness in young children and aim to prevent social and emotional and behavioral issues from developing?
- What is being done to ensure that professionals who conduct screenings of young children and their families have programs and providers available for referral to services?
- What is being done to elevate knowledge and competency around children's healthy social and emotional development among the professional groups who work with young children and their families?
- What is being done to ensure that agencies that provide services to adults are collaborating with agencies that provide services and supports to young children (i.e., Substance Abuse, Mental Health, Justice, Housing, Labor)?
- What is being done to encourage care coordination among providers who are working to ensure the social and emotional wellness of children?
- What is being done to ensure collaboration among the early intervention system and early care and education providers?
- What is being done to address transitions of all children from birth to three, preschool, and to elementary school, especially for those children who are Individuals with Disabilities Education Act (IDEA) eligible?
- What is being done to ensure access to wellness and health promotion, as well as prevention education and other relevant activities, for young children and their families from pregnancy through the early childhood years?

Use the following table to provide information about activities that promote *mental health and social and emotional* wellness available in the community. When completing the table at the state/tribal level, be sure to include programs that span the entire state/tribe or large areas of the state/tribe. The first entries, in *italics*, are offered as examples.

Sample Table for Mental Health and Social and Emotional Wellness

Service Provided	Organization Delivering the Service	Activity Type, i.e., Promotion? Prevention? Intervention?	Population Served	Targeted Outcomes	Funding Amount and Source	Involvement in Project LAUNCH
Early childhood mental health consultation	*Smith County Mental Health Center*	*Prevention and intervention*	*All children birth to five in licensed child care and education facilities within county limits*	*Prevention of expulsion from child care*	*$53,000, from state general funds*	*Expansion of program*
Maternal depression screening	*Home visitation programs*	*Prevention*	*All very low income children birth to three in three neighborhoods*	*Strong attachments between babies and mothers*	*$15,000, from Catholic Charities*	*Expansion of program*
Suicide Prevention; Intervening Early	*Tribal wellness counselors and early intervention program-teams*	*Prevention*	*Siblings (birth to five) and their families of at-risk teens*	*Enhanced self-esteem, social skills, attachment to culture*	*SAMHSA prevention grant for $50,000*	*Expansion of program*

3. Early Care and Education

When scanning the environment related to *early care and education*, consider the following questions:

- What is being done to ensure access to high-quality early care and education services for children?
- How are child care providers involved in the young child-serving system (e.g. services and governance)?
- How is information shared between early care systems, K–12 systems, and other child-serving systems?
- What is being done to reach out to small and/or informal providers of child care?
- What is being done to build a local workforce with competence in young child social, emotional, and behavioral health?
- What is being done to ensure that early care and education providers are knowledgeable about healthy child development and are able to recognize early warning signs of developmental problems across all domains (physical, social, emotional, etc.)?
- What is being done to develop or strengthen a network of child care health consultants?
- What is being done to make developmental screenings available through early care systems?
- What is being done to ensure that early care and education providers know how and when to make referrals into the early intervention system?
- What is being done to help early care and education providers link families to parenting education resources and programs?
- What is being done to ensure that children with special needs are included in appropriate early care and education settings?
- What is being done to ensure that early care and education settings serve as an access point for health insurance and medical homes?
- What is being done to ensure that early care and education settings are culturally sensitive and appropriate?
- How does the early care and education system collaborate with other agencies or stakeholders related to young child wellness?

Use the following table to provide information about the *early care and education* programs available in the community. When completing the table at the state/tribal level, be sure to include programs that span the entire state/tribe or large areas of the state/tribe. The first entries, in *italics*, are offered as examples.

Sample Table for Early Care and Education

Service Provided	Organization Delivering the Service	Activity Type, i.e., Promotion? Prevention? Intervention?	Population Served	Targeted Outcomes	Funding Amount and Source	Involvement in Project LAUNCH
Training on developmental assessments	*Child Development Division, Department of Education*	*Promotion and prevention*	*Preschool providers*	• *Trained Early Childhood Education (ECE) workforce* • *Adoption of assessments in preschool settings*	*$250,000 per year, from State Education Agency (SEA)*	*Participation of preschool providers that operate in LAUNCH target area in training sessions*
Coordinates ECE training and facilitates state and regional networks of providers	*Child Development Division, Department of Education, Preschool Instructional Network*	*Promotion and prevention*	*Preschool providers*	• *Trained ECE workforce.* • *Increased collaboration among providers*	*$500,000 per year, from SEA*	*Representative participating on State Child Wellness Council*
Statewide coordination with professional ECE provider associations to plan annual staff trainings regarding social and emotional development and working with young children and their families	*Department of Health*	*Promotion and Prevention*	*Lead preschool teachers in state-funded programs*	*Trained ECE workforce in social-emotional development of young children*	*$5,000 from ECCS funds*	*Coordination with LAUNCH training plan; participation of teachers in LAUNCH target areas*

4. Primary Care

When scanning the early childhood environment related to *primary care* consider the following questions:

- What is being done to ensure that all children are connected to a medical home?
- What is being done to encourage medical providers to conduct regular comprehensive developmental assessments?
- What is being done to ensure that the state Medicaid system recognizes developmental assessment as a critical component of the well-child visit and reimburses providers for the service?
- What is being done to ensure that medical providers are able to provide appropriate referrals when developmental screenings reveal concerns and to ensure medical providers link to other professionals also serving the children and family?
- What is being done to ensure that the results of the referral are shared and the relevant providers and family members are involved in making follow-up decisions?
- What is being done to ensure that medical providers know how to access the early intervention system?
- What is being done to ensure that medical providers provide information to families about the importance of a safe, high-quality child care environment?
- What is being done to ensure that medical providers explore mental health issues with family members?
- What is being done to ensure that services provided to adult caregivers are coordinated with supports and services provided to the young child (i.e., incarcerated women with children receive supported visits with foster parent and child)?
- What is being done to ensure that other agencies providing services to adults are collaborating with those agencies providing services to young children (i.e., Substance Abuse, Justice, Housing, Labor)?
- What is being done to encourage care coordination and communication between other early childhood providers (e.g., home visitors, early intervention specialists, WIC, child care) and medical providers?
- What is being done to connect families to traditional and spiritual leaders?

Use the following table to provide information about the *primary care* activities available in the community. When completing the table at the state/tribal level, be sure to include programs that span the entire state/tribe or large areas of the state/tribe. The first entries, in *italics*, are offered as examples.

Sample Table for Primary Care

Service Provided	Organization Delivering the Service	Activity Type, i.e., Promotion? Prevention? Intervention?	Population Served	Targeted Outcomes	Funding Amount and Source	Involvement in Project LAUNCH
Community referral source notebook	*Local coordinating council within county*	*All three*	*Birth to five*	*Increased likelihood of facilitated referrals*	*$25,000, donated by local businesses*	*Continuation of work*
Statewide task force – advising design of higher-education curriculum module regarding behavioral health for pediatrician training programs	*Department of Health*	*Promotion and Prevention*	*Medical students*	*Pediatricians are knowledgeable about and trained in behavioral health issues for young children, integration of physical and behavioral health services*	*$2,000 from MCHB block grant*	*Coordination with LAUNCH statewide advisory council, integration with LAUNCH training plans for primary care providers*

5. Systems Development

The environmental scan should include information about systems development. We offer the following questions to help grantees identify relevant system-level factors that will inform the environmental scan and ultimately, the grantees' strategic plans. This information may best be captured in narrative form. The questions are not exhaustive and grantees are not required to answer all of them.

Governance and Interagency Coordination and Collaboration

- Is there a coordinating body on the state/tribal level (outside of the Council on Young Child Wellness) that addresses cross-agency, cross-organizational issues?
- Are there coordinating bodies at the local level that address cross-agency or cross-organizational issues?
- Do these coordinating bodies include both the public and private (both for-profit and nonprofit) sectors?
- Are there efforts to ensure that early childhood issues have a high profile on the public policy agenda in the state/tribe and community?
- Are there policies and procedures that address the needs of young children and their families?

Family and Community Involvement

- Are family members encouraged to be active participants in every component of service delivery (i.e., are family members encouraged to advise and participate in the development and monitoring of policies, procedures, and practices)?
- What efforts are under way to ensure that true family and community voice is informing the system?
- Are policies being changed to reflect family-driven practices?
- Are families hired by agencies to ensure that a family voice is included in decision-making and policy development?

Evidence-based Practices

- How are the state/tribe and the local community supporting training, coaching, and effective implementation of evidence-based practices (EBPs)?
- What EBPs are being used at the current time?
- Is there a cross-agency data collection system?
- Are services being evaluated for effectiveness?

Funding

- What is being done to ensure that financing opportunities exist that can encourage the delivery of comprehensive, integrated, family-centered services?
- What financing strategies have been developed or utilized to encourage cross-agency coordination?
- Are all funding streams maximized to cover services for this population?

Effective Workforce

- What efforts are under way to build a workforce that is trained from a public health perspective?
- What efforts are planned or under way to provide interdisciplinary training on understanding healthy child development?
- Describe the current state/tribal and local workforce development plan for staff working with children, birth to eight, and their families.

Cultural and Linguistic Competence

- What efforts are under way at the state/tribal and community level to develop a strategic plan for ensuring cultural and linguistic competence among providers and policy-makers?
- What efforts are being made to reduce disparities among families from different cultural or linguistic backgrounds?
- What policies exist to address linguistic competence (i.e. interpretation and translation of documents)?

Statewide or Broad Tribal Adoption of Local Practice

- What efforts are under way to replicate successful local efforts around promotion and prevention for young children and their families?

Coordination with other Federally-Funded Efforts

- How is the Project LAUNCH effort being coordinated with other federally-funded programs at the state/tribal and community levels?

Legislation and Regulation

- What legislation is currently in place that supports a public health approach?
- Who oversees early childhood activities across the state/tribe and local community? If more than one entity or agency, how well-coordinated are these efforts?

Part 4: Analyzing the Scan and Drawing Conclusions

From the scan of the current service delivery system—that is, the data gathering process as well as the information gathered—grantees are now well positioned for critical, strategic analysis. In that analysis, grantees will want to systematically consider **conclusions that can be drawn** and how those conclusions can inform the project's plans moving forward. The conclusions will inform and fold into the development of a comprehensive strategic plan that is based on a strong understanding of where the project began. To analyze the data and identify next steps in the development of a comprehensive strategic plan, grantees might consider the following questions:

- What gaps were identified between the needs of the young children and families in the state/tribe and community? What are available programs, supports, and services designed to meet these needs?
- Are there any major problems that are not getting addressed by any service, program or activity?
- Are the individuals and families who should be receiving wellness promotion and prevention programs, services, and supports in fact receiving them? If not, why not?
- Are there duplicative services, programs, and supports attempting to address the same problem? If so, which are more effective and which are less so? Are those who are implementing the separate programs coordinating their efforts in any way?
- Is there blending of funding across these various programs and efforts?

Answering the questions above should help grantees organize the data from their environmental scans. Having a more complete understanding of both the needs and the resources in the state/tribe and community should lead to greater clarity of where the gaps and the most critical unmet needs exist. In addition, this scan might highlight ways in which service delivery, policies, and funding structures can be improved. The strategic plan should be a direct response to the outstanding needs; it presents the project's vision for how best practices in infrastructure reform and service delivery can most effectively meet these needs.

We will provide additional guidance on the development of the Project LAUNCH comprehensive strategic plan in a separate document. The Project LAUNCH Technical Assistance Team is also available to provide customized support to grantees throughout the environmental scan and strategic planning process.

We are also interested in your feedback on this guidance, and any questions, concerns, or comments you have related to the environmental scanning process. Please share your thoughts with your LAUNCH Federal Project Officer at SAMHSA and/or your TA liaison.

Project LAUNCH Strategic Plan Guidance
March 30, 2009

As noted in the Request for Applications, Project LAUNCH grantees will submit comprehensive state- or territorial- and local-level strategic plans to Substance Abuse and Mental Health Services Administration (SAMHSA) Project Officers in the first year of their grant. Tribal grantees, with combined tribal and local governance structures, will engage in a single, comprehensive strategic planning process that results in a single plan. Grantees will use these deliverables to reflect their engagement, thus far, in simultaneous local and state, territorial, or tribal planning processes to support comprehensive child wellness. Grantees will submit draft strategic plans and updated logic models in May 2009 and will revise them based on feedback from their federal project officers (FPO). Grantees will also periodically review and revise the plans to reflect changes in their state, tribes, territories, and communities. The format of grantees' submissions may vary because no single format is required.

In this document, SAMHSA establishes expectations for the deliverable and provides guidance on how grantees can most effectively move forward in their strategic planning. We offer the guidance to support grantees in developing comprehensive strategic plans that advance the vision and implementation of Project LAUNCH. SAMHSA and the Project LAUNCH Technical Assistance Team are available to provide individualized technical assistance regarding comprehensive strategic plans to each grantee as needed.

This comprehensive strategic plan guidance is organized into three sections:

Part 1: Framing the Comprehensive Strategic Plan provides context for the purpose and critical elements of the strategic plan.

Part 2: Developing the Comprehensive Strategic Plan provides a guide to developing the strategic plan, including how the environmental scan, needs assessment, and grant application process support and inform this process.

Part 3: Documenting the Comprehensive Strategic Plan provides a sample template (suggested but not required) for organizing the key elements of the strategic plan.

Part 1: Framing the Comprehensive Strategic Plan

A strategic plan sets out the broad overall goals and objectives of the grant project and identifies how the grantee intends to achieve them. In addition to programmatic elements, the Project LAUNCH comprehensive strategic plan will address how financing will be structured to promote achieving these goals and objectives during the grant period. The plan should also address how the grantee intends to sustain the system of services that is developed or enhanced through the LAUNCH grant, including services and practices that are directly funded by Project LAUNCH and those that are not.

Grantees should view their strategic plan deliverables as living documents—developed and evolving as part of an ongoing, iterative process. As they meet objectives and identify new needs and strategies, grantees will continue to plan and adjust implementation accordingly.

State, Territorial, or Tribal Plan. The strategic plan should describe the full range of activities that grantees will engage in at the state, territorial, or tribal level, including but not limited to, the work of the state-, territorial or tribal-level council, policy reforms, infrastructure reforms, financing strategies, workforce development activities, and coordination with the local LAUNCH community.

Local Plan. The local strategic plan should describe how the grantee will implement systems reforms and services and practices at the local level to support the development of a comprehensive, family-centered public health approach for children birth to eight and their families. Community-level aspects of LAUNCH include service implementation, workforce development, systems reform and policy change efforts, coordination with the state, financing and sustainability-focused activities, local-level council efforts, evidence-based programs and practices, and public education campaigns.

Grantees that are submitting both state- and local-level plans should also include an account of how the planning processes at each level were coordinated and how, if at all, the plans themselves are linked.

Part 2: Developing the Comprehensive Strategic Plan

This section provides a guide to developing the strategic plan. Although the suggested process below appears linear, SAMHSA recognizes that grantees' LAUNCH planning is likely to be less straightforward and not as simple as the discussion below suggests. Grantees will conduct the planning process in a number of different ways and the following sequence simply represents steps in the process that are important to have covered at some point in the process of LAUNCH strategic planning, or through related, overlapping processes. Grantees should demonstrate in some way how they engaged in the following steps in their final strategic plan documents.

A. Engage Stakeholders

Engaging a range of stakeholders creates opportunities for your LAUNCH partners to contribute resources and take ownership for shared outcomes. In addition to the local, state, territorial, or tribal councils, grantees should consider other stakeholders, including family members and other caregivers, to be involved in strategic planning. Grantees could identify and utilize existing and/or new strategies, such as list serves, discussion boards, and subcommittee meetings, to ensure participation from the full group. Grantees should link the local, state, or territorial councils in some way (e.g., common participants on each council, shared Web site, presentations for/to each other) to ensure collaboration and communication across all stakeholders involved in Project LAUNCH.

B. Gather Existing Information to Inform the Process

Grantees' strategic plans should build on previous efforts focused on resources, services, supports, policies, and programs available to address identified problems. Grantees may submit a plan that expands on a strategic document already in place, such as an Early Childhood Comprehensive Systems Initiative (ECCS) state plan, Early Childhood Advisory Council, tribal talking circles, or other related system reform effort documents. Likewise, previous planning activities that contributed to grantees' Project LAUNCH proposals, needs assessments, project goals, early evaluation data collection efforts (e.g. , Abt's cross-site evaluation), logic model, and environmental scan can be valuable information and useful in framing the approach to the strategic planning process. SAMHSA encourage grantees to revisit and reuse such information to inform and extend their thinking at this point in the project. For example, focus groups with families, pediatricians, or home visitors that grantees conducted early in Project LAUNCH grant planning may have yielded important information regarding service delivery challenges and potential solutions. Ideas for specific activities and objectives that emerged from those earlier conversations continue to have an important place at this stage of setting a LAUNCH grantee's strategic direction.

C. Conduct Strategic Analyses of the Environmental Scan

Additional analysis of the ES data should be key in helping grantees to think through their strategic plan. The following questions may help shape strategic analyses of grantees' environmental scan data:

- What policies, programs, services, and resources are already in place to address the identified problems?
- Do these programs, services, etc. have an evidence base?
- Have they been effective for the population receiving them?
- Are the individuals or families who should be receiving the programs, services, and so forth, in fact receiving them?
- Are there duplicative programs, services, or resources in place attempting to address the same problem?
- If so, which are more effective? Less effective?
- Are those who are implementing the separate programs or services talking to each other about their efforts?
- Is there some major problem that is not getting addressed by any program, service, or resource?
- How will Project LAUNCH address (or better address) the needs in communities?
- How will the state, territory, or tribe align, adapt, or develop policies and procedures that best support the community?

As grantees and their stakeholders consider the answers to such questions as those above, they may decide to review and refine their LAUNCH vision, mission, values, goals, and objectives. Grantees should ideally engage in this process in collaboration with their stakeholders, and it is from that collaborative work that the project will most effectively set its strategic direction.

D. Review and Refine Project LAUNCH Vision, Mission, and Project Values Statements, and Goals and Objectives

In their LAUNCH funding application, grantees included proposed mission, goals, and objectives. The strategic analyses of environmental scan data and the related strategic planning process provide an opportunity for stakeholders to revisit these and reflect more deeply on their vision for Project LAUNCH and the values that will guide its implementation. To facilitate this process, stakeholders might wish first to agree on what is meant by various terms, such as *goals* and *objectives*, to ensure the group is operating on a share understanding of key terms. SAMHSA provides some guidance regarding these terms below.

Mission: *Statement that describes the purpose of the project, what the project does, how it does it, and for whom.*

Vision: *Idealized description that inspires, energizes, and creates an image of the desired outcome.*

Goal: *Broad statement of what the project hopes to accomplish.*

Objective: *Specific, measurable condition that must be attained in order to accomplish a particular project goal.*

At this stage of the process, state, tribal, territorial, and local coordinators might engage stakeholders in a facilitated discussion, guided by the following questions:

- What is the mission of the state, territorial, tribal, or local project? Consider the aim of Project LAUNCH, who it serves, how it serves, and why it exists.
- What is the vision for Project LAUNCH? What will the LAUNCH state, territory, tribe, or community look like if the project is successful?
- What values will guide the design and implementation of Project LAUNCH?
- Are the goals defined in the LAUNCH application supported by the results of the environmental scan?
- Do the goals reflect both programmatic and policy-level changes?
- How will these changes be achieved? Are they realistic?
- Which goals should be retained? Eliminated? Added or modified?
- Which objectives will serve as interim steps in achieving the broad goals?

Grantees may use Part 3 (tables 1 and 2) of this guidance to document their revised mission, vision, values, goals and objectives, if desired.

E. Refine the Logic Models, including the Outcomes and Indicators

In light of grantees' review of goals and objectives (described above), grantees should revisit the state, territorial, tribal and local-level logic models they included in their funding application. For this deliverable, grantees should provide one logic model for the state, territory or tribe and one for the local-level that demonstrates the linkage between the identified needs, the proposed approach, and expected outcomes. Grantees may submit their revised logic models in a format of their choosing.

State, territorial, and tribal teams should continue to review and update the logic models frequently so that they continue to represent the most current theory of change–or how the project's resources and activities are expected to produce the desired results. Grantees can also articulate their project's strategic direction through the outcomes and indicators they identify and illustrate in the logic model.

Grantees should revisit the outcomes and indicators in their original LAUNCH funding application to ensure they mesh with:

- the newly refined goals and objectives
- outcomes and indicators from the LAUNCH cross-site evaluation or site-specific evaluations

The local evaluator can play a key role in this process and in ensuring that all outcomes and indicators meet the "SMART" test. Outcomes and indicators that are SMART—Specific, Measurable, Action-oriented, Realistic, and Timed—are easier to convey and track.

Outcomes represent the results of program implementation. They can be expressed in terms of changes in knowledge, skills, behavior, attitudes, values, and status or life condition and often begin with words such as *decrease, increase,* or *reduce.* Outcomes can be short-term, intermediate, or long-term. Short-term and intermediate outcomes focus on the immediate effect(s) the program has on the children and families served. Long-term results are the systemic

changes the program may influence for children, families, or other organizations over time, including lasting changes in attitudes, behaviors, achievement, policies, or capacity.

Indicators represent outcomes in measurable and observable terms. Outcomes are measured by specific and concrete indicators, which provide evidence that a specific change has occurred. Questions to consider in developing indicators include the following:

- Is the indicator a reasonable and accurate measurement of the outcome?
- Is the program currently collecting data for this indicator?
- Can data collection instruments be adapted or created to collect data on this indicator?
- Will the indicator provide sufficient evidence that a change has occurred or progress has been made?

Outcomes: *Results or consequences of an action or intervention.*

Indicators: *Outcomes stated in measurable and observable terms to help stakeholders assess achievement toward intended outcomes.*

F. Develop or Refine Program and Policy Strategies

Successful LAUNCH projects will both (1) design and deliver programs and services to meet the needs of current children and families in the LAUNCH target community and (2) institute policy, financial, and other infrastructure changes that will promote positive child wellness for future children and families in the target community and the state, territory, or tribe as a whole. Grantees can use Part 3 (table 3) of this guidance to document the program and policy strategies they intend to implement to achieve their goals and objectives.

Programs, Services, and Resources. In their LAUNCH application, grantees proposed a number of program-related goals (e.g., ensure developmental screenings occurs in early childhood settings). For each program goal, they also proposed a set of objectives (e.g., a trained early childhood workforce skilled in administering developmental screenings). During the strategic planning process, stakeholders at the state, territorial, tribal, and local levels will revisit these objectives that include implementing evidence-based practices to determine if they are still appropriate given the information that has emerged through the environmental scan and strategic planning process and will update them as necessary.

Policy Strategies. Based on the scanning and planning conducted to date, grantees should develop (or review and refine) strategies related to:

- updating policies to create a more integrated and streamlined child-serving system for promoting the wellness of young children and their families,
- developing a cross-agency fiscal strategy to promote sustainability of the state, territorial, tribal, and local infrastructures developed through the grant, reduce program redundancy, and support the incorporation of evidence-based programs and practices

- aligning indicators and measures of young children's wellness across service systems, including health, mental health, child welfare, substance abuse prevention, early childhood education, and primary education as part of the evaluation process.

When identifying policy strategies, grantees might consider whether there are specific policies, legislation, regulations, and Memoranda of Understanding (MOUs) that would help them achieve their goals. Identifying the resources, supports, and stakeholders needed to support policy reform is another important step in developing an effective approach to systems-change initiatives through Project LAUNCH.

G. Plan Financing and Sustainability

Developing a vision and a plan for sustainability should begin in the first year of the LAUNCH grant. Sustaining a program requires action and creativity in multiple domains including leadership, strategic planning, partnership and collaboration, capacity building, communications and marketing, public policy, evaluation, and financing. Embracing this more complex and comprehensive view toward sustainability can help grantees sustain program elements and outcomes whether or not they receive additional funding.

A systemic approach to financing and sustaining the services, supports, and infrastructures developed through the Project LAUNCH initiative involves the identification, understanding, and utilization of *all* existing financial resources. Given that so many different agencies and entities at the state, territorial, tribal, and local level provide and fund services and supports for young children and their families, collaboration among involved agencies, providers, families, and community members is essential to a sustainability plan.

The framework for a financing and sustainability plan first identifies the services and supports the community desires to implement as part of Project LAUNCH and then lists all available federal, state, territorial, tribal, local governmental, and nongovernmental sources of funding that might support those services and supports. By matching the desired services with available resources (and their eligibility requirements, restrictions, etc.) the gaps and duplications will become readily apparent. Grantees should have done much of this work as part of the environmental scanning and financial processes mapping.

The financing and sustainability plan should reflect the project's overarching vision, priorities to pursue, statements of need and strategy, and conclusions drawn from analyzing the financial data. There are a number of resources that may be helpful to grantees in this process:

- *Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness,* by Kay Johnson and Jane Knitzer http://www.nccp.org/publications/pdf/text_634.pdf)

- *Funding Early Childhood Mental Health Services & Supports;* by Amy Wishmann, Donald Kates, and Roxane Kaufman http://gucchd.georgetown.edu/files/products_publications/fundingpub.pdf

- "Legacy Wheel," developed by the National Center for Mental Health Promotion and Youth Violence Prevention
  http://www.promoteprevent.org/resources/legacy_wheel/

H. Identify Tasks and Move Forward

To ensure that the strategic planning process leads to thoughtful and timely implementation of Project LAUNCH, it is important to include the steps to be taken and identify those stakeholders who are responsible for carrying out identified tasks. Grantees can use table 4 in Part 3 to document this information. Grantees at the state, territorial, tribal, and local levels should develop a structured mechanism to revisit the plan on a regular basis, and to use it to inform ongoing decision-making, (e.g., placing the review of the plan on the council agenda twice a year). Using the strategic plan to develop a work plan helps to ensure that the work on the ground reflects stakeholders' strategic direction.

Part 3: Documenting the Comprehensive Strategic Plan

Part 3 offers a template for grantees to use to document key elements of their strategic plan. It is intended as a helpful guide and not a requirement for grantees to follow. Grantees may choose to submit their plan in narrative form or some combination of tables and narrative. The template includes a series of tables aligned with Part 2 of this guidance, as follows:

- Table 1: Sample Mission, Vision, and Project Values Statements
- Table 2: Sample Goals and Objectives
- Table 3: Sample Implementation and Sustainability Strategies

We have included blank tables for grantee use at the end of this document,

Table 1: Sample Mission, Vision, and Project Values Statements

Mission Statement: Grantees may want to use this section to describe the purpose of their state, territorial, tribal, or local project. For example, grantees may want to consider what function the project plays, who it serves, how it serves, and why it exists. *Example: The mission of the XYZ Community Project LAUNCH initiative is to build a communitywide system that supports the overall wellness of all children in our community. Through strategic partnerships, training, and funding, we support families, early education staff, pediatricians, and other professionals who see and care for young children on a regular basis in adopting proven strategies that promote the social, emotional, mental, physical, and cognitive development of our youngest children.*
Vision Statement: Grantees may want to use this section to paint a picture of the future the project is seeking to create. *Example: When we are successful, XZY Community will have a seamless early childhood system with an array of family-centered, culturally competent, community-based supports and services that promote health and development, identify risk factors, intervene early, and provide high-quality services to ensure the social, emotional, mental, physical, and cognitive development of our youngest children.*
Project Values: Grantees may want to use this section to describe the values that help shape the work of the project. *Example: The XYZ Community Project LAUNCH initiatives are* • *driven by the fundamental value and dignity of every child* • *child-centered, youth-guided, and family-driven* • *community-based and locally adapted* • *culturally and linguistically competent* • *equitable, providing the resources for all children's health and wellness*

Table 2: Sample Goals and Objectives

Sample Goals and Objectives *(Proposed)*	Sample Goals and Objectives (*Updated*)
Goal 1: ***Ensure Developmental Screening Occurs in Early Childhood Settings***	**Goal 1:** ***Ensure Developmental Screening Occurs in Pediatric Health Care Settings***
Objective 1 *A trained early childhood workforce skilled in administering developmental screenings (e.g., at the state, tribal, territorial, or community level)*	*A trained pediatric primary care workforce skilled in administering developmental screenings (e.g., at the state, tribal, territorial, or community level)*
Objective 2 *Use of uniform screening measure to be used across all early childhood settings*	*Use of uniform screening measure to be used across all pediatric health providers*
Objective 3	*Coordination of screening efforts with local chapter of American Academy of Pediatrics*

Table 3: Sample Implementation and Sustainability Strategies

For each goal documented in table 2, grantees should describe how they plan to achieve the goal, including the rationale, objectives, targeted outcomes, indicators, strategies designed to achieve the outcomes, timeframe for the strategies, and the stakeholders or agencies responsible for carrying out the strategies. In addition, grantees should consider larger systems-change issues in regard to each goal, including the following:

- **Policy implications** (e.g., infrastructure development, policy reforms to promote cross-agency collaboration, planning, and data sharing)
- **Workforce issues** (e.g., training and technical assistance needs at the local level, workforce development for cross-training of staff)
- **Coordination and collaboration across agencies and at the state, territorial, tribal, and local level**
- **Sustainability of the project over time**, which may include plans related to financing, as well as leadership, strategic planning, partnership and collaboration, capacity building, communications and marketing, public policy, and evaluation

Goal 1: *Ensure Developmental Screening Occurs in Pediatric Health Care Settings*	
Rationale	*Current lack of mental health screening in primary care.*
Objective 1	*A trained pediatric primary care workforce skilled in administering developmental screenings (e.g., at the state, tribal, territorial, or community level).*
Targeted Outcome	*Increased use of standardized screening instruments by primary care professionals (e.g., at the state, tribal, territorial, or community level).*
Indicators	• ***State level:*** *Member survey from state chapter of American Academy of Pediatrics (AAP) shows a 50% increase of pediatric professionals who use appropriate instruments by the end of year two.* • ***Tribal level:*** *Provider self-report shows that all community pediatric professionals use culturally and developmentally appropriate measures.* • ***Local level:*** *Provider data shows 50 percent increase in the number of young children in the community who receive screening by the end of year two.*
Strategy	• ***State level:*** *Convene cross-disciplinary work group to select common screening instrument.* • ***Tribal level:*** *Consult with primary care physicians, tribal elders, and families to select screening instrument.* • ***Local level:*** *Conduct training on instrument among pediatric health professionals across the community.*
Timeframe	*Ongoing in years 1 and 2*
Stakeholders Responsible	• ***State level:*** *Young Child Wellness Council, AAP Chapter Contacts, Family Organization Project Coordinator.* • ***Tribal level:*** *Young Child Wellness Council, Tribal Elders, family members, Tribal Council.* • ***Local level:*** *Local Young Child Wellness Council, Local Child Wellness Coordinator, pediatric health professionals, family members.*
Policy Implications	• ***State, Tribal, Territorial level:*** *Affects periodicity of preventive and developmental services covered by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits as well as potential cost increases for training of health professionals, and re-allocation of Indian Health Service dollars.* • ***Local level:*** *Coordination of screening efforts across related services including home visitation, early intervention, and primary care practices.,*
Coordination and Collaboration	*State and Local Young Child Wellness councils coordinate with state and local public health leaders, pediatric health professionals, and family groups to determine most appropriate screening instruments to be used.*
Workforce Implications	*Coordination of training efforts for early childhood professionals across the sectors, including mental health consultants, home visiting nurses, pediatric health professionals to build developmental screening capacity.*
Sustainability Strategies	*Funding changes, EPSDT periodicity scheduling, continued coordination across Young Child Wellness Council, development of policies and MOUs to clarify responsibilities and expectations of multiple collaborators.*

Blank Tables for Grantee Use

Table 1: Mission, Vision, and Project Values Statements

Mission Statement: Grantees may want to use this section to describe the purpose of their state, territorial, tribal, or local project. For example, grantees may want to consider the function the project plays, who it serves, how it serves, and why it exists.
Vision Statement: Grantees may want to use this section to paint a picture of the future the project is seeking to create.
Project Values: Grantees may want to use this section to describe the values that help shape the work of the project.

Table 2: Goals and Objectives

Goals and Objectives *(Proposed)*	Goals and Objectives (*Updated*)
Goal 1:	**Goal 1:**
Objective 1:	**Objective 1:**
Objective 2:	**Objective 2:**
Objective 3:	**Objective 3:**
Goal 2:	**Goal 2:**
Objective 1:	**Objective 1:**
Objective 2:	**Objective 2:**
Objective 3:	**Objective 3:**
Goal 3:	**Goal 3:**
Objective 1:	**Objective 1:**
Objective 2:	**Objective 2:**
Objective 3:	**Objective 3:**

Table 3: Implementation and Sustainability Strategies

GOAL X:	
Rationale	
Objective X	
Targeted Outcome	
Indicators	
Strategy	
Timeframe	
Stakeholders Responsible	
Policy Implications	
Coordination and Collaboration	
Workforce Implications	
Sustainability Strategies	
Objective X	
Targeted Outcome	
Indicators	
Strategy	
Timeframe	
Stakeholders Responsible	
Policy Implications	
Coordination and Collaboration	
Workforce Implications	
Sustainability Strategies	

Project LAUNCH – Washington DC: Abstract

Through **Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)** the District of Columbia (DC) Department of Health (DOH) proposes to create a system of connected programs that will increase and improve services to children ages 0-8 and their families in the city's poorest neighborhoods. The goal is to promote the wellness of young children so they can thrive in safe, supportive environments and enter school ready to learn.

The early years of a child's development are a critical stage in establishing a foundation for the social, emotional, intellectual and academic skills needed for success in school and beyond into adulthood. Project LAUNCH will bring local child-serving agencies together to coordinate and streamline policies and practices for families and children most in need, and to fill service gaps where they exist. The project will incorporate five basic services:

- Developmental assessments in a range of child-serving settings
- Integration of behavioral health programs and practices into primary care
- Home visiting programs
- Mental health consultations
- Family strengthening and parent skills training

The target population for this project will be children residing in Wards 7 and 8 -- areas that demonstrate alarming health and economic disparities and suffer disproportionately from elevated levels of the indicators of ill health. Unemployment is high in the target Wards, drug use and violence are prevalent in the community, and per capita income is lowest of anywhere in DC. Children living in these communities are largely poor, African-American and living in single-parent households, and they have limited access to primary and mental health services when compared to their counterparts throughout the city. They are DC's children who need the most help, yet they have the fewest options outside the public social services system.

To focus this child-centered work on a common set of goals, Project LAUNCH will establish the DC Council on Young Child Wellness (DCCYCW), which will oversee all Project LAUNCH activities and develop a comprehensive strategy for both infrastructure and programmatic work. An initial meeting of this group was convened on April 21, 2009 to discuss this application and establish cross-departmental priorities for a successful partnership. During Year One, Project LAUNCH will serve 1,440 children and families with a variety of evidence-based programs, each with a specific target audience: (1)Incredible Years (children 2-8 years and parents/caregivers); (2) Primary Project (children 5-8 years); (3) Ages and Stages Questionnaire/ASQ:SE (children 6 months-5 years); (4) Parents as Teachers: Born to Learn (prenatal-2 years and parents); and (5) Strengthening Families (children 3-8 years and parents).

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SECTION A: Statement of Need

I. *Local Geographic Area to be Served*

Wards 7 and 8 in the District of Columbia (DC) are the most densely populated communities in our nation's capital. Located in the southeastern quadrants of DC, these Wards are for the most part isolated from the city by the Anacostia River as illustrated by Diagram 1 below. Both Wards are predominantly comprised of English-speaking, African-Americans. All of the census tracts in these two Wards have been federally designated as Medically Underserved Areas (MUAs), and the community suffers from elevated levels of all the indicators of ill health. The area also is challenged by the significant shortage of health care specialists in pediatrics, behavioral health and substance abuse treatment. A high percentage of the area residents fall below the federal poverty level, with the majority of employed residents working in an office or service-supported industries. A significant percentage of the population, although employed, is presumed to depend on public health entitlement benefits to cover their health care costs. Additionally, individuals in these two Wards suffer disproportionately from a variety of chronic and acute health conditions, including heart disease, cancer, HIV/AIDS, diabetes, and chronic respiratory disease. Children in particular suffer significantly from asthma, poor nutrition, and a host of behavioral health conditions. Further, the infant mortality rate in these areas is approximately 6 percentage points higher than the average in DC (which itself is the highest in the nation), and only half the women in Wards 7 and 8 report that they receive adequate prenatal care.[1,2]

Diagram 1: Map of Washington, DC with Electoral Wards

Table 1 (below) provides more details about DC's residents by each of the eight electoral Wards, highlighting data for the areas where services will be offered.

Table 1: Population Facts in Washington, DC [By Electoral Wards][3,4,5]

	Wards							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Population								
Total Population	73,364	68,869	73,718	74,092	75,527	68,035	70,540	70,914
% Children <1 yr	1%	1%	1%	1%	1%	1%	1%	2%
% Children 1 – 4 yrs	4%	2%	4%	5%	4%	4%	6%	9%
% Children 5 – 9 yrs	4%	2%	4%	5%	5%	4%	7%	10%
% Adults 20 - 64 yrs	77%	84%	76%	60%	57%	70%	56%	55%
Income/Poverty/Socio-Economic Demographics								
Median Income	$36,902	$44,742	$71,875	$46,408	$34,433	$41,554	$30,533	$25,017
% Children in Poverty	34%	26%	3%	16%	28%	36%	37%	51%
% Low-Income Children	62%	52%	7%	35%	50%	58%	61%	72%

	Wards							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
% Female Headed Households	14%	5%	4%	21%	26%	17%	33%	42%
% Unemployed	5%	6%	7%	4%	8%	6%	7%	12%
% No HS diploma	31%	13%	4%	22%	28%	21%	29%	34%
% Low weight births	10%	9%	8%	10%	14%	10%	14%	15%
% Teen mother births	11%	5%	0.3%	10%	15%	9%	20%	18%
Race/Ethnicity								
% White *(including Hispanic)*	32%	65%	84%	18%	9%	32%	1%	5%
% Black *(including Hispanic)*	46%	20%	6%	71%	87%	63%	97%	92%
% Hispanic/Latino	25%	10%	7%	13%	3%	3%	1%	1%

As illustrated in Table 1 above, Wards 7 and 8 exhibit some of the worst socio-economic indicators and behavioral risk factors throughout the city, such as:

- Highest percentage of children living in poverty (Ward 7 = 37%; Ward 8 = 51%)
- Highest percentage of children classified as low-income (Ward 7 = 61%; Ward 8 = 72%)
- High unemployment rates (Ward 7 = 7%; Ward 8 = 12%)
- Highest percentage of female only headed households (Ward 7 = 33%; Ward 8 = 42%)
- Lowest median incomes (Ward 7 = $30,533; Ward 8 = $25,017)
- Highest number of minority residents, including children ages 0-8 – specifically African Americans (Ward 7 = 97%; Ward 8 = 92%)

As a result, the DC Department of Health (DOH) recognizes the urgent need to promote the wellness of young children ages 0-8 by developing and implementing programs that enhance physical, emotional, social and behavioral health in these designated communities. The District promotes several programs emphasizing child well-being and school readiness in an attempt to ensure that all children, specifically those ages 0-8, are physically, developmentally, emotionally and cognitively ready to learn. These programs include, but are not limited to:

- The DC DOH Perinatal and Infant Health Bureau (PIHB), which houses the Healthy Start Program and is partially funded by the Title V Block grant
- The Early Childhood Comprehensive Systems Initiative, which operates through the DC DOH Child, Adolescent School Health Bureau
- The School Mental Health Program, which is administered by the DC Department of Mental Health (DMH)
- The establishment of the Interagency Collaboration and Services Integration Commission (ICSIC), which oversees work pertaining to early child issues across agency boundaries
- The development of the 2008 Children's Health Action Plan, which highlights nine key strategies to improve children's health outcomes within the District by implementing evidence-based practices and public health models focusing on system change.

Despite these efforts, Wards 7 and 8 continue to face many challenges in providing necessary services to their youngest children. The former Mayor's Advisory Committee on Early Childhood Development (MACECD) 2006 report highlights the following evidence:

- 22% of children 0 – 3 years are exposed to 3 or more risk factors, twice the national average.
- More than one-third of all mothers did not have adequate prenatal care.
- 56% of all births in DC were to single mothers, with 80% of those births in Wards 7 and 8.

- An estimated 2,000 at-risk families in the District could benefit from home visiting services, but less than 30% of that group receives them.
- Medicaid reimbursement rates in the District are among the lowest in the country.
- The District of Columbia is one of only a few states that do not dedicate any state or local funds for early intervention (IDEA Part C) services.
- Only 4% of eligible children (age 0-3) receive Early Head Start services.
- Child care data gathered over a four-year period indicates that the quality of child care in many infant/toddler classrooms in the District is inadequate.

DC DOH recognizes that our families are our community's most important resource and must be respected, valued, and encouraged to build upon their strengths. As such the racial, cultural and ethnic heritage of children and their neighborhoods are honored and supported as strengths, and ethnic and racial child-rearing practices are valued. Project LAUNCH will create systems that both support children *and* preserve families.

II. *Current Systems & Infrastructure*

a. Infrastructure & Systems: Citywide

The District of Columbia acts in many ways as a state in meeting the needs of the area residents. To this end, many governmental agencies fulfill the mission of both state- and local-level government simultaneously. In the DC government current systems and infrastructure within agencies that exists with specific programs for children in the target age range include:

Early childhood programs administered by the **DC DOH** Community Health Administration (CHA) – which is also responsible for administering the Title V Maternal and Child Health Services Block Grant – include:

- The *Early Childhood Comprehensive Systems (ECCS) Project* - In collaboration with stakeholders, ECCS has conducted an environmental scan; developed a workplan and timeframes; and developed linkages to other key early childhood stakeholders to implement a number of initiatives, including developing early childhood outcomes and indicators. Ground work done by ECCS will be used as a "road map" for Project LAUNCH initiatives.
- The *PIHB* – Administers the *Healthy Start Program* that focuses on the needs of pregnant women and infants. Its goal is to reduce infant mortality in areas with the highest needs.
- The *Integrated Community Systems for CSHCN Project* – Aims to improve access to quality, comprehensive, coordinated community-based systems of services for children with special health care needs (CSHCN) and their families in Washington, DC.
- School Nurses and Oral Health Programs – Includes the placement of contracted personnel through a formal arrangement with the National Children's Hospital and a group of private dental providers. These teams work in tandem to ensure DC public and charter school students have access to on-site nursing services. The oral health services are provided in a selected number of public schools. Oral health services have been restricted to the demographic areas that are the target of this project, due mainly to poor utilization of services and poor oral health outcomes for children up to 8 years old.

The **Early Care and Education Administration** (ECEA) of the Office of the State Superintendent of Education (OSSE) provides leadership and coordinates and implements early care and education services for children. These services come through a single, comprehensive, District-wide, multi-disciplinary, culturally sensitive and responsive system of public- and

private-sector partnerships. ECEA serves as the lead state agency that administers the Child Care and Development (CCDF) Block Grant State Plan.

The **DC Public Schools** administers *Head Start/Early Head Start*, whose mission is to design and implement innovative and integrated services that create empowered, self-sufficient families, promote community wellness, and encourage the total development of children ages 0-4.

The **DC DMH** administers the *Child and Family Therapy Program*, offering a comprehensive range of outpatient psychiatric services including treatment for emotional, learning and/or behavioral problems, as well as Attention Deficit Hyperactivity Disorder (ADHD). DMH also administers the *School Mental Health Program*, providing prevention, early intervention and clinical services to youth and their families via the public schools.

The **Department of Health Care Finance** (DHCF) is DC's state Medicaid agency; it serves young people by administering insurance programs for immigrant children, the State Child Health Insurance Program and Medical Charities (a locally funded program).

The **DC Child and Family Services Agency** identifies and assists children 0 -18 years old who require child protective services, supportive family services and foster care; DCFS also conducts case management services for coordinating and linking follow-up care.

The current DC Mayor, Adrian Fenty, has created the **Interagency Collaboration and Services Integration Commission (ICSIC),** which serves as a coordinating body for all District services for children. ICSIC monitors, aligns, and supports child and youth initiatives and determines where opportunities for collaboration exist for DC agencies who serve children, youth, and families. The DC Council on Young Child Wellness (DC CYCW) will be a sub-committee of ICSIC. This will allow Project LAUNCH to take advantage of the already-developed early childhood infrastructure and partnerships between agencies and community-based organizations.

Community based programs also offer services to children ages 0-8 and their families. These include the (1) **DC Primary Care Association,** which administers the Medical Homes DC Project (MHDC) to ensure that every DC resident has access to quality primary health care (four clinics operating in Ward 7 and six in Ward 8); (2) the **DC Children's Trust Fund,** which works to prevent child abuse and neglect; and (3) **Neighborhood Collaboratives**.

b. <u>Infrastructure & Systems: Wards</u>

Currently, many neighborhood services in Wards 7 and 8 are coordinated through the *Healthy Families/Thriving Communities Collaborative Council (Collaboratives)* that provides three basic types of services: family stabilization/case management; information/referrals; and community capacity-building. The Neighborhood Collaboratives are part of a public-private partnership between city government and community-based service organizations. The Collaboratives are staffed with individuals from the surrounding communities with extensive experience in providing services to the target population. However, despite their best efforts and their strong partnerships with health services, community-based organizations such as DC Children's Trust Fund, and government entities (e.g. DC DOH, DC CFSA), many of the services offered within these Wards still remain fragmented and uncoordinated.

c. <u>Integration of Culturally-Based Assets in Current Wellness System</u>

Throughout DOH history of working with diverse urban populations, DOH has continually ensured that all areas of programming are sensitive to the cultural and linguistic needs of the

populations it serves. All of our programming areas must comply with the District's requirements for cultural and linguistic appropriateness of services. When selecting program models to respond to the ever-changing needs of the communities we serve, the Department will evaluate all aspects of service delivery for quality, for effectiveness in meeting the community needs, and for the recognition of the unique cultural values of the target community. In addition to being culturally competent, initiatives will be family-centered and age-appropriate, and all activities associated with Project LAUNCH will include cultural sensitivity training.

III. Current State & Need for Infrastructure Development: Citywide & Wards

High poverty levels and rising unemployment rates in Wards 7 and 8 foment serious bio-psychosocial risk factors such as: violent crime, poor school performance, high teen pregnancy rates, high parental stress, and child abuse and neglect. This in turn diminishes the child's overall potential as they transition through adolescence into adulthood. A 2005 report from the National Center for Children in Poverty indicates that in DC, 63% of young children are exposed to one or more risk factors, making them more likely to experience serious developmental burdens during the early childhood years and to incur substantial costs in the future.

Despite the development and implementation of these programs, efforts often remain limited and/or fragmented, resulting in systems being built and implemented in silos, unable to collaborate efficiently and share resources. Although many of the individual programs are successful, they do not work together as a cohesive system to serve the whole child. The overarching effort of Project LAUNCH will be to link these disparate programs into one, cohesive system and develop and implement new initiatives where necessary. Systemic and programmatic gaps include:[6,7]

- Insufficient resources to efficiently and timely accomplish goals and tackle priority areas, including Assuring Better Child Health and Development (ABCD) expansion and mental health consultation for young children.
- Need for integrated data management from stakeholders to more efficiently integrate partnerships and link existing early childhood resources.
- Insufficient referrals linking CSHCN and their families to resources.
- Segregation of behavioral health and primary care services for children.
- Medicaid and other medical insurances often do not authorize or reimburse mental health services for children under five years old.
- Other reimbursement systems require a child to be diagnosed with a DSM-IV or ICD 9 diagnosis in order for his or her treatment to be reimbursable
- Lack of social/emotional screening as part of standard pediatric care.
- Standardized screening tools to identify social/emotional development delays are not typically used in the majority of early care and education environments.
- A lack of appropriate treatment resources and a fear of "labeling" young children often results in reluctance to screen children for problems.
- Limited access in Wards 7 and 8 to primary care, prenatal, and pediatrics compared to other Wards.
- Shortage of mental health services for pregnant and post-partum women, including parenting women with school-aged children.

Without intervention, many children living in Wards 7 and 8 are destined to continue the cycle of poverty and its accompanying risks. Data shows that children who enter school ready to learn, are more likely to sustain the principles of inquiry, experimentation and learning past the third

grade and therefore more likely to succeed. Therefore, the quality of and accessibility to comprehensive early childhood programs is critical.

SECTION B: Proposed Evidence-Based Services/Practices

I. Evidence-Based Programs & Practices

How Programs Will Address Risk & Protective Factors

As discussed in the previous **Section A**, 63% of young children in DC are exposed to one or more risk factors. The proposed model of service delivery will facilitate access to early identification and prevention services to children ages 0 to 8 who currently have limited or not access to the cadre of services we are proposing to offer through this project. The DC Project LAUNCH will introduce a full compliment of services that will address a significant number of bio-psychosocial conditions and disparities experienced by the children in Wards 7 and 8. DC will implement evidence-based programs that are age-appropriate, culturally competent and family-centered to support and enhance young child wellness. Programs will be developed and/or existing programs enhanced to support wellness amongst our youngest children ages 0-8 in several programmatic areas as discussed in the upcoming section. The proposed service delivery model will provide access to following interventions:

The Incredible Years

i. **Evidence Base –** The *Incredible Years (IY)* curricula are research-based, effective programs proven to reduce children's aggression and behavior problems and increase social competence at home and school. *IY* is guided by developmental theory concerning the role of multiple interacting risks and protective factors in the development of conduct problem[8] and is listed as an evidence based program (EBP) by SAMHSA's *Guide to Evidence-Based Practices*[9]. *IY* provides three curricula for parents, teachers, and children. Components of the program cover children from two to eight years and their families, providing structured thematic training sessions. The family component helps parents/guardians to identify children's problem behaviors, develop positive strategies to correct behaviors and foster positive family communication. Nine randomized control trials showed that it significantly reduces Oppositional Defiant Disorder and internalizing problems and strengthen positive child-parent relationships[10].

ii. **Factors to be Addressed** – **Risk:** (1) academic failure in children, and (2) poor parenting skills. **Protective**: (1) emotional and social competence in children, (2) healthy social and emotional development in children, (3) parental resilience, and (4) adequate knowledge of parenting and child development.

iii. **Adaptation Justification –** In 2006, *IY* was piloted in two DC Public Charter Schools in collaboration with the Youth Policy Institute for the Center of Student Support Services. The study revealed that there was a strong need for universal prevention programs to bolster the capacity of children to adjust to structured classroom settings and strategies to address protective factors at the individual, family and community levels[11].

DMH currently administers the School Mental Health Program, which offers a comprehensive array of services to children enrolled in DC schools and their families. However, no similar services are currently being offered to DC's youngest population and their families. Therefore, DMH will implement early childhood mental health consultation (ECMHC) services and implement the *IY* curricula for the District's children and their families as part of the consultation services. Mental Health Consultants will ensure, when possible, that the child's primary care

provider receives developed behavior plans. Some strategic interventions that will be included are: group parenting skills training; teacher classroom management training; support for parents, teachers, and children; and self-management skills training.

iv. **Cultural Competency –** The *IY* curricula were implemented with measureable success in the DC Public Charter schools that were used as pilot sites, and the program is designed to be flexible, cost-effective and able to address the needs of a growing numbers of minority groups served in community mental health settings. The *IY* parenting program has shown promising effects in many random control studies with diverse racial and cultural groups.[12] *IY* component activities are aimed at a range of age and ability levels, which allows for varying degrees of literacy and physical skill among child participants.

v. **DC's Goals–** (1) Promote emotional and social competence; and (2) prevent, reduce and treat aggressive, defiant, oppositional and impulsive behaviors in young children.

Parents as Teachers (PAT) Born to Learn™ Program

i. **Evidence Base –** The *Parents as Teachers (PAT) Born to Learn*™ program is an evidence-based, home visiting curriculum that promotes optimal child development and positive parent-child relationships while delivering developmental, hearing and vision screenings to ensure early identification of developmental delays and significant health concerns. The curriculum is based on reliable and current research in the areas of child development and neuroscience. The 2005 edition places a special emphasis on social-emotional development in the early years. The *Born to Learn*™ program has three core curricula: (1) *Born to Learn*™ *Curriculum Prenatal to 3 Years*; (2) *3 Years to Kindergarten Entry*; and (3) *2 Years to Kindergarten Entry*. All three core curricula consist of the following four service delivery components: (a) personal visits; (b) group meetings; (c) screening; and (d) resource network.

ii. **Factors to be Addressed** – **Risk:** (1) poverty (low income residents often do not access preventing health care services), and (2) poor parenting skills. **Protective:** (1) emotional and social competence in children, (2) healthy social and emotional development in children, (3) parental resilience, and (4) adequate knowledge of parenting and child development.

iii. **Adaptation Justification –** The *Born to Learn*™ model often is implemented into the structure of an existing program. In this case, it will be incorporated into DC's Healthy Start program, which falls under the purview of the CHA's PIHB. The Healthy Start program focuses on the needs of pregnant women and infants, with the goal of reducing infant mortality in Wards 5, 6, 7, and 8. Healthy Start Community Health Workers (CHW) will be trained as parent teachers using the *PAT Born to Learn*™ curricula. The *Born to Learn*™ model initially will be offered to families in Wards 7 and 8.

iv. **Cultural Competency –** The *PAT Born to Learn*™ *Program* curricula were developed to allow users to provide services in a culturally competent manner that demonstrates understanding of the role of cultural values, beliefs and behaviors in the development of humans, supports the preservation of cultural ways of being, and works to eliminate cultural, ethnic, racial and sexual orientation bias. Information supporting cultural competency may be found throughout the curriculum and will be reinforced to all CHW to be trained. CHW are parents who often are from the same neighborhoods that they serve; as a result, they will likely be of the same race and have similar cultural norms and family values of the target population.

v. **DC's Goals –** (1) To increase parenting skills; (2) Strengthen family relationships; and (3) Improve health development/growth of young children.

Ages and Stages Questionnaires

i. **Evidence Base –** The *Ages and Stages Questionnaire (ASQ)* is used worldwide to identify infants and young children (3 months to 5 years of age) who show potential developmental delays. The validity and reliability of the *ASQ* has been studied extensively with psychometric studies showing high reliability, internal consistency, sensitivity, and specificity[13,14]. Children who score below the cut-off on the *ASQ* are referred to professionals for further evaluation.

The *ASQ: Social-Emotional (ASQ:SE)* identifies infants and young children whose social and emotional development requires further evaluation to determine if referral for intervention services is necessary. Designed for children ages 6 months to 5 years, it was developed to help home visiting, early intervention, Early Head Start, Head Start, child welfare agencies, and other early childhood programs accurately screen infants and young children determine who would benefit from an in-depth evaluation in the area of social-emotional development.

ii. **Factors to be Addressed** – **Risk:** (1) poverty (low income residents often do not access preventing health care services). **Protective**: (1) emotional and social competence in children, (2) healthy social and emotional development in children, and (3) accessing health care services.

iii. **Adaptation Justification –**DC's Assuring Better Child Health and Development (ABCD) Childhood Developmental Screening Initiative pilot project used the ASQ in three hospital settings: Howard University Hospital, Children's National Medical Hospital and Chartered Family Health Center. The soon-to-be-released final report will show that the cost-efficiency and user-friendliness of the *ASQ* was viewed favorably by the providers. *ASQ* also is used as a screening tool by DC DOH Healthy Start. As part of Project LAUNCH, providers will be trained on the use of the *ASQ* tools and educated about the fact that Medicaid will now reimburse for developmental screening. *ASQ* also will facilitate the integration of behavioral health programs into primary care, since physicians will be conducting social/emotional screenings and making referrals.

iv. **Cultural Competency –** It is used worldwide and was developed to allow users to provide services in a culturally competent manner. Test-giver training materials include instruction on how to present the materials in a culturally competent manner that respects differences in race, gender, ethnicity, background, etc. The questionnaire can be presented in writing or administered orally to those whose disabilities or lack of reading skills cause them to be unable to manage the written materials.

v. **DC's Goals–** (1) Implement a uniformed screening tool; and (2) increase the percentage of children identified at an early age with developmental delays.

Primary Project

i. **Evidence Base –** The *Primary Project* is a school-based early intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade. It uses early screening tools with all children to identify those in need of additional supports early in their school career. Typical candidates include children who are acting out, display mild aggression, are anxious or withdrawn, or have learning problems that interfere with progress in school. The teachers, parents, and school counselors of each student collaborate to develop an intervention plan that establishes goals for the student's treatment. Progress is

assessed during regular meetings between the child associate and school mental health professionals and through the use of pre and post T-CRS (Teacher Child Rating Scales) and A-CRS (Associate Child Rating Scales).

The comparison of pre-test and post-test T–CRS results in a recent evaluation of a *Primary Project* site in Hennepin County, MN, showed statistically significant changes in the following four competence areas: (1) task orientation; (2) behavior control; (3) assertiveness; and (4) peer sociability[15]. *Primary Project* is currently in approximately 20 school districts – including DC – and has been highlighted by the National Registry of Evidence-based Programs and Practice, the U.S. Department of Education's Safe, Disciplined and Drug-Free Schools Expert Panel, the 1999 U.S. Surgeon General Report on Mental Health, and the National Mental Health Association.

ii. **Factors to be Addressed – Risk:** (1) anti-social behavior and alienation, (2) delinquent beliefs/general delinquency involvement, (3) early onset of aggression and/or violence, (4) life stressors, (5) victimization and exposure to violence, and (6) negative attitude toward school. **Protective**: (1) perception of social support from adults and peers, (2) positive/resilient temperament, (3) positive expectations/optimism for the future, (4) self-efficacy, (5) social competencies and problem-solving skills, and (6) positive attitude toward school.

iii. **Adaptation Justification –** *Primary Project* is one of five evidence-based programs currently implemented by ICSIC in DCPS. DMH hired a qualified coordinator and 24 child associates to implement Primary Project in 12 schools. Child associates who were trained reported extremely favorably about the training experience, and early anecdotal evidence points to program successes. Formal data analyzing the program's first year in DC will be released in June 2009. Project LAUNCH will continue the expansion of Primary Project into more DC public schools in Wards 7 and 8.

iv. **Cultural Competency –** Child Associates receive 16 hours of training at the beginning of the program and an additional 8 hours a year in subsequent years, which includes training in cultural awareness and multicultural development. Child Associates also receive a minimum of 24 hours of individual or group supervision with a mental health professional every school year. Among the topics measured by supervisor evaluation is attention to cultural competency and proper handling of multicultural issues. One of *Primary Project*'s official "Standards of Excellence" requires that Child Associates and mental health professionals recognize and understand the differences in cultural style and language among children. All play materials are developmentally appropriate for the age range of the children in the program and reflect the languages and cultures of the families served. DMH also makes every attempt to hire Child Associates who represent and understand the schools where they will work by hiring individuals who are from the school's surrounding neighborhood.

v. **DC's Goals –** (1) Increase the number of children in need of additional support early in their school career who are identified and referred to the appropriate services; (2) decrease the social, emotional, and behavioral problems experienced by children; and (3) strengthen children's coping and peer sociability skills and ability to adjust to school.

Strengthening Families Program

i. **Evidence Base –** The *Strengthening Families Program* (*SFP*) is a 14-session, evidence-based parenting skills, children's life skills, and family life skills training program specifically designed for high-risk families. The curriculum focuses on three age groups: 3-5 years, 6-11 years and 12-

16 years; to align with the target audience of Project LAUNCH, the 3-5 and 6-11 curricula will be used to target children ages 0-8. Parents and children participate in *SFP*, both separately and together. The parenting sessions review appropriate developmental expectations, teach parents ways to interact positively with children, foster positive family communication, and using effective and consistent discipline techniques. The children's skills training content includes communication, resilience, problems solving, feelings identification, anger management and coping skills. The family practice sessions allow the parents and children time to practice what they learned in their individual sessions in experiential exercises. This is also a time for the group leaders to coach and encourage family members in improving parent/child interactions.

SFP has been evaluated in as many as 15 different research studies by independent evaluators, including examinations in rural settings and among ethnically diverse populations. The program was found to be highly effective in decreasing anti-social behaviors, conduct disorder, and aggression with Effect Sizes (ES) ranging from .85 to 1.11 range depending on outcomes measured.[16] It receives top ratings from international and national review groups including the prestigious World Health Organization, the Cochrane Collaboration Reviews in Oxford, the United Nations Office of Drugs and Crime in Vienna, The White House, the National Institute on Drug Abuse (which supported most of the *SFP* research), and the Office of Juvenile Justice and Delinquency Prevention.

ii. **Factors to be Addressed – Risk:** (1) behavioral problems, (2) academic problems, (3) emotional and social problems, (4) substance abuse, (5) delinquency. **Protective:** (1) increased family strength, (2) increased resilience, (3) improved family relationships, (4) improved parenting skills, and (5) improved child's social and life skills.

iii. **Adaptation Justification** – Research shows that the presence of the abovementioned protective factors is linked to a decrease in child maltreatment. In collaboration with the DC Children's Trust Fund, *SFP* will be offered to targeted child care centers, Head Start centers and community-based centers in Ward 7 and 8 communities that exhibit high incidences of parental and child risk factors. Though ideal for families of children ages 3 – 8, the positive parenting skills can be applied to children of all ages.

iv. **Cultural Competency** – The core *SFP* course materials were extensively revised to be both multicultural and culturally sensitive. All *SFP* group leader trainings stress the necessity in implementation of adapting to the needs and culture of participating families. Both culturally sensitive and culturally specific versions of the *SFP* curriculum have been found extremely successful with African-American, Hispanic-American and Asian-American families.

v. **DC's Goals –** (1) Increased family strengths and resilience; (2) reduced risk factors for problem behaviors in high risk children; (3) Improved positive results in preventing substance abuse and delinquency risk factors by improving family relationships; and (4) strengthening of protective factors by improving family relationships, parenting skills, and improving the youth's social and life skills.

II. Program Consideration of Issues: Age, Race, Ethnicity, Etc.

Project LAUNCH initiatives will serve all families of children ages 0-8. In addition to the adaptations highlighted in each evidence-based program's description, enthusiastic program participants will be recruited and retained by working closely with the Neighborhood Collaboratives. These Collaboratives are often staffed by individuals from the communities they

are serving and as a result have established a relationship built on trust and based on their understanding and respect of their residents' cultural background. All Project LAUNCH staff will receive additional training to ensure that they respect, understand and exhibit competence and sensitivity towards all Project LAUNCH beneficiaries. All efforts will be made to recruit staff who can easily relate to the clients – for example; Primary Project's Child Associates and staff from the DC Children's Trust Fund who will provide the *Strengthening Families Program* are often from the communities they serve. Project LAUNCH also will work closely with Family Voices of DC to ensure that CSHCN families in these neighborhoods are properly engaged and involved in both the planning and implementation phases.

SECTION C: Proposed Implementation Approach

I. *Purpose, Goals and Objectives*

The purpose of DC's Project LAUNCH initiative is to create a connected system of child-centered services, using existing programs and new programs that will efficiently and appropriately serve DC's children in Wards 7 and 8. The goal of the project is **to promote the wellness of young children, ages 0-8, so they can thrive in safe, supportive environments and enter school ready to learn and able to succeed**.

Though DC will combine its "state" and "local" activities, DC's Project LAUNCH includes both infrastructure ("state level") and programmatic ("local level") objectives. Infrastructure objectives will build system capacity by creating an integrated, effective system of coordinated services designed to make efficient use of current child-focused programs and to best integrate new programs added. Programmatic objectives will produce meaningful results in children's lives by improving the amount and quality of mental, physical and social care they receive, by improving their caregivers' parenting skills, and by ensuring that they have positive learning experiences early in their lives.

Infrastructure Objectives (IO):

1. Complete an external environmental scan and needs assessment.
2. Strengthen partnerships and programmatic alignment and increase collaboration among all major stakeholders working with children ages 0 – 8 and their families.
3. Improve data-sharing capabilities regarding children ages 0 – 8 and their families.
4. Make wellness/prevention programs more available to children ages 0 – 8 and their families.
5. Convene high-level political, philanthropic and public agency leaders for systemic changes.
6. Clearly articulate the relationship between Federal, District, and local planning resources.
7. Increase # of outreach services to children ages 0 – 8 and their families.
8. Make programmatic and financial management more efficient and effective.
9. Develop a core set of indicators for early childhood health.
10. Create a centralized data reporting system to monitor and track Project LAUNCH activities.

Programmatic Objectives (PO):

1. Increase # of young children who receive developmental screening before entering school.
2. Increase # of children and their parents who access preventive health care services that include integrated behavioral health screening.
3. Increase # of "at-risk" children who receive home visitation services before age 2.
4. Increase # of children who access early childhood mental health consultation services.
5. Increase # of families who receive the parenting-skills training necessary to embrace the importance of early childhood development

II. *Proposed Project Plan*

Initial planning has already identified many gaps in the current child wellness system, and Project LAUNCH partners recognize the need for updated data regarding the wellness of young children and their families. Therefore, to strengthen infrastructure an environmental scan and needs assessment (including a financial map) will be conducted within the first six months of this initiative. The results will be used to develop a strategic plan that will guide the subsequent work of the DC CYCW, including both infrastructure and programmatic objectives in the logic model below. During its first year, Project LAUNCH will:

- Implement ECMHC that incorporates Incredible Years (IO: 2, 3, 4 & 7; PO: 2 – 5)
- Expand of the Healthy Start Home Visitation Project to include *PAT Born to Learn* (IO: 2, 3, 4 & 7; PO: 1, 3 & 5)
- Implement the *Strengthening Families Program* (IO: 3, 4 & 7; PO: 5)
- Enhance the *Primary Project* (IO: 2, 3, 4 & 7; PO: 2, 4 & 5)
- Enhance the ABCD initiative (IO: 2, 3, 4 & 7; PO: 2)
- Increase collaboration between existing systems as a result of the DC CYCW and greater referrals between Project LAUNCH activities and its stakeholders (IO: 2-4, 7-10; PO: 1-5)
- Increase family involvement due to greater partnership with community-based organizations such as Neighborhood Collaboratives and Family Voices (IO: 2, 4, 5 & 7; PO: 1 – 5)

III. *Logic Model*

According to the terms of the Project LAUNCH grant, DC's singular governmental status allows the combination of state and local duties into one non-duplicative logic model and work plan.

Goal: To promote the wellness of young children, ages 0-8, so they can thrive in safe, supportive environments and enter school ready to learn and able to succeed.

Infrastructure Activities	Inputs	Outputs	Outcomes: Short Term	Outcomes: Long Term
Establish DC CYCW	Council Members	Roles & responsibilities of CYCW established	Increased collaboration among all major early childhood stakeholders and families.	Strengthened partnerships & programmatic alignment
	SAMHHA T/A	DC CYCW meetings, agendas & minutes		
		CYCW sub-group/ committees formed	High-level political, philanthropic & public agency leaders for systemic changes convened	Programmatic & financial management more efficient and effective.
	Wards 7 & 8 Communities	Needs assessment/ environmental scan conducted		
		Strategic plan developed	Relationship between Federal, District, & local planning resources clearly articulated	
		Evaluation plan developed and evaluation conducted		
Environmental Scan/Needs Assessment	DC CYCW; LCWE; YCWE	Early childhood data collected	Increased sharing of data amongst stakeholders	Improved data-sharing capabilities regarding children ages 0 – 8 & their families.
	Georgetown University			
	0.5 FTE Evaluator		Findings used in development of Strategic Plan	Increase availability of wellness/ prevention programs to children
	SAMHHA T/A	Environmental scan and Needs Assessment		
	ECCS			

Infrastructure Activities	Inputs	Outputs	Outcomes: Short Term	Outcomes: Long Term
	Environmental Scan	completed		ages 0 – 8 and their families.
Strategic Plan Development	DC CYCW; LCWE; YCWE	Strategic plan developed & submitted to SAMSHA for approval	Greater coordination & collaboration among LAUNCH partners	Development of an integrated system of early childhood services
	Georgetown University			Development of policies, financial mechanisms and other reforms
	0.5 FTE Evaluator			Early childhood wellness infrastructure reform
	SAMHHA T/A			All early childhood stakeholders & families/communities have a shared vision, mission and plan for child wellness
	Communities & Families			
Evaluation Plan Development	DC CYCW; LCWE; YCWE	Survey instruments designed	Year 1 data collected & evaluated & used to improve project implementation for years 2 – 5	Integrated system of services &/or LAUNCH partners resource sharing
	Georgetown University	Evaluation of all LAUNCH activities conducted		Findings used to achieve the overall LAUNCH goal.
	0.5 FTE Evaluator		A core set of indicators for early childhood health developed	
	SAMHHA T/A	Evaluation plan developed		

Programmatic Activities	Inputs	Outputs	Outcomes: Short Term	Outcomes: Long Term
Behavioral & mental health programs including: Healthy Start Home Visitation, Early Childhood Mental Health Consultation, Strengthening Families Program, ABCD, & Primary Project	Wards 7 & 8 children 0 – 8 years & their families	# of settings served	Children receive more screenings	Effect of developmental delays, behavioral health issues, etc. mitigated
	Community Health Workers	# of Community Health Workers trained	Referrals for developmental delays, behavioral health care, etc. increase	
	Pediatricians	# of children/ caregivers/ families screened;		Children succeed in school
	Assessment tools tailored to each program	# of children/caregivers participating in services who are referred to LAUNCH partners	More children with developmental delays, behavioral health issues, etc. are identified early and referred	Participating families increase their knowledge about early childhood development;
	Early Childhood Mental Health Consultants	# of Project LAUNCH staff trained on LAUNCH initiatives		
	Teachers/Caregivers; Child Associates	# of families educated	Participating families improve parenting practices	Stronger families

Programmatic Activities	Inputs	Outputs	Outcomes: Short Term	Outcomes: Long Term
Public Awareness Campaign	DC CYCW; LCWE; YCWE	# of LAUNCH stakeholders websites updated	Increased awareness and knowledge about child wellness	Stronger, more resilient children families, and community members
	Parents/caregivers	# of Public service Announcements		
	Pediatricians	# of informational material about Project LAUNCH & other early childhood initiatives distributed		
	Teachers/Caregivers			
	Community members	# of trainings provided		
	LAUNCH Staff	# of visits to websites		
	LAUNCH Stakeholders IT	Other activities to be determined		

IV. *<u>DC Council on Young Child Wellness</u>*

The DC Council on Young Child Wellness (DC CYCW) will develop the environmental scan and strategic plan, oversee the Project LAUNCH initiative, and participate in infrastructure reform, policy development, financial mapping and workforce development activities. The DC CYCW will be a sub-committee of the existing ICSIC body, which serves as a coordinating body for all District services for children.

The DC CYCW will meet monthly (or as needed) and report directly to the mayor or his representative during regular ICSIC meetings. In addition to this larger group, smaller working groups/sub-committees will be formed as needed. They will initially meet at least bi-weekly and will have more direct oversight in implementing and monitoring activities in conjunction with the Young Child Wellness Coordinator and the Local Child Wellness Coordinator.

The DC CYCW will include the following members:

DC DMH: **Barbara Parks, Marie Morilus-Black**	
DC DOH Community Health Administration (CHA): ECCS: **Twana Dinnall**	
DC DOH CHA: Child, Adolescent and School Health Bureau: **Alvaro Simmons**	
DC DOH CHA: **Nathaniel Beers, MD**	
DC DOH CHA: Perinatal Infant Health Bureau: **Karen Watts, RN**	
DC DOH Addiction Prevention & Recovery Administration: **Tori Whitney**	
DC HCFA/Medicaid: **John McCarthy**	DC CSFA: **Loren Ganoe, Cheryl Williams**
DC EOM: **Jenna Grant**	DC OSSE: **Carla Thompson**
DC OSSE – ITDD: **Jerry Johnston**	DC OSSE – Child Care Licensing Division: **Valerie Ware**
DC DCPS: **Diana Bruce, Andrea Shore, Brocklin Qualls** & **Catherine Graham, Psy.D.** (Head Start)	
DC Children's Trust Fund: **Kinaya Sokoya**	Family Voices of DC, Inc: **Doreen Hodges**
Ward 7 Collaborative - East River Family Strengthening Collaborative: **Mae Best**	
Ward 8 Collaborative: **Perry Moon**	

<u>Relationship between Young Child Wellness Expert & Local Child Wellness Coordinator</u>

The Young Child Wellness Expert (YCWE) will have experience in the areas of maternal child health, early childhood development, family dynamics, service implementation, and delivering services to a cultural minority population. The YCWE will work closely with the Local Child Wellness Coordinator (LCWC) in collaborating with existing early childhood systems/projects – including ECCS as well as the DC CYCW – to coordinate activities supported by Project

LAUNCH; working towards improving citywide early childhood policies; and providing overall coordination across service systems. To ensure that all timelines are met, the YCWE will be a member of DC DOH staff who has the appropriate experience and expertise. The program structure will require ongoing consultation, including direct contact with various constituent groups serving the target population.

V. Family Organizations and Representatives

Community members, family organizations and a myriad of stakeholders have participated in the planning and design of Project LAUNCH. The DC Children's Trust Fund and Neighborhood Collaboratives – two community-based organizations that communicate regularly with residents of our target neighborhoods – have been involved with the preparation of this grant application. The DC CYCW also will work closely with the family and community partners of the DC's Integrated Community Systems for CSHCN project, such as Family Voices of DC, Inc., which expects to be of particular help to Project LAUNCH with engaging CSHCN and their families. Additionally, the ECCS working group committee that has extensive representation from both governmental and community-based organizations also was consulted in the development of this grant application. Project LAUNCH stakeholders believe that it is imperative that families of children ages 0-8 continue to be engaged as full partners in any future planning, execution, and evaluation of the project. In the past, families have complained that their voices have not always been heard. Therefore, this project will respond to those criticisms in the following ways:

- Build on existing relationships with families.
- Offer appropriate incentives to aid in recruitment for programs .
- Assign specific staff time to support family and youth participation in activities.
- Work with community-based organizations serving minorities to involve family representation.

VI. Implementation of Project LAUNCH in Wards 7 & 8

DC will implement new and current evidence-based programs that are age-appropriate, culturally competent and family-centered to support and enhance the wellness of children ages 0-8 in the target communities. Table 2 below provides more details.

Table 2: Programmatic Areas of Proposed Activities

Programmatic Area	Activity[±]	EBP Model Program/Practice	Target Group
Early Childhood Mental Health Consultation (ECMHC)	DMH/ECCS Mental Health Consultation **[NP]**	*Incredible Years*	2 – 8 years: Children; their parents & caregivers
	Primary Project **[EP]**	*Primary Project*	5 – 8 years: Children
Developmental Assessments	Healthy Start & ABCD/ECCS **[EP]**	*Ages and Stages Questionnaire* (ASQ)	1 month – 5 years: Children
		ASQ: SE	6 months – 5 years: Children
Family Strengthening & Parenting Skills Training	DMH/ECCS ECMHC **[NP]**	*Incredible Years*	2 – 8 years: Children; their parents & caregivers
	Primary Project **[EP]**	*Primary Project*	5 – 8 years: Children
	Healthy Start **[EP]**	Parents-as-Teachers *Born to Learn*	Prenatal – 2 years: Parents
		Nurse-Family Partnerships	Prenatal – 2 years: 1st time parents & their children
	DC Children's Trust Fund	*Strengthening*	3 – 8 years: Parents

	[EP]	*Families Program*	
Home Visitation	DMH/ECCS ECMHC **[NP]**	*Incredible Years*	2 – 8 years: Children; their parents & caregivers
	Healthy Start **[EP]**	Parents-as-Teachers *Born to Learn*	Prenatal – 2 years: Parents
Integrating Behavioral Health Programs into Primary Care	DMH/ECCS ECMHC **[NP]**	*Incredible Years*	2 – 8 years: Children; their parents & caregivers
	ABCD/ECCS – Pediatric Community **[EP]**	*ASQ:SE*	6 months – 5 years: Children

[±]**Note:** ***EP*** indicates Enhanced Existing Program and ***NP*** indicates New Program.

Evidence that Adaptations will be Effective for Population

Each evidence based program (EBP) was chosen because it proved to have the strongest research evidence of preventing risk factors and strengthening families and protective factors. The EBPs selected also exhibited the strongest evidence of being successfully adapted to suit the needs, culture and beliefs of our targeted population: low-income African-Americans. DC's Project LAUNCH aims to promote the wellness of young children so they can thrive in safe, supportive environments and enter school ready to learn and able to succeed. By implementing the EBPs identified, the project will address the needs of DC's youngest residents in a holistic, seamless manner by identifying integrating behavioral health programs and increasing the use of developmental assessments in primary care; by having ***ASQ*** used as a routine screening tool through ABCD; and Healthy Start; the behavioral health concerns of children by implementing ***Incredible Years*** as part of the Early Childhood Mental Health Consultation (ECMHC) as well as ***Primary Project***; increasing access to care for children and their families identified at risk through ***Healthy Start Home Visitation Project***; ensuring that families have the skills they need to provide their children with the nurture and support they need by collaborating with DC Children's Trust Fund and implementing the ***Strengthening Families program, Incredible Years*** through ECMHC and ***Parents as Teachers*** through Healthy Start.

VII. Timeline

Table 3 provides a timeline for DC's Project LAUNCH and shows key activities, milestones and responsible staff for all proposed activities.

Table 3: Implementation Timeline

Activity	Responsible Party	Year 1	Y2	Y3	Y4	Y5
Build Infrastructure/Council on Youth and Child Wellness						
Hire YCWE, LCWC and EV	DOH, DMH	Q1				
Add stakeholders to CYCW	YCWE, LCWC, CYCW	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Develop MOU/MOA/LOC	YCWE, LCWC, CYCW	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Create program working groups	YCWE, LCWC, CYCW	Q1				
Bi-monthly CYCW mtgs/monthly working group mtgs	YCWE, LCWC	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Develop strategic plan	YCWE, LCWC, CYCW	Q1-Q2				
Implement program sustainability plans	YCWE, LCWC, CYCW	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Conduct Environmental Scan & Needs Assessment						
Purchase incentives for participation	YCWE	Q1	Q1	Q1	Q1	Q1
Develop interview protocols	YCWE, LCWC, CYCW, EV	Q1				
Conduct site visits/interviews to gather data	CYCW, YCWE, LCWC, EV	Q1-Q2				
Identify gaps/create linkages between early care community and health providers	CYCW, YCWE, LCWC, EV	Q1-Q2				
Produce unified scorecard report of early childhood indicators/outcomes	CYCW, YCWE, LCWC, EV	Q1-Q2				
Map existing early childhood resources	CYCW, YCWE, LCWC, EV	Q1-Q2				
Estimate economic impact of child development	CYCW, YCWE, LCWC, EV	Q1-Q2				
Submit strategic plan to SAMHSA	CYCW, YCWE, LCWC, EV	Q3				
Develop/update health promotion plan	CYCW, YCWE, LCWC, EV	Q3-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Create workforce development strategy	CYCW, YCWE, LCWC, EV	Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Participate in cross-site evaluation	CYCW, YCWE, LCWC, EV	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Implement Early Childhood Mental Health Consultation Activities						
Hire 3 Mental Health Consultants (MHC)	DMH, LCWC	Q1				
Develop/revise MOUs, letters of commitment and process flow for MHCs	DMH, LCWC, YCWE	Q1-Q2				
Analyze programs for cultural competence	DMH, YCWE, LCWC, EV	Q1				
Identify ECEs to participate	NC, YCWE, LCWC	Q1				
Purchase educational materials	YCWE, LCWC	Q1				

Train MHC/staff: *Incredible Years*	LCWC, consultant	Q1				
Train MHC/staff: EC MH Consultation	LCWC, consultant	Q1	Q1	Q1	Q1	Q1
Provide program to target pop.	MHC	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Implement evaluation tools	DMH, YCWE, LCWC, EV, MHC	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Collect data on health indicators	EV, MHC	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Submit data to CYCW	EV, MHC	Q4	Q4	Q4	Q4	Q4
Implement Strengthening Families Project						
Identify pilot project participants	NC, CYCW, YCWE, DCTF	Q1				
Develop/revise MOUs, letters of commitment and process flow for MHCs	SHCN, CYCW, YCWE, LCWC	Q1-Q2				
Purchase educational materials	YCWE, LCWC, DCTF	Q1				
Train DCTF staff: *Strengthening Families*	YCWE, DCTF, consultant	Q1				
Provide program to target pop.	DCTF	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Implement evaluation tools	DCTF, YCWE, LCWC, EV	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Collect data on health indicators	DCTF, EV	Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Submit data to CYCW	DCTF, EV	Q4	Q4	Q4	Q4	Q4
Implement Primary Project						
Identify program participants	DCPS, DMH, YCWE	Q1				
Develop/revise MOUs, letters of commitment and process flow for MHCs	DCPS, DMH, YCWE, CYCW	Q1-Q2				
Purchase educational materials	YCWE, LCWC, DMH	Q1				
Hire "child associates"	YCWE, LCWC, DMH, DCPS	Q1				
Train/recertify staff: *Primary Project*		Q1	Q1	Q1	Q1	Q1
Provide program to target pop.		Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Implement evaluation tools		Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Collect data on health indicators		Q2-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Submit data to CYCW		Q4	Q4	Q4	Q4	Q4
Implement Healthy Start Activities						

Develop sub-grant agreement with East of the River Collaborative	DOH, YCWE	Q1				
Develop/revise MOUs, letters of commitment and process flow for MHCs	DOH, CYCW, YCWE	Q1				
Identify 12 Healthy Start Community Health Workers (CHW) for *Born to Learn* training	DOH, YCWE	Q1				
Hire 2 Certified parent educators as CHWs	YCWE, DOH	Q1				
Purchase educational materials	DOH, YCWE	Q1				
Train/recertify CHWs/staff: *Born to Learn*	YCWE, consultant	Q1-Q2	Q1	Q1	Q1	Q1
Develop strategic plan for implementation	DOH, EV, YCWE, CYCW	Q3-Q4				
Home visits using ASQ for target pop.	DOH, CHW	Q3-Q4				
Collect data on pilot project families	DOH, CHW, EV, YCWE	Q3-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Implement evaluation tools	DOH, CHW, EV, YCWE	Q3-Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Submit data to CYCW	YCWE, EV	Q4	Q4	Q4	Q4	Q4
Implement ABCD Enhancement Project						
Educate providers about ASQ and Medicaid billing codes/rate	HCFA, YCWE, PA	Q1-Q4	Q1-Q4			
Implement policies to make child developmental screening standard practice	HCFA, YCWE		Q1			
Standardize referral process between pediatricians, MCOs and EI program	HCFA, YCWE, MCO, DMH		Q1			
Implement evaluation tools	HCFA, YCWE, EV		Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
Collect/analyze data on children 9, 18 and 24 months who were screened	HCFA, YCWE, EV		Q1-Q4	Q1-Q4	Q1-Q4	Q1-Q4
SUBMIT FINANCIAL STATUS REPORT		**Q4**	**Q4**	**Q4**	**Q4**	**Q4**
SUBMIT PROGRESS REPORT		**Q4**	**Q4**	**Q4**	**Q4**	**Q4**

ABCD-Assuring Better Child Health and Development; **ASQ**-Ages & Stages Questionnaire; **CYCW**-DC Council on Young Child Wellness **DCPS**-DC Public Schools; **DCTF**-DC Children's Trust Fund; **DOH**-Dept of Health; **DMH**-Dept of Mental Health; **HCFA**-Health Care Financing Admin; **MCO**-Managed Care Organizations; **EPSDT**-Early/Periodic Screening, Diagnostic & Treatment; **EV**-Evaluator **LCWC**-Local Child Wellness Coordinator; **MOU**-Memorandum of Understanding; **NC**-Neighborhood Collaboratives; **SHCN**-Special Health Care Needs Bureau; **YCWE**-Young Child Wellness Expert

VIII. *Unduplicated Number*

During year one of the grant the following services will be offered in Wards 7 and 8: **Primary Project** will be expanded to 3 additional schools and serve **240 children** (Primary Project in DC screens an average of 80 children per school). **Early Childhood Mental Health Consultation** will be implemented in 18 early childcare educational center/Head Start centers and serve **800 children** (on average, each center has 64 children enrolled); of those children 256 will be offered **Incredible Years.** The **Strengthening Families Program** will be offered to **100 families** (this is the target number established by the DC Children's Trust Fund based on their previous experiences with families). **PAT-Born to Learn** will be offered by through the Healthy Start Home Visitation Program to **300 mothers/families** (this is the target number established by the DC DOH Healthy Start Program based on their previous experiences with families). This is a total of **1,440**.

IX. *Target Population*

The DC Children's Trust Fund and DC Neighborhood Collaboratives were involved with the preparation of this Project LAUNCH grant application. Both organizations are community-based and through their existing work, and planning activities related to Project LAUNCH, have been in communication with the communities where services will be initially implemented. Through their own partnerships with community-based organizations, District agencies were able to discuss Project LAUNCH with their community-based partners and receive feedback. Additionally, the ECCS working group committee that has extensive representation from both governmental and community-based organization was also consulted in the development of this grant application. As a result, community members, family organizations and myriad of representatives have participated in the planning and design of Project LAUNCH activities. The DCPCA will also assist in the implementation of the project by marketing Project LAUNCH activities to their member organizations. Additionally, target populations from Wards 7 and 8 will be identified, recruited and retained by:

- Building on existing relationships with families.
- Compensating youth and family participants appropriately; offer appropriate incentives to aid in recruitment for programs.
- Assigning specific staff time to support family and youth participation in activities.
- Working with community-based organizations to involve family representation.

X. *Existing Systems*

DC has clearly demonstrated its early childhood focus with the establishment of ICSIC, developing the DC Child Health Action Plan, and the work done by ECCS and others. As a result of these larger city-wide initiatives, Project LAUNCH will incorporate and enhance existing systems/infrastructure when addressing its five priority areas.

1. *Developmental assessments in a range of child-serving settings*: The ABCD pilot project that encourages primary care providers to use ASQ for uniform developmental screening is one initiative of the ECCS. Additionally, DC DOH Healthy Start Home Visitation Project also uses ASQ. Project LAUNCH will build on existing successes of the ABCD project by expanding it to additional primary care physicians/pediatrician offices within Wards 7 and 8 and allowing more families and children to benefit from developmental screening.
2. *Integration of behavioral health programs and practices into primary care:* Besides the ABCD efforts mentioned in #1 above, Project LAUNCH also will partner with the CSHCN

3. *Home visiting programs* - This component will heavily depend on the existing system of the DC DOH Healthy Start Home Visitation Program that uses a modified version of the evidence-based practice of nurse-family partnerships. In addition to developmental assessments, the home visitation will be enhanced by incorporating the evidence-based program of *PAT-Born to Learn*. *Incredible Years* also will include home visitations.
4. *Mental health consultations* - Early Childhood Mental Health Consultation (ECMHC) is one of the key priority areas of the ECCS initiative. While the effort is not yet fully implemented, ECCS stakeholders have consulted extensively with Georgetown University, University of Maryland College Park and the Tulane Institute of Infant and Early Childhood Mental Health. Project LAUNCH will build on the existing infrastructure developed by ECCS stakeholders by implementing the program within early childcare centers and Head Start Centers within Wards 7 and 8, and also by incorporating the EBP *Incredible Years*. *Primary Project* also will include some consultation components, since it involves meetings with parents and staff in developing an intervention plan for children.
5. *Family strengthening and parent skills training* - Project LAUNCH will use the existing system/partnerships of ECCS (through the incorporation of the EBP *Incredible Years* within the ECMHC); DC Children's Trust Fund incorporating the EBP *Strengthening Families Program*; and the incorporation of the EBP *PAT – Born to Learn* into the existing Healthy Start Program.

Additionally, all neighborhood services will be coordinated through the Neighborhood Collaboratives to ensure that not only existing community systems are incorporated but also families and community members are involved in all phases of Project LAUNCH. Existing systems within DC agencies and community based organizations will continually be incorporated into Project LAUNCH initiatives as a result of regular meetings of DC CYCW.

XI. Groundwork for Timely Action

Project LAUNCH will build upon existing health, behavioral and social service systems to develop and implement all proposed plans for young child wellness. As part of the planning process, a wide variety of stakeholders met three times. Meeting objectives included:

1. Outline the objectives and goals of Project LAUNCH
2. Identify additional existing programs which promote the wellness of children ages 0-8 and discuss how these programs can be integrated into Project LAUNCH
3. Determine the missions, goals, and roles of stakeholders in Project LAUNCH
4. Identify the gaps in current services for children ages 0-8
5. Develop logic model (per Project LAUNCH specifications) for each program area
6. Identify existing data sources and determine how they can be linked

Project LAUNCH stakeholders have been active participants in the planning process by signing Letters of Commitment and committing to sign MOUs within 3 months. Table 4 (below) shows a list of organizations that have taken part in Project LAUNCH planning. For more details on all of the roles and responsibilities of stakeholders see Appendix 1, which contains a draft MOU and Letters of Support. All stakeholders are aware of this initiative's goals and objectives and are in support of the proposed activities. Additionally, the existence of a current ECCS implementation plan and environmental scan will serve as a template in the implementation of an environmental scan and development of a strategic plan for Project LAUNCH. Therefore all pre-planning

efforts will ensure that **implementation of services/projects (building on existing programs) will begin no later than six months after receiving funds**.

Table 4: Project LAUNCH Stakeholders

Category	Agencies & Organizations	Roles & Responsibilities
Intra-Agency	DC DOH-CHA; ECCS Initiative	• Collaborate with YCWE and LCWC to ensure Project LAUNCH activities incorporates ECCS initiatives
	DC DOH – CHA; Perinatal and Infant Health Bureau/ Healthy Start Program	• Implement *Parents as Teachers (PAT) Born to Learn*™ Program within Healthy Start program • Implement *ASQ:SE* as a developmental assessment • Enhance linkages with the ABCD Program to share ASQ data
	DOH-CHA Data Analysis & Program Eval. Division	• Provide technical support in the development of the evaluation and data collection component of Project LAUNCH
	DC DOH APRA	• Provide preventative/treatment services related to substance abuse to children and their families who are identified as "in-need" through LAUNCH services • Refer children and their families to Project LAUNCH services
Inter-Agency	OSSE: Early Care & Education Administration, Early Intervention – Infants and Toddlers Program & Child Care Licensing Division	• Provide additional screening and/or appropriate referrals through Part C for eligible children identified with developmental, social and behavioral delays through LAUNCH services • Implement uniform early ID and reporting system for children with developmental delays • Conduct uniform case management services for coordinating, collaborating and linking follow-up services • Identify appropriate licensed Early Childcare Educational Centers that are fully accessible, complaint with ADA and well known and available to the target population
	Department of Health Care Financing: Medicaid	• Provide technical support in the development of a marketing/educational campaign to make both providers and parents aware of the use of the ASQ and increased Medicaid reimbursement rates for utilizing this tool • Partner in the development of a sustainability plan by identifying possible mechanisms to reimburse services using Medicaid fund
	DC Department of Mental Health: Prevention & Early Intervention & School Mental Health Programs	• Train Early Childhood Mental Health Consultants in *Incredible Years* and *Parenting Wisely* programs • Implement ECMHC in ECEs and Head Start Centers to childcare staff, children and families • Conduct uniform mental, social, and behavioral health case management services for coordinating, collaborating and linking follow-up services • Conduct uniform data collection and reporting • Use standardized program reports to address challenges, barriers and accomplishments
	DC Public Schools: Early Intervention Services; Early Head Start/Head Start & School Readiness and Early Childhood Programs	• Create Head Start and pre-K classrooms that are complaint with ADA and well known and available to the target population • Collaborate with Project LAUNCH to enhance health care services for school-aged children (particularly mental health consultation) • Provide data on 3rd grade performance for children who have received comprehensive services • Implement uniform early identification and referrals to therapeutic services for children with developmental delays

		• Conduct uniform mental, social, and behavioral health case management services for coordinating, collaborating and linking follow-up services • Identify appropriate licensed Head Start Centers
	DC Child and Family Services Agency	• Identify children ages 0-8 who require child protective services, supportive family services, and foster care • Implement uniform early identification and reporting system for children requiring a continuum of mental, social and behavioral health care services • Conduct uniform case management services for coordinating, collaborating and linking follow-up services
Private Partnerships	Mary's Center – Healthy Start	• Implement *Parents as Teachers (PAT) Born to Learn*™ Program within Healthy Start • Implement *ASQ:SE* as a developmental assessment • Enhance linkages with the ABCD Program to share ASQ data
	Neighborhood Collaboratives	• Act as a liaison between Project LAUNCH and the communities to be served
	DCPCA	• Market Project LAUNCH initiatives amongst its members
	DC Children's Trust Fund	• Teach positive parenting using *Strengthening Families* program
	Private Practitioners – Pediatric Community	• Integrate behavioral health program into their practice by using *ASQ:SE* as a regular screening tool

XII. Potential Barriers to Success

Like other projects nationwide that emphasize linkages of existing systems, this initiative is a challenging one because its success will depend on the efforts of many different providers, each with its own vested interest in continuing business as usual. In any organization, change is difficult; in a system of so many cooperating parts, the difficulties increase exponentially.

Management Challenges: Within the last few years, DC agencies have experienced numerous changes in leadership. Although there have been attempts to maintain a sense of programmatic continuity within the public agencies when leadership turns over, many stakeholders suffer from "planning fatigue." To address this challenge, the DC CYCW will meet monthly and report directly to the mayoral level; the council's status as a sub-committee of ICSIC ensures that its voice will be heard in the executive offices. This level of mayoral attention will serve as a buffer from many of the negative effects of frequent management changes.

Family Engagement: In the past, families have complained that their voices have not always been heard. This project will resolve these challenges by:

- Building on existing relationships with families; for instance, enlist the family representatives who participated in other Collaboratives or other family advocates associated with other DC Agencies (e.g. OSSE; CFSA and DMH)
- Partnering with community-based organizations (e.g. DC Children's Trust Fund and the Neighborhood Collaboratives) who will be a part of the DC CYCW and will train and develop family leadership
- Compensating family participants and reimburse for transportation and child care as needed

Partnerships: Potential partners typically have their own organizations to manage and their clients to serve, often making it difficult to convince them to coordinate and integrate services in the absence of additional funds. Fortunately, Project LAUNCH stakeholders currently participate in several on-going efforts, such as ECCS and ICSIC, which are beginning to show positive results in the area of coordination and integration. Continued involvement in these efforts will

nurture the working relationships that have been established at the staff level and will bridge organizational barriers.

Internal Contracts Process: Issuing contracts, Memoranda of Understanding and other contractual documentation can be challenging. However, once the program receives the Grant Award Notification the staff will complete and gain necessary approval for contractual documentation, for the contracts to be generated by the beginning of the fiscal year which begins Oct 1, 2009 or shortly thereafter.

XIII. Project Sustainability

DC has, and will continue to, prioritize the wellness of children. DC has demonstrated its commitment to promoting the wellness of young children so they can thrive in safe, supportive environments and enter school ready to learn and able to succeed by: (1) establishing ICSIC, which serves as a coordinating body for all District services for children.; (2) developing the Children's Health Action Plan, which provides strategies to improve the health of District children in eight major health areas including obesity, asthma, substance abuse, lead, well-child visits, infant mortality, oral health, HIV/AIDS and other STDs; and (3) continuing to support child serving agencies such DC DOH, which houses ECCS and Healthy Start, and DC DMH, which houses the School Mental Health Program. Additionally, the District has increased its overall spending on children by 6.8 percent from FY 2008 to FY 2009.

By implementing Project LAUNCH, DOH will create an opportunity for stakeholders to work even closer with existing early childhood systems such as ECCS and Title V programs through structured groups such as the DC CYCW that will report directly to the mayoral level through ICSIC, thus helping to protect LAUNCH from of the negative impact associated with leadership/staff turnover. The DC CYCW will develop a five-year strategic plan that will address sustainability, including how to handle turnover in key roles.

Several of the Project LAUNCH activities are expected to be self-sustaining when the grant period ends in 2014, resulting in:

- Intensified collaboration and strengthened partnerships (e.g. regular meetings of the DC CYCW and sub-committees)
- Continued planning among the DC agencies and the DC CYCW
- Increased cost-sharing and innovative use of existing resources (e.g. existing funding streams highlighted through the environmental scan and needs assessment)
- Continued development and/or renewing/revising of interagency agreements and MOUs
- Cross-training among partners and utilization of train-the-trainer programs (e.g. Community Health Workers training other parents using *PAT Born to Learn*™ Program)
- Collaboration for the development and implementation of outreach and education campaigns
- Pursuing Medicaid billing options for early childhood mental health consultation with DHCF and cost-sharing options with OSSE and DCPS. In years 4 and 5, potential options will be explored so that reimbursements can be received for up to 50% of the consultant's time.

Project LAUNCH also will produce increased data about the wellness of children ages 0-8 and their families. This data will more clearly articulate the needs of this population and will guide the development of more effective ways to raise funds and sustain project activities beyond their designated end dates. In recent years, DC has implemented the Safe Passages Information System (SPIS) aimed at integrating all data systems throughout the District. Project LAUNCH

will work closely with SPIS to ensure that data about children and families is shared in an efficient and timely manner without violating privacy regulations.

SECTION D: Staff & Organizational Experience

This grant application is submitted by the DC Department of Health Community Health Administration (CHA), which administers the Title V Block grant and is the designated unit for adolescent, child, and family health related activities within DC DOH. CHA has six bureaus under its jurisdiction:

- Child, Adolescent & School Health Bureau (CASH)
- Cancer & Chronic Disease Prevention Bureau
- Pharmaceutical Procurement & Distribution Bureau
- Perinatal & Infant Health Bureau
- Nutrition & Physical Fitness Bureau
- Primary Care Bureau

I. Capability of State & Local Entities

Through an environmental scan, a capacity assessment effort, the adoption of guiding principles and practices, development of firm cross-functional partnerships and the collective achievements of the past year, the ECCS Initiative has developed a strong foundation on which to continue building lasting successes. Priority focus in the coming year will be on:

- Heightening public awareness of the importance of the early childhood period, using the Department of Health web site as well as online resources of partner organizations
- Supporting DOH-CHA in developing a common data port through which information can be shared and linked with existing Medicaid and other agency databases
- Reinstating the use of child care health consultants – mental health, oral health, general health – to provide on-site supports to child care facilities
- Contributing to building of a cross-trained and integrated early childhood work force in order to produce the best outcomes for children and families
- Facilitating more effective linkages among existing early childhood planning groups
- Supporting the development of statewide child health indicators for children ages 0-8
- Supporting ongoing efforts of existing early childhood planning groups such as the Universal School Readiness Stakeholders Group (USR), the Deputy Mayor for Education's Work Group on Early Childhood Education, and others
- Assisting in maximizing the use of Head Start programs for eligible children and families
- Encouraging the use of standardized developmental screening tools for earlier identification of children with delays.

II. List of Project LAUNCH Staff and Their Demonstrated Experience

CHA, under the leadership of Dr. Carlos Cano, is the Department of Health's designated unit for family health related activities. CHA consists of two main offices (Program Support Services and Grants Monitoring and Program Evaluation) and six bureaus (listed above). CHA plans, coordinates, manages and evaluates health programs and services targeting children and families. CHA also is responsible for administering the Title V Maternal and Child Health Services Block Grant. The ECCS project is currently housed within the Child, Adolescent & School Health Bureau (CASH). This group has been responsible for managing the planning and implementation of the ECCS grant since May 2006. Other units within the Administration, such as the Data Collection and Analysis Division within the Grants Monitoring and Program Evaluation Office, will continue to support CASH in its effort during the coming years.

Alvaro Simmons, MS.Ed., MSW, LCSW, ACSW is the CASH Bureau Chief and will provide general oversight of the project. He is responsible for the development of state-wide child,

adolescent and school health plans: policy development, monitoring, implementation, and program evaluation of School-based Health Centers; policy development, coordination and administrative oversight of the School Health Nursing Program, including management and implementation oversight of contracts and/or other agreements entered into with organizations providing direct services to students under the program. Prior to this appointment in March 2009, he served as Chief Operating Officer of Mary's Center for Maternal and Child Care in Washington DC.

The YCWE – to be hired – will serve as project director and is responsible for providing coordination of the District's young child wellness efforts through work with the DC CYCW. The person selected for the job will have expertise in the public health approach and early childhood development and will serve as the official responsible for the fiscal and administrative oversight of Project LAUNCH. If the project is funded, the YCWE position will be filled before the end of September.

Shana Bellow, Ph.D. is a Clinical Psychologist with the DC Department of Mental Health School Mental Health Program (SMHP) and will act as the Local Child Wellness Coordinator (LCWC) and will work closely with the YCWE. Her core responsibilities will be the development and implementation of programs and activities, particularly the Primary Project program and early childhood mental health consultation efforts, assisting with the creation of a strategic plan, and establishing inter-agency collaborations.

Ginny Hsieh, Ph.D., MPH will lead the internal Data Analysis and Program Evaluation Unit to support Project LAUNCH activities. Dr. Hsieh recently joined CHA and is responsible for ensuring all grants and programs within CHA are meeting evaluation protocols, and for providing technical assistance to program staff and sub-grantees. She received a Ph.D. in health services research from Johns Hopkins, and she completed a Post-Doc fellowship at National Cancer Institute in program evaluation and outcomes research. She has had work experience in the healthcare provider settings, federal government, as well as research institutes.

Deborah Perry, who will provide evaluation services on a contract basis, has a Ph.D. in maternal and child health and a master's degree in psychology. She has served on the faculty of the Georgetown University Center for Child and Human Development for nearly a decade, has written numerous peer-reviewed articles and translational publications, and has given more than 50 national trainings, presentations, and lectures on a wide variety of maternal and child health and early child development topics. Dr. Perry's research focuses on community-based participatory approaches to designing and testing preventive interventions for young children and their caregivers. She has delivered technical assistance to states and communities on building systems of care for young children and families as part of: the National Early Childhood technical Assistance System; the National Technical Assistance Center for Children's Mental Health; and in collaboration with Project THRIVE.

The YCWE and LCWC will meet weekly in the initial phases of Project LAUNCH and bi-weekly once activities are solidified. They will both participate in all DC CYCW general and sub-committee meetings. The LCWC also will work closely with the Neighborhood Collaboratives and other community-based organizations. Section H contains further details pertaining to Job Descriptions and *c.v.* of key project staff.

III. *Resources Available at the Local Level*

The Neighborhood Collaboratives, DCPS (Head Start/Early Head Start), OSSE Childcare Licensing Division and other stakeholders will work with Project LAUNCH to identify early childcare educational centers and Head Start centers that are appropriate and licensed (with an appropriately equipped playground, if possible). These partners also will collaborate in identifying appropriate community-based centers for parental educational classes. All facilities used will be fully accessible, compliant with ADA and familiar to residents of Wards 7 and 8.

Section E: Evaluation

The Project LAUNCH budget includes a line item for salary for a 0.5 FTE staff evaluator, who will be hired to manage all aspects of Project LAUNCH evaluation. In addition, project staff and stakeholders will play an essential role in the evaluation process, as will academic partners at the Georgetown University Center for Child and Human Development. Multifaceted designs will be used to assess the Project LAUNCH infrastructure, activities, implementation of evidence-based programs, and their impact and sustainability; expert evaluators will guide the design of data collection strategies. The proposed evaluation plan will include three major components: process, outcome and cost evaluations.

I. *Process Evaluation*

Project LAUNCH process evaluation will examine staffing, training, fidelity of implementation, collaboration, program capacity building, and sustainability. Questions asked will include:

- To what level of adherence are the evidence-based models implemented in DC? Are study protocols being observed properly?
- What type, frequency, and duration of training are provided to staff? Do the trainings meet the requirements of the programs' creators?
- What are the frequency and duration of services implemented at each site? Are the children getting all the interaction and encounters they are due?
- What percentage of the target population do the programs reach? Can improved recruiting help bring the service to more children?
- What are the barriers to success at each service site? How can those barriers be overcome?
- Describe type, frequency, duration and dates provide of public awareness activities that increase knowledge about child wellness.

Process evaluation activities will be carried out as follows:

- Project team and the stakeholders will meet monthly (or as needed) with evaluators to discuss any evaluation-related issues.
- Standardized, rigorous evaluation protocols will be observed, and the evaluator will provide cross training on data collection and confidentiality issues to all staff involved.
- Cultural sensitivity issues impacting evaluation will be assessed to help the participating sites work more successfully with families and children.
- Analysis of successes and challenges in recruitment or various staff training activities will be shared with participants and stakeholders.
- Team meetings will yield qualitative data that can be used to interpret program impact so that reasonable conclusions can be drawn regarding the ultimate outcomes of program participation that can last up to five years.

II. Outcome Evaluation

Project LAUNCH outcome evaluation will include both an assessment of the overall collaborative system and independent assessments of individual program effectiveness of each of the evidence-based models adapted to the DC environment.

For the overall system outcomes of Project LAUNCH, the evaluation will focus on measures identified in the project logic model for clients, providers, referral sources, and the larger child wellness system as a whole. The Government Performance Results Act (GPRA) outcomes measures and indicators will be incorporated into data collection instruments and included in the outcome evaluation.

Short-term and intermediate outcome variables will be selected based on specific program elements to determine what appropriate child and family assets, risk and protective factors, family communication skill levels, family literacy levels, family functioning, and other indicators can be efficiently measured. For example, the success of *Incredible Years* will be measured by its ability to reduce the number of children with mental health and behavioral issues. Comparison studies will be conducted whenever useful and feasible.

Appropriate statistical tests will be determined to assess the effects of each program and the overall impact of the collaborative. The evaluation will compare outcome measures of the target populations before the program participation and at different points following program completion.

III. *Cost Evaluation*

The cost per person at the programmatic level, averaged over the life of the project, will be estimated more accurately after the environmental scan to take place within the first six months of Project LAUNCH. The program costs of all the stakeholders and participating agencies will be tallied and the total number of children ages 0-8 in the District of Columbia will be estimated over the same period. After reviewing the cost of implementing the program across various populations served, the average cost can be derived from diving the program costs by the number of recipients. The average benefit also can be calculated from dividing by each child the estimated savings to the system when children enter school healthy and ready to learn.

IV. *Data Collection and Management*

The evaluator will work with program leadership to develop ongoing process evaluation activities that can regularly inform program improvement strategies. This will occur through data analysis, interviews, observations, document review, checklists and stakeholder surveys implemented on a regular basis.

As a first step after the grant award, stakeholders will further clarify the collaborative objectives and benchmarks that represent a successful accomplishment of the goals, and will refine the logic model to describe the major categories of outcomes. At that point, they will develop a more detailed evaluation plan, include an inventory of resources needed to successfully meet benchmarks and timelines, as well as a list of individuals responsible for each task.

While the DC Council on Young Child Wellness will collaborate on an environmental scan to map out services and funding streams, the evaluator is expected to develop additional collection strategies and a comprehensive data framework. Data collection instruments are expected to include the following: (1) documentation of system barriers and facilitators, (2) collaborative activities, (3) stakeholder interviews, and (4) surveys of providers, families and children. These instruments will be used to collect both qualitative and quantitative data. The data collection,

management, analysis and reporting to the stakeholders will be reviewed and expanded accordingly.

The data collection instruments and the protocols shall include GPRA outcomes measures and other instruments provided by SAMHSA. Evaluation forms and instructions will be prepared for staff implementing the evidence-based programs, and staff will receive training on the instruments. Project LAUNCH data analysis will start within a year, and formal results will be reported annually. Complementary continuous quality improvement updates with the project team and stakeholders will occur monthly and quarterly.

V. Assessing the Quality of Implementation

The process evaluation will introduce measures for each specific evidence-based program to monitor the fidelity of implementation, as well as the validity of the local adaptations. A sample of participants will be asked to complete program-specific fidelity instruments. Clinicians, child associates, teachers, administrators, and referral providers will be scored on their fidelity measures and will be interviewed for their knowledge and adherence to protocols, processes, treatment, referral, and case management techniques. Fidelity of the programs also will be assessed using on-site observations, focus groups, and periodic completion and analysis of program implementation checklist instruments at various sites.

The evaluators are expected to use modified participatory methods of evaluation to establish avenues of feedback both within and outside of the project. Both the process and outcome evaluation data will be reported regularly to inform strategic planning and quality improvement activity by Project LAUNCH. Both the curricula and the evaluators' materials, including pre- and post-test assessments, will be adapted to ensure cultural competency. The evaluation team will make adaptations based on input from program staff and administrators, parents, and other community members.

VI. Ensuring Continuous Quality Improvement

Specific process, output and outcome measures for the proposed project are identified within the logic model. The proposed logic model incorporated quantifiable and measureable objectives that will be closely monitored by YCWE and LCWC as well as the Project LAUNCH evaluator. Utilizing customary performance improvement methodologies, the staff responsible for monitoring the Continuous Quality Improvement (CQI) process will evaluate the performance of the project's activities and recommend alternative action as necessary. DC DOH anticipates that the evaluation of the proposed project will demonstrate a significant health status return on investment.

Process data will be reviewed at the monthly meetings with the YCWE, LCWC and evaluator. The evaluator and project director will lead discussions to identify data elements and review analyses to guide future project planning and decision-making. Indicators for quality will be selected using the Results Based Accountability method for community change initiatives, and will be revisited regularly to assess whether real change is occurring.

VII. Collecting and Reporting on Required Measures

Project LAUNCH will employ an evaluator who has extensive experience working on federal grant programs, especially demonstrating the ability to conduct, document, and report on assessment activities using SAMHSA's web-based GPRA system. DC DOH's evaluator also will

work with the national cross-site evaluation contractor to collect and share cross-site data on processes, outcomes and costs.

Within the first six months of the grant period, the evaluator will set up a team to oversee and monitor all evaluation activities according to a specific timeline that captures all relevant performance measures through both the process and outcome evaluations. The performance measures applicable to both the cross-site evaluation as well as DC-specific evaluation shall include but not limited to:

- Measures of infrastructure development, collaboration, and coordination
- Surveys of change in knowledge, attitudes and behavior among parents, educators, physicians and early childhood caregivers as a result of training, education and/or consultation efforts
- Measures of child development, including individual assessments of program participants
- Measures of community awareness of young children's wellness
- Other information related to Project LAUNCH activities

A participatory evaluation method will enable team members to communicate regularly with the clients, consumers and family advocates, sharing interim findings and receiving feedback on the cultural aspects of the project. The evaluator will participate in all project management and advisory group meetings, provide monthly reports on the progress of evaluation activities, and prepare quarterly and annual reports.

SECTION F: Literature Citations

(1) *Briefing Paper on the 2000 IM rate for the District of Columbia*, DC DOH State Committee for Health Statistics Administration, 2002.

(2) *Selected Birth Data By Ward: District Of Columbia Residents*, DC DOH State Committee for Health Statistics Administration, 1998.

(3) OSEE ECEA Child Care Profiles. http://www.seo.dc.gov/seo/cwp/view,a,1224,q,561963,seoNav,|31193|.asp

(4) DC Office of Planning/State Data Center using block group data provided by Caliper Corporation to derive ward data.

(5) http://neighborhoodinfodc.org/wards/wards.html

(6) The District of Columbia's Mayor's Advisory Committee on Early Childhood Development – Health Promotions Subcommittee – Early Childhood Mental Health Task Force Issue Brief. 2006

(7) The District of Columbia's Mayor's Advisory Committee on Early Childhood Development – Health Promotions Subcommittee – Early Childhood Mental Health Task Force Issue Brief

(8) The Incredible Years: Parents, Teachers and Children Training Series. http://www.incredibleyears.com

(9) SAMHSA's Guide to Evidence-Based Practices. www.samhsa.gov/ebpwebguide.

(10) Stratton-Webster, C. Unpublished manuscript. *Adapting the Incredible Years according to the Developmental Needs of the Children*.

(11) Youth Policy Institute, *Key Findings from a Study of School Adjustment of Students from Pre-School through the Third Grade*.

(12) Webster-Stratton, C. 2007. Unpublished manuscript, University of Washington, Seattle *Affirming Diversity: Multi-Cultural Collaboration to Deliver the Incredible Years Parent Programs*.

(13) Ages & Stages Questionnaires: A Parent Completed, Child-Monitoring System Development Check for Children Ages Birth to 5 Years. http://asq.uoregon.edu

(14) Ages and Stages Questionnaire. http://www.agesandstages.com/research/index.html

(15) FindYouthInfo.gov. http://www.findyouthinfo.gov/cf_pages/programdetail.cfm?id=396

(16) http://www.strengtheningfamiliesprogram.org/docs/detailed_info.html

SECTION G: Budget Justifications
SAMHSA – Cooperative Agreements for Linking Actions for Unmet Needs in Children (Project LAUNCH)

I.	**PERSONNEL**	**$396,085**
	District	*$356,240*
	Evaluation	*$39,845*

The positions recommended are based upon the specific requirements of the activities contained in the proposal from the Substance Abuse and Health Services Administration. The salary is based upon the classification of positions within the District of Columbia's Personnel and Wage System.

District

Young Child Wellness Expert (*1.0 FTE @ $76,996*)
The Young Child Wellness Expert is responsible for serving as a liaison between the DC government and the Project LAUNCH Steering Committee and overseeing all activities associated with this initiative by performing the following duties:

- Serves as Project Director for providing coordination of State-Level young child wellness efforts through work with the Steering Committee
- Serves as a liaison to other State officials and agencies to support young child wellness
- Develops and implements comprehensive strategic plan addressing young child wellness
- Develops interagency involvement in the initiative's structure and process by developing and/or changing interagency agreements and other public policies relevant to goals of the Project
- Conducts and coordinates consultation to identify and assess community needs and expectations
- Serves as the bridge between DC agencies and funded community to provide coordination and technical assistance to the Local Child Wellness Coordinator
- Serves as the official responsible for the fiscal and administrative oversight of Project LAUNCH
- Consults and works with key stakeholders, including service providers, to facilitate Project
- Responds and make recommendations to the Child Wellness Coordinator as appropriate about any issues and trends
- Develops project status reports systems to ensure coordination of all projects for the Director of the Department of Health and identifies any deviations from plan in terms of time, budget and other resource requirements

Local Child Wellness Coordinator (*1.0 FTE @ $88,545*)
The Local Child Wellness Coordinator works in close collaboration with the Young Child Wellness Coordinator and is responsible for overseeing the development and implementation of all activities, particularly mental health consultation, and ensuring that all activities have a mental health component by performing the following duties:

- Develops and implements program structure for early childhood mental health consultation and other evidence-based young child wellness activities.
- Hires staff to work as early childhood mental health consultants at the local level.

- Manages interagency collaborations with key stakeholders including but not limited to health, schools, childcare providers, Child and Family Services, Head Start, Medicaid Administration, and Health Care Professionals including physicians.
- Provides and supervises the direct early childhood mental health consultation services to childcare providers/facilities.
- Manages the implementation of all early childhood wellness strategies outlined in the project.
- Communicates with the Project LAUNCH Steering Committee and other stakeholders to keep them apprised of all wellness activities.
- Provides training to childcare, mental health, and health staff on early childhood mental health.
- Coordinates with local university graduate programs for the placement of student externs/interns in wellness activities to build early childhood consultation workforce.
- Supervises intern/extern placements.
- Makes recommendations to the Young Child Wellness Expert as appropriate about local issues and trends.
- Participates in ensuring coordination of care for youth identified at risk and their families and evaluates, plans, and helps address system-level barriers that prevent continuity of services.

Evaluator (*0.50 FTE @ $79,690*)
The Evaluator will be responsible for coordinating all activities pertaining to designing and implementing comprehensive evaluations for Project LAUNCH initiatives; the data collection, and development of performance measurements; and performance assessment. Incumbent will work closely with the contractual evaluator and provide oversight in developing/conducting the needs assessment and environmental scan and contributing the development of a strategic plan by performing the following duties:

- Analyze services within the context of policy, assessing program effectiveness in relation to public and private expenditures.
- Develop data collection and analysis plans to monitor Project LAUNCH program activities.
- Design and conduct program evaluations to assess the performance and effectiveness of Project LAUNCH's initiatives.
- Develop and implement methods for periodic review and updating of data collection methodology in concert with DC Council on Young Child Wellness, the Young Child Wellness Expert, the Local Child Wellness Coordinator, and the contractual Evaluator.
- Provide effective technical assistance and consultation to the Administration related to data collection and reporting protocols, development of performance measures specific to each program and the development of program evaluation designs.
- Interpret data and prepare written reports as needed drawing conclusions about program effectiveness identifying potential reasons for the results.
- Provide accurate and appropriately referenced information in response to data requests.
- Assess the need for early childhood services and their geographical distribution in the District of Columbia.
- Identify program weaknesses and strengths based on research and evaluation results and work with programs in a collaborative manner to understand the reasons for the results to develop practical alternatives and innovative approaches to improve service delivery.
- Collaborate with consultants for specific writing and program evaluation purposes.
- Develop and/or maintain grant planning and development tools, reporting requirements, and review/evaluation techniques.

Early Childhood Mental Health Consultant (*2.0 FTE @ $79,690*)
The Mental Health Consultant works in close collaboration with both the Young Child Wellness Coordinator and Local Child Wellness Coordinator. The incumbent provides prevention, early intervention and treatment services for children birth to age 8 years of age, including consultation to identified childcare facilities by performing the following duties:

- Provides childcare facility staff with recommendations regarding social-emotional climate and interventions to improve social, emotional and behavioral functioning of the children.
- Assesses and evaluates students and their families and establishes social work goals and objectives in relation to psychiatric diagnosis, and recommends treatment.
- Obtains and writes comprehensive psychosocial assessments and individualized treatment plans. Provides comprehensive social work services to students and their families through evaluations of their problems.
- Provides individual, group and family treatment to children and their families, utilizing specific techniques and other clinical modalities to assist students and their families with social problems and concerns.
- Provides crisis intervention services and assists with the development and implementation of individual child and childcare center-wide crisis interventions.
- When applicable, serves as a member of the multidisciplinary team based within a childcare center or school, presenting results of comprehensive assessment and proposing intervention and therapeutic strategies. As part of the team, establishes long and short-range goals and objectives for students and their families and makes recommendations to the team as a part of the treatment planning process.
- Works collaboratively with other health or childcare professionals in the childcare facility and other center staff while adhering to all laws, policies, and regulations regarding confidentiality.
- Provides case management services to students and their families. Identifies, coordinates, connects, and refers students and their families to community based services or linkages to outside agencies that provide the identified service. Determines eligibility for needed or required services and monitors referrals.
- Makes community and home visits when necessary for the purpose of ensuring continuity of care and to provide outreach services.
- Completes statistical reports of clinical activities on a monthly basis, and provides other reports as required.

Health Promotions Educator (*1.0 FTE @ $31,319*)
The Certified Parent Educator will implement the *Born to Learn* curriculum to provide evidenced-based, home-visiting curriculum that promotes optimal child development and positive parent-child relationships, while delivering developmental, hearing and vision screenings to ensure early identification of developmental delays and significant health concerns. Duties will include:

- Participates in all *Born to Learn* training activities and any other career development tools
- Conducts community outreach activities targeted at specific populations for the purpose of encouraging participation of pregnant women, parenting women and their "families" in the D.C. Healthy Start project using the *Born to Learn* curriculum
- Develops trusting relationships with indigent women and their families and motivates them to enter and continue themselves and their children into health care.

- Conducts case finding and community outreach by locating new and expectant mothers and their families through neighborhood contacts, prenatal and OB/GYN clinics, or direct referrals to the program.
- Plans and conducts community-based meetings for the purpose of providing support and information to project area residents.
- Enters specified data on case management forms.
- Refers identified females to the D.C. Healthy Start Nurse Case Manager for indicated services.
- Promotes health among project participants through reinforcement of appropriate health education topics, in accordance with established health education protocols.
- Maintains records on all identified females and a log of daily schedule.

II. FRINGE BENEFITS (*17.95% of Salary*) **$71,097**

District *$63,945*

Evaluation *$7,152*

The government of the District of Columbia sets the fringe benefit rate of 17.95%. The following are the components included in the fringe benefit rate for employees of the District of Columbia.

District

Benefit	Rate	Young Child Wellness Expert	Local Child Wellness Coordinator	Mental Health Consultants (2)	Health Promotions Educator
GRP Life Insurance	0.13%	$100	$115	$207	$41
Health Benefits	6.58%	$5,066	$5,826	$10,487	$2,061
Retirement Contribution – FICA	4.10%	$3,157	$3,630	$6,535	$1,284
Retirement Contribution – CIVIL	2.94%	$2,264	$2,603	$4,686	$921
Optical Plan	0.11%	$85	$97	$175	$34
Dental Plan	0.45%	$346	$398	$717	$141
Medicare Contribution	1.10%	$847	$974	$1,753	$345
Retirement	2.52%	$1,940	$2,231	$4,016	$789
DC Health Benefit Fees	0.02%	$15	$18	$32	$6
TOTAL	**17.95%**	**$13,821**	**$15,894**	**$28,609**	**$7,152**

Evaluation

Benefit	Rate	Program Evaluator
GRP Life Insurance	0.13%	$41
Health Benefits	6.58%	$2,061
Retirement Contribution – FICA	4.10%	$1,284
Retirement Contribution – CIVIL	2.94%	$921
Optical Plan	0.11%	$34
Dental Plan	0.45%	$141
Medicare Contribution	1.10%	$345
Retirement	2.52%	$789

DC Health Benefit Fees	0.02%	$6
TOTAL	**17.95%**	$5,622

III. INDIRECT COSTS (*46.5% of Personnel Costs)*
Personnel costs in the District of Columbia incur a rate of 46.5% for indirect costs.

District

Total Personnel Costs (Salary + Fringe Benefits)	$420,185
Indirect Costs (@ 46.5%)	$195,386

Evaluation

Total Personnel Costs (Salary + Fringe Benefits)	$46,997
Indirect Costs (@ 46.5%)	$21,854

IV. CONTRACTUAL SERVICES **$154,079**
District *$109,079*
Evaluation *$45,000*

District

	Contractual	**In-Kind from DMH**
Early Childhood Mental Health Consultation Training	$6,500	$0
Primary Project		
6 – 0.45 FTE	$59,979	$0
Strengthening Families Program (SFP)		
SFP Training	$4,000	$0
2 – 0.5 FTE SFP Community Workers	$11,200	$0
SFP Material	$3,400	$0
Incredible Years Curriculum		
Training	$6,000	$0
Dina Dinosaur Tool Kit	$0	$1,150
Basic Parent Training (3 - 6 Year Old Tool Kit)	$0	$1,455
Basic Parent Training (Baby & Toddler Tool Kit)	$0	$1,295
Incredible Years Pre-Post Evaluation Survey Tool	$0	$1,000
Born to Learn Curriculum		
Travel	$2,500	$0
Training Day	$7,000	$0
Curriculum	$4,500	$0
ABCD Screening Initiative	$4,000	$0

1. **Early Childhood Mental Health Consultation Training** – Mental Health Consultants and any other necessary staff will receive Early Childhood Mental Health Consultation Training. This will be done by a contractual individual/organization. Early Childhood Mental Health Consultation is also one of the main focus areas of the DC Early Childhood Comprehensive Systems (ECCS) therefore, the ECCS will supplement any needed resources. This training will be offered during years 1 - 4. The Early Childhood Mental Health Consultation Training will be

conducted in a train-the-trainer model therefore fewer resources will be spent on it in subsequent years of the project ($2,000 per year in years 2 – 4).

2. **Primary Project** – 6 – 0.45 FTE Child Associates will be contracted to provide child play therapy sessions under supervision for 18 hrs per week for 39 weeks. The purpose of Primary Project is a school-based early intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade who have social or emotional school-adjustment difficulties (but not serious dysfunction).

3. **Strengthening Families Program** (SFP) – 2 0.5 FTE SFP Community Workers will be contracted to implement the SFP program. SFP Community Workers will receive training on the SFP evidence-based model and appropriate material purchased. SFP is a 14-session, evidence-based parenting skills, children's life skills, and family life skills training program specifically designed for high-risk families. DC's Project LAUNCH will utilize curriculum which focuses on the following groups: 3-5 years, 6-11 years (addressing the 6 – 8 years population).

4. ***Incredible Years* Curriculum** – Mental Health Consultants and any other necessary staff will be trained in the *Incredible Years* curricula. The *Incredible Years* provides three curricula for parents, teachers, and children. Its goals are to (1) promote emotional and social competence; and (2) prevent, reduce and treat aggressive, defiant, oppositional and impulsive behaviors in young children. Components of the program cover children from two to eight years and their families providing structured thematic training sessions. The family component helps parents/guardians to identify children's problem behaviors, develop positive strategies to correct behaviors and foster positive family communication. Funds will be used to provide the training for staff (which includes travel expenses for the *Incredible Years* trainers) and purchasing necessary tool kits. $1,000 will also be spent each year of the grant period to purchase and implement Pre-Post Evaluation Survey Tool.

5. ***Born to Learn* Curriculum** – Certified Parent Educators will be trained in the *Parents as Teachers (PAT) Born to Learn*™ program which is an evidenced-based, home-visiting curriculum that promotes optimal child development and positive parent-child relationships, while delivering developmental, hearing and vision screenings to ensure early identification of developmental delays and significant health concerns. The *Born to Learn*™ program has three core curricula: (1) *Born to Learn*™ *Curriculum Prenatal to 3 Years*; (2) *3 Years to Kindergarten Entry*; and (3) *2 Years to Kindergarten Entry*. Funds will be used to provide the training for staff (which includes travel expenses for the *Born to Learn* trainers and the actual cost of training each day) and purchasing necessary tool kits. In Years 2 – 5, $525 will be used annually to recertify those who received training in the curriculum.

6. **ABCD Initiative** – The Assuring Better Child Health and Development (ABCD) Childhood Developmental Screening Initiative pilot project aims to (1) implement policies and practices that will move the use of standardized childhood developmental screening tools as a part of well-child care from a "best practice" to a "standard practice" and (2) standardize referral process between DC pediatric providers, Medicaid Managed Care Organizations (MCOs), and early Intervention Program. Funds will be used to host forums to educate providers about (1) Ages and Stages Questionnaire (the standardized screening tool being used by ABCD); and (2) the fact that

CPT 96110 and 96111 and the EPSDT rate will now be reimbursed by Medicaid. It is expected that Project LAUNCH education will reach its educational target, therefore funds will not be provided in years 3 – 5 of this project. Data will however continue to be collected to determine the number of children 9, 18 and 24 months who are receiving standardized screenings.

Evaluation

Contractual Evaluator	**$45,000**

1. **Evaluator** – A consultant will be acquired who will provide support to the 0.5 FTE Evaluator in the management of data collection and evaluation activities. This will include conducting a needs assessment and environmental scan (including a financial map); developing a strategic plan; providing technical assistance in utilizing the comprehensive strategic planning approach in planning and implementing all activities; and leading DC's Project LAUNCH initiative in participating in the national cross-site evaluation.

V. OTHER **$11,500**

District *$11,500*
Evaluation *$0*
In-Kind *$1,500*

	District	In-Kind
Primary Project		
Materials & Therapeutic Supplies	$3,350	$1,500
Local Travel (Travel for 3 within Washington DC Area)	$1,000	$0
General Office Supplies	$1,500	$0
Desktop Computers (2)	$2,650	$0
Printers (2)	$1,000	$0
Incentives	$2,000	$0

Primary Project – Materials and therapeutic supplies will be purchased. The Child Associates will use them during play therapy sessions with children. Materials and therapeutic supplies will include a variety of informational booklets and manuals, expressive toys and materials (e.g. art media, building toys, imaginative toys).

As required by the Project LAUNCH grant, at least three members of the grantees' team are expected to attend mandatory meetings in Washington DC area. The YCWE, LCWC and the Project Director will all attend these meetings.

Office supplies will be purchased to be used by all Project LAUNCH staff. These will be used for regular daily use as well as for any community-based events (such as forums, family/parenting sessions etc.). Two desktop computers and printers will be purchased for the new 1.0 FTE hires.

Appropriate incentives will be purchased to acknowledge participants who voluntarily participate in Project LAUNCH activities.

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health

Short Title: Project LAUNCH
(Initial Announcement)

Request for Applications (RFA) No. SM-09-009

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Key Dates:

Application Deadline	**Applications are due by May 20, 2009.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their State(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate State and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

Kathryn Power, M.Ed.
Director
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration

Eric B. Broderick, D.D.S., M.P.H.
Acting Administrator
Substance Abuse and Mental Health
Services Administration

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Executive Summary:

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2009 for Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health (Project LAUNCH). The purpose of Project LAUNCH is to promote the wellness of young children, birth to 8 years of age. Project LAUNCH defines wellness as optimal functioning across all developmental domains, including physical, social, emotional, cognitive and behavioral health. The goal is to create a shared vision for the wellness of young children that drives the development of Federal, State, Territorial, Tribal and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed.

Funding Opportunity Title:	Cooperative Agreements for Linking Actions for Unmet Needs in children's Health
Funding Opportunity Number:	SM-09-009
Due Date for Applications:	May 20, 2009
Anticipated Total Available Funding:	$11,004,000
Estimated Number of Awards:	12
Estimated Award Amount:	Up to $850,000 per year
Length of Project Period:	Up to five years
Eligible Applicants:	Eligible applicants are State and Territorial governments and federally recognized American Indian/Alaska Native (AI/AN) Tribes and Tribal organizations. [See Section III-1 of this RFA for complete eligibility information.]

I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2009 for Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health (Project LAUNCH). The purpose of Project LAUNCH is to promote the wellness of young children, birth to 8 years of age. Project LAUNCH defines wellness as optimal functioning across all developmental domains, including physical, social, emotional, cognitive and behavioral health. For this program behavioral health includes mental health and positive development free from substance abuse and other negative behavior. The goal of Project LAUNCH is to create a shared vision for the wellness of young children that drives the development of Federal, State, Territorial, Tribal and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed.

Project LAUNCH is grounded in the public health approach, working towards coordinated programs that take a comprehensive view of health, addressing the physical, emotional, social, cognitive and behavioral aspects of wellness. The public health approach addresses the health needs of the population rather than only addressing the health problems of individuals. Project LAUNCH seeks to improve outcomes at the individual and community levels by addressing risk factors that can lead to negative outcomes. Project LAUNCH promotes protective factors that support resilience and healthy development which can protect individuals from later social, emotional, cognitive, physical and behavioral problems.

Project LAUNCH will award cooperative agreements to States, Territories and Tribes, each of which will select a locality within the larger jurisdiction to be a partner in Project LAUNCH. States/Territories/Tribes will bring together child-serving systems to develop a vision and a comprehensive strategic plan for promoting the wellness of all young children, and will develop policies, financial mechanisms and other reforms to improve the integration and efficiency of the child-serving system. State/Territories/Tribes will identify and work closely with a locality that will engage in infrastructure reform, and will use Project LAUNCH funds to enhance and expand the delivery of services and practices that promote the wellness of young children and their families. The development of a comprehensive plan and coordinated system to promote young child wellness at the local level will serve as a model throughout the State/Territory/Tribe to be replicated in other jurisdictions.

Project LAUNCH cooperative agreements are authorized under Section 520A of the Public Health Service Act (42 U.S.C. 290bb–32). This announcement addresses Healthy People 2010 focus area 18 (Mental Health and Mental Disorders).

2. EXPECTATIONS

2.1 Population of Focus

The Project LAUNCH grant program requires that the population of focus be children from birth to 8 years of age and their families.

Project LAUNCH supports positive development for our youngest citizens and their families. Children with a solid foundation in early childhood are more likely to succeed socially, participate and thrive in school, and avoid substance use and other negative behaviors. This positive change will lead not only to positive individual outcomes but also will affect community norms and lead to a general understanding that supportive social environments promote healthy child development and stronger families. It is anticipated that children, families and other stakeholders participating in Project LAUNCH activities will contribute to healthy environments at work and in school, supportive communities and neighborhoods, improved connections with families and friends and reduced levels of drug abuse and crime.

Project LAUNCH activities at the local level will seek to promote wellness among young children through the enhancement of evidence-based direct services. However, it is also recognized that the wellbeing of young children is largely dependent on the family and community contexts in which children are embedded, and thus LAUNCH activities also include family- and community-focused interventions such as public outreach and education campaigns, family support services, and systems integration changes that improve access to care.

2.2 Guiding Principles

The Project LAUNCH model is guided by some underlying principles, which are outlined below. These principles are delineated here in order to help applicants develop a better understanding of the theoretical basis for Project LAUNCH. Grantees do not specifically need to address the principles outlined in this section in their applications; rather, these principles should be infused in whatever approaches applicants develop as part of their proposed projects. Specific, required program activities (both infrastructure development and service delivery components) are described in Sections 2.4 and 2.5 below.

Applicants are also invited to go to the Project LAUNCH website to learn more about the Project LAUNCH model and to find examples of activities and approaches of current LAUNCH grantees. (**http://projectlaunch.promoteprevent.org.**)

Project LAUNCH embraces three guiding principles for promoting young child wellness:

A public health approach

Project LAUNCH is directed toward ensuring that all children have the opportunity to reach their full potential and experience optimal development. A public health approach incorporates multiple spheres of influence to understand the determinants of health and wellness. These spheres of influence go beyond individual characteristics to also address the

physical and social environments in which people live, work, play and interact. Prevention and promotion activities are key aspects of a public health approach, in addition to efforts to treat problems after they occur.

A holistic perspective
Project LAUNCH defines child wellness as optimal functioning across **all** developmental domains, including cognitive, social, emotional, behavioral, and physical health. The goal is to work across disciplines and with those involved in the lives of young children to come to a shared understanding of healthy child development and young child wellness.

An ecological framework
Project LAUNCH recognizes that child wellness is predicated upon children living in healthy, stable, safe, and supportive families and communities. The work involves not only addressing the strengths and challenges faced by the individual child, but also those experienced by his/her family, community and culture.

Project LAUNCH activities align with the following elements:

Evidence-based prevention and promotion practices that build upon the strengths and resiliency of children, families, and communities and lead to measurable and well-defined outcomes.

Cross-training, workforce development, and communications activities to ensure that all members of the community share a vision, a mission, and a plan for child wellness.

Cross-sector collaboration and systems integration efforts at the federal, State/Territorial/Tribal and local levels to ensure that resources are shared, used efficiently, and are aligned with State/Territorial/Tribal and local strategic plans for young children.

Family-centered and culturally competent practices that include families as partners and leaders, and that value the cultural and linguistic richness and diversity within communities.

For the purposes of this grant program, promotion and prevention are defined as follows:

Promotion – activities aimed at fostering or enhancing well-being across one or more domains of health (physical, social, emotional, cognitive, and behavioral). Promotion activities are implemented regardless of participants' current health status or risk for later problems.

Prevention – activities implemented to prevent later problems across all (or any) domain(s) of health (physical, social, emotional, cognitive, and behavioral). Such activities may be targeted towards children and families with unknown risk or who are at increased risk for later problems.

Promotion activities are implemented to foster health and wellbeing and are derived from a wellness model, while prevention activities are implemented specifically to prevent later problems and are derived from an illness model.

2.3 Using Evidence-Based Practices

SAMHSA's grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the target population. An evidence-based practice, also called EBP, refers to approaches to prevention or treatment that are validated by some form of documented research evidence. In the application, applicants will need to:

- Identify evidence-based practices Project LAUNCH grantees will need to implement.
- Identify and discuss the evidence that shows that the practices are effective. [See note below.]
- Discuss the population(s) for which these practices have been shown to be effective and show that they are appropriate for the identified target population(s). [See note below.]

  Note: SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other interventions that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an intervention that has not been formally evaluated with that population are encouraged to provide other forms of evidence that the practice(s) they propose is appropriate for the target population. Evidence may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. Applicants may describe experience either with the target population or in managing similar programs. Information in support of the proposed practice needs to be sufficient to demonstrate the appropriateness of the practice to the people reviewing your application.

- Document the evidence that the practices chosen are appropriate for the outcomes you want to achieve.
- Explain how the practices you have chosen meet SAMHSA's goals for this grant program.
- We expect that applicants will implement the evidence-based services/practices in a way that is as close as possible to the original services/practices. However, SAMHSA understands that applicants may need to make minor changes to the services/practices to meet the needs of their target population or their program, or to allow applicants to use resources more efficiently. You must describe any changes to the proposed services/practices that applicants believe are necessary for these purposes. Applicants may describe their own experience either with the target population or in managing similar programs. However, they will need to convince the people reviewing the application that the proposed changes are justified.
- Explain why these evidence-based practices were chosen over other evidence-based practices.

Resources for Evidence-Based Practices:

Information on evidence-based practices can be found in SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide. SAMHSA has developed this Web site to provide a simple and direct connection to Web sites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of Web sites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

Please note that SAMHSA's Guide to Evidence-Based Practices also references another SAMHSA Web site, the National Registry of Evidence-Based Programs and Practices (NREPP). NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool, not as an authoritative list of effective interventions. Being included in NREPP, or in any other resource listed in the Guide, does not mean an intervention is "recommended" or that it has been demonstrated to achieve positive results in all circumstances. Applicants must document that the selected practice is appropriate for the specific target population and purposes of the project.

In addition to the Web site noted above, applicants may provide information on research studies to show that the services/practices they plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, applicants may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts. Resources such as the RAND Corporation's Promising Practices Network (http://www.promisingpractices.net/about_ppn.asp) and the Center on the Social and

Emotional Foundations for Learning (http://www.vanderbilt.edu/csefel/) may also be useful in identifying evidence-based practices and obtaining research about them.

Note: Although there may not be evidence-based practices for infrastructure reform efforts, there are best practices established in areas such as infrastructure building, sustainability, resource sharing, strategic planning and policy change. Grantees are encouraged to look to other States/Territories/Tribes or communities for examples of successful models of collaboration and systems change in developing their proposals.

2.4 Infrastructure Development and Services Delivery

SAMHSA's Project LAUNCH cooperative agreements involve both infrastructure development and service delivery components. At the State/Territorial/Tribal level, activities focus primarily on infrastructure reform efforts aimed at creating an integrated system for promoting the wellness of young children, and workforce development activities. At the local level, grantees are involved in both local infrastructure and service delivery improvements. All activities share a common goal of building a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and their families.

Sections I-2.5.1 through I-2.5.3, below, delineate the specific responsibilities of grantees at the State/Territorial/Tribal, and local levels. State/Territorial/Tribal activities and local-level activities are described separately for the purposes of clarity.

Please note that the District of Columbia and some Tribal applicants may face a situation where the State/Territorial/Tribal government also serves as the locality (see instructions on choosing a locality in Section I-2.5.1). In such cases applicants may combine the activities described in the following sections in such a way that they address the functions described in I-2.5.1 and I-2.5.2 without creating duplicative efforts. For example, a Tribal grantee without distinct Tribal and local governments may decide not to create a separate Councils on Young Child Wellness for the Tribal and local levels, combining the functions of these two councils. However, Tribal applicants and the District of Columbia will still be required to have both a Young Child Wellness Expert and Local Child Wellness Coordinator who will work together to fulfill the leadership roles in the program and oversee programmatic and infrastructure improvement activities. Specific guidance for Tribal applicants is included in I-2.5.3.

2.5.1 Infrastructure - State/Territorial/Tribal Level

The State/Territory/Tribe is the recipient of Project LAUNCH funding and is responsible for fiscal oversight of the project. The State/Territory/Tribe can retain up to 20% of grant funds and will engage in a process of infrastructure reform intended to improve the coordination and collaboration among systems serving young children and their families. The State/Territorial/Tribal leadership must work closely with the selected locality to ensure that planning and policy reforms at the State/Territorial/Tribal level are consistent with and supportive of work at the local level. Key activities at the State/Territorial/Tribal level will be carried out by the Young Child Wellness Expert and the LAUNCH State/Territorial/Tribal Council on Young Child Wellness.

The State/Territory/Tribe must create a full-time Young Child Wellness Expert position to provide guidance and leadership for the initiative at the State/Territorial/Tribal level. The person hired for this position should have expertise in public health and early childhood mental health and development. This individual will provide overall coordination across service systems, work towards State/Territorial/Tribal policy and infrastructure improvements, and provide technical assistance to the local level. If the State/Territory/Tribe is unable to find a person with the requisite background for this position, they may consider two persons to share the position as long as they submit documentation that it was not possible to find one person with the requisite skills. Professional development for this position can also be included in the overall plan. This person will be expected to communicate regularly with the Local Child Wellness Coordinator (counterpart at the local level). If the grant is in a State or Territory with an existing Early Childhood Comprehensive Systems (ECCS) grant, the Young Child Wellness Expert must work with the ECCS coordinator and the ECCS coordinating council to coordinate activities supported by Project LAUNCH and the ECCS program.

The State/Territory/Tribe will also create an integrated State/Territorial/Tribal service system planning and oversight Council on Young Child Wellness, to include representation from Health (including representatives from the private sector), Mental Health, Child Welfare, Medicaid,

Substance Abuse Prevention, Early Childhood and State Education (Early Head Start, Head Start and Part C), the Child Care Accrediting Agency, Title V administering agencies (if applicable), the office of the governor or chief executive of the State/Territory/Tribe, and families in the target population. The State/Territorial/Tribal Council on Young Child Wellness can be integrated into an existing body of senior level officials whose primary function is oversight of young child wellness if representation from all of the above mentioned sectors is included. If you are a State or Territory with an existing ECCS grant these functions should be integrated into the ECCS coordinating council. Tribal applicants should also include the Indian Health Service. Applicants are encouraged to involve child care systems.

Applicants are expected to begin working with the partners who will comprise the State/Tribal/Territorial Council during the application process and are required to include documentation of this involvement in the form of a memorandum of agreement (MOA) or a letter of intent in **Appendix 1** of their applications. The following agencies must be included in such documentation: Health, Mental Health, Child Welfare, Medicaid, Substance Abuse Prevention, Early Childhood and State Education (Early Head Start, Head Start and Part C), Title V administering agencies and the office of the governor or chief executive of the State/Territory/Tribe.

The MOA must describe the specific roles and responsibilities of each of the partners in the State/Territorial/Tribal collaboration and their roles on the State/Territorial/Tribal Council on Young Child Wellness. Partner responsibilities include, but are not limited to, working with the Council to develop the environmental scan and strategic plan, participation in oversight of the LAUNCH initiative at the State/Territorial/Tribal and local levels, and participation in infrastructure reform, policy development, financial mapping, and/or workforce development activities.

A letter of intent from a partnering agency should make explicit the intention to have representation and active participation on the State/Territorial/Tribal Council on Young Child Wellness if the grant is funded. If letters of intent are submitted in place of signed MOA, applicants must submit a signed MOA from each of their required partners within 3 months after grant award.

If the applicant's State/Territory/Tribe is also a recipient of the ACF Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment grant and/or HRSA Early Childhood Comprehensive Systems grant, grantees must provide assurance that they will create a linkage between the activities of these grants, including use of common measures and indicators where possible.

If an applicant's State has a Children's Cabinet or Council, they should inform this entity of the Project LAUNCH grant and coordinate activities where common priorities exist.

While grantees are engaged in planning and systems reform activities at the State/Territorial/Tribal level, the majority of Project LAUNCH funds are allocated for system reform and service delivery efforts within a locality that is chosen by the State/Territory/Tribe. The State/Territory/Tribe is responsible for identifying an appropriate locality, which may be a

county or municipality. The locality must be described in the application, along with a rationale for the selection of the identified locality that includes surveillance data linked with local risk and protective factors related to young children's wellness (including physical, emotional, social, cognitive and behavioral health).

Applicants may provide a justification in Section A if they would like to serve a locality that does not fall into the strict definition of a county or municipal government (as may be the case in some Tribal lands, rural areas, or subsections of large metropolitan areas). This justification should show that the chosen locality has a cohesive service system with a set of entities that represent the required members of the Local Council on Young Child Wellness. The justification should also make the case that the chosen locality is suitable for the implementation of the Project LAUNCH framework, and that the area served is not so large in terms of population or geography that the project cannot make a significant impact on the local service system.

Applicants must include an MOA with the chosen locality in **Appendix 1**. This MOA should explain the roles of the entities (local agencies) involved in implementing the grant, with a description of the mechanism(s) that the locality will use to distribute grant funds across the systems involved in implementation.

Applicants must provide a logic model for the State/Territorial/Tribal level of their project in Section C of their Narrative. The logic model should link program resources with program activities, outputs, and outcomes. This logic model should include detail about infrastructure enhancement efforts at the State/Territorial/Tribal level, workforce development activities, and efforts to build collaboration with the local level. This logic model should be updated as the grant is implemented and an updated logic model should be submitted annually with performance reports. For examples of State/Territorial/Tribal and local logic models see Appendix D.

Required Activities the State/Territorial/Tribal Level

NOTE: These activities are delineated here in order to help applicants better understand and share with their potential partner's information about the work that grantees engage in during the grant period at the State/Territorial/Tribal level. Documentation related to these activities is not required as part of the application process.

Grantees will conduct an environmental scan in the first 6 months of the grant to map out the systems and programs (including Federal and private grants) that serve children from birth to 8 years of age and their families at the State/Territorial/Tribal level. The environmental scan will build upon the needs assessment data that is collected as part of the application process, and it will also be a key step towards the development of a comprehensive State/Territorial/Tribal Project LAUNCH strategic plan. Grantees are encouraged to build on existing scans, such as those completed by some states and territories through the ECCS grant.

Grantees will be provided with guidance for conducting their environmental scan after grants are awarded. The scan is a "living document" that may change over the course of the project to

reflect changes in the community, as well as systems and supports that address the well-being of children and families. The environmental scan will be conducted in partnership with the State/Territorial/Tribal Council on Young Child Wellness, and will provide the opportunity for information sharing and ongoing discussions regarding the current system serving children 0-8 and their families. The scan must include information about the Federal, State/Territorial/Tribal and private funding streams that support programs to address the physical, emotional, social, cognitive and behavioral health of children 0-8.

Project LAUNCH's technical assistance team and Federal staff will work with grantees to provide guidance, resources and support related to the development of the environmental scan. The results of this environmental scan will be shared with Federal staff and with partners at the State/Territorial/Tribal level and the Local Council on Young Child Wellness.

Grantees will also be required to create a strategic plan for their initiative. This plan can expand on an existing plan to support wellness for young children. In fact, when a State or Territory has an existing ECCS plan in place the grantee must build upon the ECCS plan to address the goals of Project LAUNCH. Guidance on the development of the strategic plan will be provided by the federally-funded technical assistance provider and Federal staff. The creation of this plan must actively engage the partners participating in the State/Territorial/Tribal Council on Young Child Wellness and will be coordinated with the local Project LAUNCH planning effort. Within six months of initial funding the Project LAUNCH strategic plan must be submitted to Federal Staff for approval. Further funding will be contingent on approval of the Project LAUNCH plan.

> **NOTE:** the strategic planning process is intended to be continuous over the course of the grant. While grantees are expected to have completed an initial phase of the planning process at 6 months, the plan will continue to be developed and refined over the life of the project.

Each grant year, in collaboration with the chosen locality, the State/Territorial/Tribal Council on Young Child Wellness must develop a summary of implementation lessons learned to be shared with Federal staff and other grantees. While this summary may draw from data collected as part of the grantee-specific or national cross-site evaluation, it should serve as a separate, stand-alone document.

Grantees must cooperate with and provide State/Territorial/Tribal level data for LAUNCH evaluation efforts, as described in Sections I-2.6 and I-2.7, below.

2.5.2 Infrastructure and Service Delivery - Local Level

Activities at the local level include expansion and enhancement of evidence-based programs and practices intended to promote the wellness of young children and their families as well as infrastructure reform and workforce development activities. At least eighty percent (80%) of grant funds must be allocated for expenditure at the local level. Leadership at the local level will be provided by the local Young Child Wellness Coordinator and the Local Council on Young Child Wellness.

Applicants must identify a full-time Local Young Child Wellness Coordinator to coordinate the project at the local level. This person should have experience coordinating projects across local service systems and expertise in the field of child development. This person is expected to communicate regularly with the State/Territorial/Tribal level Young Child Wellness Expert.

Applicants must create an integrated local service system planning and oversight Council on Young Child Wellness, to include representatives from Health (including representatives from the private sector), Mental Health, Child Welfare, Substance Abuse Prevention, Early Childhood Education and Local Education Agencies (Head Start, Early Head Start and Part C) or integrate these functions into an existing body whose primary function is young child wellness. Applicants are expected to begin working with the partners who will comprise the local Council on Young Child Wellness during the application process and are required to include documentation of this involvement in the form of a memorandum of agreement (MOA) or a letter of intent in **Appendix 1** of their applications.

The MOA must describe the specific roles and responsibilities of each of the partners in the collaboration and their roles on the Local Council on Young Child Wellness. These responsibilities include, but are not limited to, working with the Council to develop the environmental scan and strategic plan, participation in oversight of the development and implementation of LAUNCH local level services and activities, and participation in infrastructure reform, policy development, and/or workforce development activities at the local level.

A letter of intent from a partnering agency should make explicit the intention to have representation and active participation on the Local Council on Young Child Wellness if the grant is funded. If letters of intent are submitted in place of signed MOA, applicants must submit a signed MOA from each of their required partners within 3 months of the grant award.

Grantees must begin to implement programs and practices no later than six months after receiving funding. Implementation includes the hiring and training of staff and initiation of services and/or program activities (including evidence-based practices). Information about implementing evidence-based practices with fidelity can be accessed through the National Implementation Research Network (http://nirn.fmhi.usf.edu/default.cfm).

Grantees are expected to implement a range of evidence-based programs/practices at the local level to support young child wellness. The programs or practices to be implemented should enhance, improve and/or build upon existing services, or address gaps in services to young children and their families. Applicants are encouraged to select evidence-based practices and programs that meet the specific needs of their communities, and which build upon and/or enhance current services and programs or gaps in service. All applicants must implement practices in the following five areas:

(1) Use of developmental assessments in a range of child-serving settings (e.g. primary care, child care, early childhood education, and behavioral health programs); assessments should be used to facilitate appropriate referrals throughout the child-serving system,

(2) Integration of behavioral health programs and practices into primary care,

(3) Home visiting programs,

(4) Mental health consultation (e.g. in primary care, child care or early education settings),

(5) Family strengthening and parent skills training.

While these five strategies are requirements of the Project LAUNCH model, applicants may tailor the specific evidence-based programs or practices they choose based on the particular needs of their communities. Applicants are encouraged to visit the Project LAUNCH website at http://projectlaunch.promoteprevent.org for examples of practices that have been selected and are being implemented by current grantees.

For all evidence-based practices and strategies chosen, applicants must explain how they intend to ensure that participants from ethnically, racially and culturally diverse populations are involved with and served by the project in a culturally and linguistically competent manner. Outreach efforts should recognize that many children (especially children 0-5) are not in continuous contact with service systems in the same way as school-aged children.

Applicants must include activities designed to increase public awareness and knowledge of child wellness, particularly among parents and other early childhood caregivers. In addition, applicants must implement a local workforce development strategy to enhance the expertise of primary care providers, mental and behavioral health providers, child welfare providers, child care providers, early childhood educators and primary grade educators related to young child wellness and healthy child development.

Applicants must include a logic model for the local level of their project in **Section C** of the Project Narrative. The local level logic model should include all program activities at the local level, including direct services/activities with children, families, and caregivers; system reform efforts (and the work of the Local Council on Young Child Wellness); and other activities such as public education campaigns and/or training/workforce development programs. In the logic model, applicants should link program resources, activities, outputs and anticipated outcomes. A sample logic model is provided in Appendix D. The logic model should be updated as the grant is implemented and an updated logic model should be submitted with annual performance reports.

Required Activities at the Local Level

NOTE: These activities are delineated here in order to help applicants better understand and share with their potential partners information about the work that grantees engage in during the grant period at the local level. Documentation related to these activities is not required as part of the application process.

Grantees must conduct an environmental scan in the first 6 months of the grant to map out the public and private systems and programs (including Federal and private grants) that serve children from birth to 8 years of age and their families at the local level.

Grantees will be provided with guidance for conducting their environmental scan after grants are awarded. The environmental scan should be developed in partnership with the State/Territorial/Tribal Council on Young Child Wellness and should provide the opportunity for information sharing and discussions regarding the current system serving children 0-8 and their families. The scan should also include a financial map of the Federal, State/Territorial/Tribal and local and private funding streams that support programs to address the physical, emotional, social, cognitive and behavioral health of children 0-8.

Grantees will also develop a local level strategic plan based on the findings from the initial needs assessment at the local level (included in this application) and the environmental scan. The strategic plan must describe the gaps and unmet needs in addressing young child wellness, and explain how program resources will be used to address these needs. This plan must link with the State/Territorial/Tribal strategic plan to support young child wellness. Within six months of initial funding, this plan must be submitted to Federal Staff for approval. Further federal funding will be contingent on the approval of this plan.

> **NOTE:** the strategic planning process is intended to be continuous over the course of the grant. While grantees are expected to have completed an initial phase of the planning process at 6 months, the plan will continue to be developed and refined over the life of the project.

Grantees must cooperate with and provide local level data for LAUNCH evaluation efforts, as described in Sections I-2.6 and I-2.7, below.

2.5.3 Information for Tribal Applicants

Because Tribal areas vary greatly in terms of size, some Tribal applicants may face a situation where the entire Tribal area served is suitable as the locality for Project LAUNCH. In this case, the Tribal applicant may choose to combine the Tribal and local functions described in this application to avoid redundancy. In this situation the Tribal applicant should provide a justification that demonstrates that the entire Tribal area is suitable to serve as the locality for the project in Section A of the application. This justification should demonstrate that the chosen locality is served by a cohesive service system with a set of entities that represent the required membership of the Local Council on Young Child Wellness. If one or more of these entities does not exist in the area in question the Tribe may describe how these roles will be filled by another entity (or entities) in Section C of the application.

The justification in Section A should also make the case that the chosen locality is suitable for the implementation of the Project LAUNCH framework, and that the area served is not so large in terms of population or geography that the project cannot make a significant impact on the local service system.

Tribes submitting this justification may combine the Tribal and local levels in the way that best supports their project. For example a Tribal applicant could have one combined Council on Young Child Wellness and undertake a single environmental scanning and comprehensive planning process. Please note that Tribes choosing to combine Tribal and local levels in their project must still devote at least a combined total of 1.5 FTEs to the Young Child Wellness Expert and Local Child Wellness Coordinator positions (All other grantees must devote one full FTE to each of these positions).

Tribes are encouraged to coordinate their grant activities with whatever entities can be helpful in building a successful service structure to promote young child wellness. However, Project LAUNCH does not require Tribal applicants to partner with non-Tribal State or local governments. As a result, the Tribal level Council on Young Child Wellness does not have to include a state representative from Medicaid, but it should include a representative who can address issues related to Medicaid for the Tribal community. The Tribal Council on Young Child Wellness should include representation from the Indian Health Service.

2.6 Data Collection and Performance Measurement

Grantees are required to participate in all aspects of the Project LAUNCH evaluation, which includes three distinct but interwoven data collection and assessment efforts (described below). At least 10% but no more than 15% of total grant funds should be used for program evaluation activities. Note: Funds allocated for evaluation should be set aside prior to calculating budgets for the State/Territorial/Tribal and local levels.

Grantee-specific Evaluation

Grantees are expected to design and implement comprehensive evaluations of their Project LAUNCH programs. Grantee-level evaluations should include process, outcome, and cost evaluation components. The process evaluation will assess the implementation of the project, including the fidelity to chosen practices and programs. The process evaluation should also include mechanisms for using data to make program improvements. The outcomes component of the evaluation should aim to demonstrate potential linkages between project activities and improved outcomes both at the State/Territorial/Tribal and local levels, as identified in the LAUNCH logic models. Cost evaluation should include, at a minimum, costs of implementing the program (and individual program components) and cost per person served.

In developing their evaluation plans, grantees may wish to consider outcome and process questions such as the following (findings may be included in the performance section of their Annual Progress Reports):

Outcome Questions:

- What were effects of the interventions on participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects?

- How sustainable were the programs?

Process Questions:

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?
- What effect did the deviations have on the planned interventions and capacity to achieve desired outcomes?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

National cross-site Evaluation

A cross-site evaluation contractor is currently working with Project LAUNCH grantees to collaboratively develop a national cross-site evaluation. All grantees are expected to participate in the cross-site evaluation (CSE). This participation will include collecting and/or sharing common cross-site data related to processes, outcomes, and costs. All sites will participate in training on the cross-site evaluation protocols, including data collection, management and reporting procedures, as well as other evaluation-related activities. Ongoing training and technical assistance related to the CSE will be available to grantees.

Some examples of common measures that might be included in the CSE include:

- Measures of infrastructure development, collaboration, and coordination
- Surveys of change in knowledge, attitudes and behavior among parents, educators, physicians and early childhood caregivers as a result of training, education and/or consultation efforts
- Measures of child development, including individual assessments of program participants
- Measures of community awareness of young children's wellness
- Other information related to Project LAUNCH activities

GPRA Data

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). This may include data that grantees are already collecting as part of the grantee-specific evaluation or as part of the national cross-site evaluation. It is also possible that additional data will be required, which will be collected and entered into the CMHS Transformation Accountability (TRAC) web-based system using data collection forms that CMHS will provide. An example of an existing data collection instrument is the Child Consumer Outcome Measures for Discretionary Programs instrument.
https://www.cmhs-gpra.samhsa.gov/TracPRD/view/docs/TRACChildNOMsCombined-Eng.pdf
Initial training and ongoing technical assistance on the use of the TRAC system will be provided.

Project LAUNCH GPRA measures are currently under development. The following developmental performance measures are proposed for use by Project LAUNCH**:**

Short-term Performance Measures:

1. Increase the level of collaboration between child-serving systems at the State/Territorial/Tribal and local levels.

2. Increase the number of providers and caregivers trained in evidence-based practices that promote young child wellness and increase understanding of healthy child development.

Intermediate-term Performance Measures:

3. Increase the number of children receiving developmental screenings, assessments, and referrals.

4. Increase the number of settings with embedded mental health consultation and/or integration of physical and behavioral health care services.

5. Increase the number of families receiving home visiting services.

Long-term Performance Measures:

6. Increase the percentage of young children who are healthy and ready to learn.*

*indicators to include data on healthy physical and cognitive development; school readiness data; and social/emotional/behavioral data from developmental assessments and other sources.

Grantees will work closely with the cross-site evaluation team and Federal staff to ensure that all assessment efforts (GPRA, cross-site and grantee-specific assessments) are well-integrated, complementary and minimally redundant.

Grantees will be required to hire evaluation personnel responsible for oversight and management of data collection and evaluation activities.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

2.7 Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) to assess their progress and use of this information to improve management of their grant projects. The assessment should be designed to help grantees determine progress in achieving stated goals, objectives and outcomes and should help to guide grantees in determining whether adjustments need to be made to the project. Grantees will be required to report on progress achieved, barriers encountered, and efforts to overcome these barriers in a performance

assessment report to be submitted annually. (This performance assessment will be one component of the Project LAUNCH Annual Progress Report which will be submitted to Federal staff each year).

2.8 Grantee Meetings

Applicants must plan to send a minimum of three people (including the Project Director) to at least two grantee meetings in each year of the grant, and must include a detailed budget and narrative for this travel in their submitted budget. At these meetings, grantees will present the results of their projects and Federal staff will provide technical assistance. Each meeting will be two days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

Funding Mechanism:	Cooperative Agreement
Anticipated Total Available Funding:	$11, 004,000
Estimated Number of Awards:	12
Estimated Award Amount:	Up to $850,000 per year
Length of Project Period:	Up to 5 years

Proposed budgets cannot exceed $850,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Cooperative Agreement

These awards are being made as cooperative agreements because they require substantial post-award Federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are:

Role of Grantee:

Grantees must comply with the terms of the Cooperative Agreement, including implementation activities described in the approved grant proposal and fulfillment of requirements described in the "Funding Opportunity Description" of the RFA. Grant recipients must agree to provide SAMHSA with all required performance data and collaborate with SAMHSA/CMHS staff in all aspects of the Cooperative Agreement, including submission of all required forms, data and reports. Grant recipients must also collaborate with the evaluation contractor to support the cross-site evaluation, with the technical assistance provider and other Federally funded resources.

Role of SAMHSA Staff:

The Government Project Officer (GPO) will participate as needed on policy, steering, advisory and other task forces for the grant. The GPO will also facilitate linkages to other SAMHSA/Federal government resources and will help grantees access appropriate technical assistance. In addition, the GPO will assure that Project LAUNCH grantee initiatives are responsive to SAMHSA's mission and help accomplish SAMHSA goals. The GPO will monitor the development and collection of process and outcome measures; ensure compliance with the Government Performance and Results Act; and promote collaboration between the Center for Mental Health Services and the Center for Substance Abuse Prevention and other Federal Partners. In order to support collaboration and integration of programs at the Federal level and to model collaborative efforts for State/Territorial/Tribal and local systems, Federal staff will participate in and provide support for a Federal Partners Young Children's Collaborative with, at a minimum, the Health Resources and Services Administration (HRSA) the Administration for Children and Families (ACF), and the Centers for Disease Control and Prevention (CDC). This collaboration will work to facilitate program integration and linkages at the Federal level.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are State and Territorial governments and federally recognized American Indian/Alaska Native (AI/AN) Tribes and Tribal organizations. Tribal organization means the recognized body of any AI/AN Tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. Consortia of Tribal organizations are eligible to apply, but each participating entity must indicate its approval.

Eligibility is limited to the State or Territorial office in charge of administering the Title V (Maternal and Child Health) program because only these offices have the capacity to assist Project LAUNCH in producing State and Territorial structures that will coordinate local efforts to integrate behavioral health into young child serving programs. Tribal applicants should choose the appropriate agency to administer this program, providing justification based on the ability of that agency to coordinate between services systems.

Eligibility is restricted to entities that have not received a prior Project LAUNCH cooperative agreement.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match are not required in this program.

3. OTHER

3.1 Additional Eligibility Requirements

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application form; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Appendix A of this document.

3.2 Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. Applicants must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client services (e.g., substance abuse prevention, mental health services) appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;
- Each direct service provider organization must have at least 2 years experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 2 years); and
- Each direct service provider organization must comply with all applicable local (city, county) and State/Tribal licensing, accreditation, and certification requirements, as of the due date of the application.

Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license.

In **Appendix 1** of the application, applicants must: (1) identify at least one experienced, licensed service provider organization; (2) include a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency if the applicant is a treatment or prevention service provider organization; and (3) include the Statement of Assurance (provided in Appendix C of this announcement), signed by the authorized representative of the applicant organization identified on the face-page (SF 424 v2) of the application, attesting that all participating service provider organizations:

- meet the 2-year experience requirement;
- meet applicable licensing, accreditation, and certification requirements; and
- if the application is within the funding range for grant award, the applicant will provide the Government Project Officer (GPO) with the required documentation within the time specified.

In addition, if, following application review, your application's score is within the funding range, the GPO will call and request that the following documentation be sent by overnight mail:

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization that has agreed to participate in the project;
- official documentation that all participating organizations have been providing relevant services for a minimum of 2 years before the date of the application in the area(s) in which the services are to be provided; and
- official documentation that all participating service provider organizations comply with all applicable local (city, county) and State/Tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/Tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist.

If the GPO does not receive this documentation within the time specified, the application will not be considered for an award.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

Applicants may request a complete application kit from the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

Applicants also may download the required documents from the SAMHSA Web site at www.samhsa.gov/grants/apply.aspx

Additional materials available on this Web site include:

- a grant writing technical assistance manual for potential applicants;
- standard terms and conditions for SAMHSA grants;
- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- a list of certifications and assurances referenced in item 21 of the SF 424 v2.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (SF 424 v2), budget forms, assurances, certification, and checklist. Applicants must use the PHS 5161-1.

Applications that are not submitted on the required application form will be screened out and will not be reviewed.

- Request for Applications (RFA) – Provides a description of the program, specific information about the availability of funds, and instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants Web site (www.Grants.gov).

You must use all of the above documents in completing your application.

2.2 Required Application Components

Applications must include the required ten application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page** – SF 424 v2 is the face page. This form is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]
- **Abstract** – The total abstract should not be longer than 35 lines. It should include the project name, population to be served (demographics and clinical characteristics), strategies/interventions, project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of the abstract, write a summary of the project that can be used, if the project is funded, in publications, reporting to Congress, or press releases.

- **Table of Contents** – Include page numbers for each of the major sections of the application and for each appendix.

- **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix H of this document.

- **Project Narrative and Supporting Documentation** – The Project Narrative describes the project. It consists of Sections A through E. Sections A-E together may not be longer than 30 pages. (Remember that if the Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V – Application Review Information" of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following the Project Narrative in Sections F through I. There are no page limits for these sections, except for Section H, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation." Supporting documentation should be submitted in black and white (no color).

- **Appendices 1 through 5** – Use only the appendices listed below. If the application includes any appendices not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Appendices 1, 3 and 4 combined. There are no page limitations for Appendices 2 and 5. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the appendices as: Appendix 1, Appendix 2, etc.

  - **Appendix 1:** (1) Identification of at least one experienced, licensed service provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) the Statement of Assurance (provided in Appendix C of this announcement) signed by the authorized representative of the applicant organization identified on the face page of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited, and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time; (4) letters of commitment/support, MOAs.
  - **Appendix 2:** Data Collection Instruments/Interview Protocols
  - **Appendix 3**: Sample Consent Forms
  - **Appendix 4:** Letter to the SSA (if applicable; see Section IV-4 of this document)
  - **Appendix 5**: A copy of the State or County Strategic Plan, a State or county needs assessment, or a letter from the State or county indicating that the proposed project addresses a State- or county-identified priority.

- **Assurances** – Non-Construction Programs. Applicants must read the list of assurances provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.

- **Certifications** – Applicants must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.

- **Disclosure of Lobbying Activities** – Applicants must submit Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes, or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members

of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. If no lobbying is to be disclosed, mark N/A on the form.

- **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that applicants have obtained the proper signatures, assurances and certifications. If applicants are submitting a paper application, the Checklist should be the last page.

2.3 Application Formatting Requirements

Please refer to Appendix A, "Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications," for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on May 20, 2009. Hard copy applications are due by 5:00 PM (EST). Electronic applications are due by 11:59 PM (EST**). Hand carried applications will not be accepted. Applications may be shipped using only Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

Applicants will be notified by postal mail that your application has been received.

The application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. Applicants are responsible for ensuring that they submit their application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, the application will be considered late and ineligible for review.

SAMHSA will not accept or consider any applications sent by facsimile.

SAMHSA accepts electronic submission of applications through www.Grants.gov. Please refer to Appendix B for "Guidance for Electronic Submission of Applications."

4. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

This grant program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing

of SPOCs is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) Web site at www.whitehouse.gov/omb/grants/spoc.html.

- Check the list to determine whether your State participates in this program. Applicants **do not** need to do this if they are an American Indian/Alaska Native Tribe or Tribal organization.

- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State's review process.

- For proposed projects serving more than one State, applicants are advised to contact the SPOC of each affiliated State.
- The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville, MD **20857**. ATTN: SPOC – Funding Announcement No. **SM-09-009**. Change the zip code to **20850** if you are using another delivery service.

In addition, if you are a community-based, non-governmental service provider and you are not transmitting your application through the State, you must submit a Public Health System Impact Statement (PHSIS)[1] to the head(s) of appropriate State and local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep State and local health officials informed of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions. States or local government or American Indian/Alaska Native Tribes or Tribal organizations are not subject to these requirements.

The PHSIS consists of the following information:

- a copy of the face page of the application (SF 424 v2); and

- a summary of the project, no longer than one page in length, that provides: 1) a description of the population to be served; 2) a summary of the services to be provided;

[1] Approved by OMB under control no. 0920-0428; Public reporting burden for the Public Health System Reporting Requirement is estimated to average 10 minutes per response, including the time for copying the face page of SF 424 v2 and the abstract and preparing the letter for mailing. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0920-0428. Send comments regarding this burden to CDC Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428).

and 3) a description of the coordination planned with appropriate State or local health agencies.

For SAMHSA grants, the appropriate State agencies are the Single State Agencies (SSAs) for substance abuse and mental health. A listing of the SSAs can be found on SAMHSA's Web site at http://www.samhsa.gov/Grants/ssadirectory.pdf. If the proposed project falls within the jurisdiction of more than one State, you should notify all representative SSAs.

If applicable, applicants must include a copy of a letter transmitting the PHSIS to the SSA in **Appendix 4, "Letter to the SSA."** The letter must notify the State that, if it wishes to comment on the proposal, its comments should be sent not later than 60 days after the application deadline to the following address. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville, MD **20857**. ATTN: SSA – Funding Announcement No. **SM-09-009**. Change the zip code to **20850** if you are using another delivery service.

In addition:

- Applicants may request that the SSA send them a copy of any State comments.

- The applicant must notify the SSA within 30 days of receipt of an award.

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at www.samhsa.gov/grants/management.aspx:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and Federally Recognized Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74, Appendix E

In addition, SAMHSA's Project LAUNCH grant recipients must comply with the following funding restrictions:

- The amount of funding spent at the State/Territorial/Tribal level is limited to 20% of the total grant award.

- The amount of funding for grantee level program evaluation at both the local level and State, Territorial or Tribal level must be at least 10% but no more than 15% of the total grant award.

SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in Appendix G.

6. OTHER SUBMISSION REQUIREMENTS

Applicants may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA accepts electronic submission of applications through www.Grants.gov. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether applicants use the electronic or paper format.

To submit an application electronically, applicants must use the www.Grants.gov apply site. Applicants will be able to download a copy of the application package from www.Grants.gov, complete it off-line, and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Appendix B for detailed instructions on submitting the application electronically.

Submission of Paper Applications

Applicants must submit an original application and 2 copies (including appendices). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Send applications to the address below:

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20857

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include **"Project LAUNCH SM-09-009"** in item number 12 on the face page (SF 424 v2) of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

Hand carried applications will not be accepted. Applications may be shipped using only Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

SAMHSA will not accept or consider any applications sent by facsimile.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-E below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-E.

- In developing the Project Narrative Section of your application, use these instructions, which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1.**
- The Project Narrative (Sections A-E) together may be no longer than 30 pages.
- Applicants must use the five sections/headings listed below in developing the Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered.** Applications will be scored according to how well applicants address the requirements for each section of the Project Narrative.
- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative, and will consider how well applicants address the cultural competence aspects of the evaluation criteria when scoring applications. SAMHSA's guidelines for cultural competence can be found on the SAMHSA Web site at www.samhsa.gov. Click on "Grants/Applying for a New SAMHSA Grant/Guidelines for Assessing Cultural Competence."
- The Supporting Documentation provided in Sections F-I and Appendices 1-5 will be considered by reviewers in assessing the applicant's response, along with the material in the Project Narrative.
- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, applicants are encouraged to respond to each bulleted statement.

Section A: Statement of Need (15 points)

- Describe the local geographic area to be served. Justify the selection of the local geographic area and population of focus. This justification should show that the chosen locality has a cohesive service system suitable for the LAUNCH model and that the area served is not so large in terms of population or geography that the project cannot make a significant impact on the local service system. Include the numbers to be served and demographic information. Discuss the target population's language, beliefs, norms and

values, as well as socioeconomic factors that must be considered in delivering programs for this population.

Note: Documentation of need may come from local data or trend analyses, State data (e.g., from State Needs Assessments), data from State Epidemiological Workgroups established through the Center for Substance Abuse Prevention's Strategic Prevention Framework State Incentive Grants and/or national data (e.g., from SAMHSA's National Household Survey on Drug Abuse and Health or from National Center for Health Statistics/Centers for Disease Control reports) and should include information about risk and protective factors related to young child wellness. For data sources that are not well known, provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.

- Describe current systems and infrastructure at the State/Territorial/Tribal and local levels designed to promote or maintain the wellness of children ages birth to 8. Discuss how culturally-based assets are integrated into the current wellness system.
- Describe the current state and the need for infrastructure development at the State/Territorial/Tribal level and infrastructure and program development at the local level specifically around promotion and prevention for young child wellness. Address the current level of coordination and collaboration across systems serving young children 0–8 and their families and the extent to which behavioral health is integrated into primary care. Describe the stakeholders and resources at the State/Territorial/Tribal level and at the local level that can help implement the needed infrastructure and programming.
- Describe current needs in the identified locality (related to physical, emotional, social, cognitive and behavioral health) based on problems or challenges faced by children and youth in that locality. Identify risk and protective factors that have been linked to those problems and needs.

Section B: Proposed Evidence-Based Service/Practice (25 points)

- Identify the evidenced-based program(s) and practice(s) that you propose to implement at the local level. Describe how the chosen practices will address risk and protective factors related to the needs identified in the Statement of Need Section (Section A). Describe the evidence base for the proposed programs/practices, and their appropriateness for addressing the wellness of children as defined in this announcement. (See Section I-2.3, "Using Evidence-Based Practice")

- Describe and justify any adaptations to the evidence-based practices/programs proposed which would be necessary to meet the needs of the target population as well as evidence that such adaptations will be effective for the population.
- Describe how the proposed program(s)/practice(s) will consider issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy and gender in the target population while retaining fidelity to the chosen practice.

Section C: Proposed Implementation Approach (30 points)

Note: For the District of Columbia and some Tribal governments the State/Territorial/Tribal government may also serve as the local government. In these cases the applicant should combine the activities described in the following section in such a way that they address the functions laid out in the following two sections without creating duplicative efforts. For example, a Tribal grantee without distinct Tribal and local governments may decide not to create a separate Council on Young Child Wellness for the Tribal and local levels, combining the functions of these two councils.

- Clearly state the purpose, goals and objectives of the proposed project at the State/Territorial/Tribal level and at the local level. Describe how achievement of these goals will produce meaningful and relevant results and build system capacity and coordination at the State/Territorial/Tribal and local level around young child wellness.
- Describe the proposed project plan. Provide evidence that the proposed activities strengthen infrastructure at the State/Territorial/Tribal level, enhance infrastructure and services at the local level and meet the project's goals and objectives.
- Provide one logic model for the State/Territorial/Tribal level and one for the local level that demonstrate the linkage between resources, proposed approach (including all proposed evidence-based programs/practices) and desired outcomes.
- Describe membership, roles and functions, and frequency of meetings of the proposed State/Territorial/Tribal Council on Young Child Wellness. Describe membership, roles and functions and frequency of meetings of the local Council on Young Child Wellness. Discuss how the State/Territorial/Tribal level Young Child Wellness Expert and Local Child Wellness Coordinator will work together and coordinate the work of their respective councils.

To demonstrate the commitment of the required members of the proposed State/ Territorial/Tribal Council on Young Child Wellness include in **Appendix 1** a letter of intent or MOA with Health (including representatives from the private sector), Mental Health, Child Welfare, Medicaid, Substance Abuse Prevention, Early Childhood and State Education (Early Head Start, Head Start and Part C), the Child Care Accrediting Agency, Title V administering agencies and the office of the governor or chief executive of the State/Territory/Tribe. If one or more of these required partners do not exist at the State/Territorial/Tribal level, then the applicant should provide a waiver in place of the MOA for that partner which confirms the absence of that partner at the State/Territorial/Tribal level as well as a description of plans to address the issues which would have been addressed by that partner. If submitting letters of intent instead of MOAs, applicants should describe their plans for obtaining MOAs in the first three months of the grant.

To demonstrate the commitment of the required members of the proposed local Council on Young Child Wellness grantees should include documentation of the involvement of Health (including representatives from the private sector), Mental Health, Child Welfare, Substance Abuse Prevention, Early Childhood Education and Local Education Agencies (Head Start, Early Head Start, and Part C) in the form of a letter of intent

or MOA in **Appendix 1**. If one or more of these required partners do not exist at the local level, then the applicant should provide a waiver in place of the MOA for that partner which confirms the absence of that partner at the local level as well as a description of plans to address the issues which would have been addressed by that partner. If submitting letters of intent instead of MOAs, applicants should describe their plans for obtaining MOAs in the first three months of the grant.

Applicants must also include a MOA with the chosen locality in **Appendix 1** (a letter of intent cannot be substituted for this MOA). This MOA should explain the roles of the entities involved in implementing the grant, with a description of the mechanism(s) that the locality will use to distribute grant funds across the systems involved in implementation.

- Describe your commitment to working with family organizations and family representatives. Include signed letters of intent from these State/Territorial/Tribal or local organizations in **Appendix 1** of your application.

- Describe how the proposed programs, supports and services will be implemented at the local level. These programs, supports and services should include developmental assessments across a range of settings, integration of behavioral health programs into primary care, mental health consultation, family strengthening and parenting skills training, and home visitation. Where relevant, discuss how the services/programs described above include improvements or enhancements to already existing programs, and/or include efforts to improve coordination between programs or eliminate service/program gaps or redundancies.

- Provide a realistic timeline for the project at the State/Territorial/Tribal and local levels (chart or graph) showing key activities, milestones and responsible staff. **Note:** The timeline should be part of the Project Narrative. It should not be placed in an appendix.

- Clearly state the unduplicated number of individuals to be served (annually and over the entire project period) at the local level with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Describe how the target population will be identified, recruited and retained.

- Describe how members of the target population and representatives from the partnering agencies helped prepare the application and how they will help plan, implement and evaluate the project.

- Describe how the project components will build upon the existing systems serving families with children and enhance the strength and breadth of their promotion/prevention efforts. This should include discussion of the work being done as part of other SAMHSA funded projects, the State ECCS plan, and Title V Maternal and Child Health Block Grant activities, if applicable. Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project.

Note: State and Territorial applicants with existing ECCS grants are required to build on the work completed by the ECCS grant.)

- Show that the necessary groundwork (e.g., planning, consensus development, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the State/Territorial/Tribal coordination activities and local coordination and planning can begin as soon as possible, and no later than 2 months after grant award. Applicants must also show that the necessary groundwork has been completed so that local implementation of programs can begin within 6 months after award.

- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.

- Describe your plan to ensure project sustainability at the State/Territorial/Tribal and local level when funding for this project ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.

Section D: Staff and Organizational Experience (15 points)

- Discuss the capability and experience at the State/Territorial/Tribal level for collaboration and work on issues related to young child wellness. Also discuss the status of the State or Territorial ECCS effort (Tribal grantees do not need to address the ECCS program), if applicable. Show that participating organizations at the local level have linkages to the target population and ties to grassroots/locally-based organizations that are rooted in the culture of the target population and are capable of providing culturally competent programs, supports and services.

- Provide a list of staff who will participate in the State/Territorial/Tribal and local Councils on Young Child Wellness and overall project, showing the role of each and their level of effort and qualifications. Include the State/Territorial/Tribal level Young Child Wellness Expert, the Local Child Wellness Coordinator and other key personnel, such as the evaluator, and promotion/prevention personnel. Show that the State/Territorial/Tribal level Young Child Wellness Expert has expertise in the public health model and early childhood mental health and development, and that the Local Child Wellness Coordinator has experience coordinating projects across local service systems and expertise in the field of child development. Also describe the relationship and plan for communication between the Young Child Wellness Expert and the Local Child Wellness Coordinator.

- Discuss how key staff have demonstrated experience in serving the population of focus and are familiar with the culture and language of the population of focus. If the target population is multi-linguistic, indicate if the staffing pattern includes bilingual and bicultural individuals.

- Describe the resources available for the proposed project at the local level (e.g., facilities, equipment), and provide evidence that programs will be provided in a location that is adequate, accessible, compliant with the Americans with Disabilities Act (ADA) and amenable to the target population.

- **Section E: Performance Assessment and Data (15 points)**

- Describe the plan for conducting the grantee-specific evaluation as specified in Sections I-2.6 and I-2.7 of this RFA and document your ability to conduct the evaluation. This plan should include activities related to the process, outcome and cost evaluation components of your grantee-specific evaluation.

- Describe how the proposed data collection measures will be used to evaluate linkages between project activities and desired outcomes at the State/Territorial/Tribal and local levels as identified in the project logic models.

- Describe plans for data collection, management, analysis, interpretation and reporting. Describe any proposed data collection instruments/interview protocols that you have identified and include these in **Appendix 2**. Describe any necessary modifications to these protocols. Provide copies of all proposed consent forms in **Appendix 3** of the application, "Sample Consent Forms."

- Describe how the grantee-level evaluation will be used to assess the quality of implementation and ensure fidelity to evidence-based programs and practices.
- Describe how the proposed project will use data to manage the project and assure continuous quality improvement.

- Document your ability to collect and report on the required performance and GPRA measures as specified in Section I-2.6 of this RFA

  NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SUPPORTING DOCUMENTATION

Section F: Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

Section G: Budget Justification, Existing Resources, Other Support. Applicants must provide a narrative justification of the items included in the proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to

show that no more than 15% of the total grant award will be used for program evaluation. An illustration of a budget and narrative justification is included in Appendix H of this document.

Section H: Biographical Sketches and Job Descriptions.

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or a letter of commitment with a current biographical sketch from the individual.

- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.

- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative Section of the PHS 5161-1 instruction page, available on the SAMHSA Web site.

Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects: Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application, using the guidelines provided below. More detailed guidance for completing this section can be found in Appendix F of this RFA.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the eight bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these eight bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to the project. If so, applicants are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage applicants to keep responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

- Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.

- State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons), and the value of any such incentives. Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven to be effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed $20. (See Appendix F: Confidentiality and Participant Protection.)

- Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in **Appendix 2** of the application, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting the specimens. If applicable, describe how the specimens and process will be monitored to ensure both the safety of participants and the integrity of the specimens.

- Explain how the proposed project will ensure privacy and confidentiality of participants' records, data collected, interviews, and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data), and who will have access to the information.

- Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 3** of the application, "Sample Consent Forms." If needed, give English translations.

- Discuss why the risks are reasonable compared to expected benefits from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria of research involving human subjects. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA Web site, under "Applying for a New SAMHSA Grant," http://www.samhsa.gov/grants/apply.aspx.

Applicants whose projects must comply with the Human Subjects Regulations must, in addition to the bullets above, fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling clients in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above. For those programs where the individual award is over $100,000, applications also must be reviewed by the appropriate National Advisory Council.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and, when applicable, approved by the Center for Mental Health Services' National Advisory Council;
- availability of funds; and
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among target populations and program size.

VI ADMINISTRATION INFORMATION

1. AWARD NOTICES

After the application has been reviewed, applicants will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice through postal mail, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows you to receive Federal funding for work on the grant project.

If you are not funded, you may re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA Web site at http://www.samhsa.gov/grants/management.aspx.

- If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA Web site (http://www.samhsa.gov/grants/management.aspx).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:
  - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
  - requirements relating to additional data collection and reporting;
  - requirements relating to participation in a cross-site evaluation; or
  - requirements to address problems identified in review of the application.

- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.

- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA Web site. You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.6, you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- Grantees will be required to submit semi-annual and final progress reports, as well as annual and final financial status reports.

- As part of these reports grantees may also be asked to collect data related to developmental assessments, referrals between agencies serving young children, level of community awareness of issues related to young child wellness, training supported by Project LAUNCH, number of families and children served through grant programs, programs costs, quality of implementation of evidence-based practices, strengths of State/Territorial/Tribal and local partnerships as well as other items identified in performance reporting materials.

- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.

- If your application is funded, SAMHSA will provide you with guidelines and requirements for these reports at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use the information contained in the reports to determine your progress toward meeting its goals.

3.2 Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., "GPRA data") from grantees. The performance requirements for SAMHSA's Project LAUNCH grant program are described in Section I-2.6 of this document under "Data Collection and Performance Measurement."

3.3 Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.

- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions about program issues contact:

Jennifer A. Oppenheim, PsyD
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, Maryland 20857
(240) 276-1862
jennifer.oppenheim@samhsa.hhs.gov

For questions on grants management issues contact:

Gwendolyn Simpson
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1085
Rockville, Maryland 20857
(240) 276-1408
gwendolyn.simpson@samhsa.hhs.gov

Appendix A – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. If you do not adhere to these requirements, your application will be screened out and returned to you without review.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- The 10 application components required for SAMHSA applications should be included and submitted in the following order:

    - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
    - Abstract
    - Table of Contents
    - Budget Form (Standard Form 424A, which is in PHS 5161-1)
    - Project Narrative and Supporting Documentation
    - Appendices
    - Assurances (Standard Form 424B, which is in PHS 5161-1)
    - Certifications
    - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
    - Checklist (a form in PHS 5161-1)

- Applications should comply with the following requirements:

    - Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
    - Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
    - Documentation of nonprofit status as required in the PHS 5161-1.

- Pages should be typed single-spaced in black ink with one column per page. Pages should not have printing on both sides.

- Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of Standard form 424 v2 are not to be numbered. Appendices should be labeled and separated from the Project Narrative and Budget Section, and the pages should be numbered to continue the sequence.

- The page limits for Appendices stated in Section IV-2.2 of this announcement should not be exceeded.

- Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix B – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

Applicants must follow the instructions in the User Guide available at the www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete four separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; 3) Credential Provider registration; and 4) Grants.gov registration.

It is strongly recommended that applicants submit your grant application using Microsoft Office 2003 products (e.g., Microsoft Word 2003, Microsoft Excel, etc.). The new Microsoft Vista operating system and Microsoft Word 2007 products are not currently accepted by Grants.gov. If you do not have access to Microsoft Office products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix A of this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- **Text legibility:** Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of at least one inch each. Adhering to these standards will help to ensure the accurate transmission of your document.

- **Amount of space allowed for Project Narrative:** The Project Narrative for an electronic submission may not exceed **15,450** words. **If the Project Narrative for an electronic submission exceeds the word limit, the application will be screened out**

and will not be reviewed. To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Keep the Project Narrative as a separate document. Please consolidate all other materials in your application to ensure the fewest possible number of attachments. Be sure to label each file according to its contents, e.g., "Appendices 1-3", "Appendices 4-5."

Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. Applicants may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

After electronically submitting your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Include the Grants.gov tracking number in the top right corner of the face page (SF 424 v2) for any paper submission. Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424 v2), the assurances (SF 424B), and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.
If you require a phone number for delivery, you may use (240) 276-1199.

Appendix C – Statement of Assurance

As the authorized representative of [*insert name of applicant organization*] _____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;
- official documentation that all service provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/Tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/Tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

_____ _____

Signature of Authorized Representative Date

Appendix D – Sample Logic Model

A Logic Model is a tool to show how your proposed project links the purpose, goals, objectives, and tasks stated with the activities and expected outcomes or "change" and can help to plan, implement, and assess your project. The model also links the purpose, goals, objectives, and activities back into planning and evaluation. A Logic Model is a *picture* of your project. It graphically shows the activities and progression of the project. It should also describe the relationships among what resources you put in (inputs), what you do (outputs), and what happens or results (outcomes). Based on both your planning and evaluating activities, you can then make a "logical" chain of "if-then" relationships.

Look at the graphic on the following page to see the chain of events that links the inputs to program components, the program components to outputs, and the outputs to outcomes (goals).

The framework you set up to build your model is based on a review of your Statement of Need, in which you state the conditions that gave rise to the project with your target group. Then you look at the **Inputs,** which are the resources, contributions, time, staff, materials**,** and equipment you will invest to change these conditions. These inputs then are organized into the **Program Components**, which are the activities, services, interventions and tasks that will reach the target population. These outputs then are intended to create **Outputs** such as changes or benefits for the consumer, families, groups, communities, organizations and SAMHSA. The understanding and further evidence of what works and what does not work will be shown in the **Outcomes**, which include achievements that occur along the path of project operation.

*The logic models presented are not in a required format and SAMHSA does not expect strict adherence to this format. It is presented only as a sample of how you can present a logic model in your application.

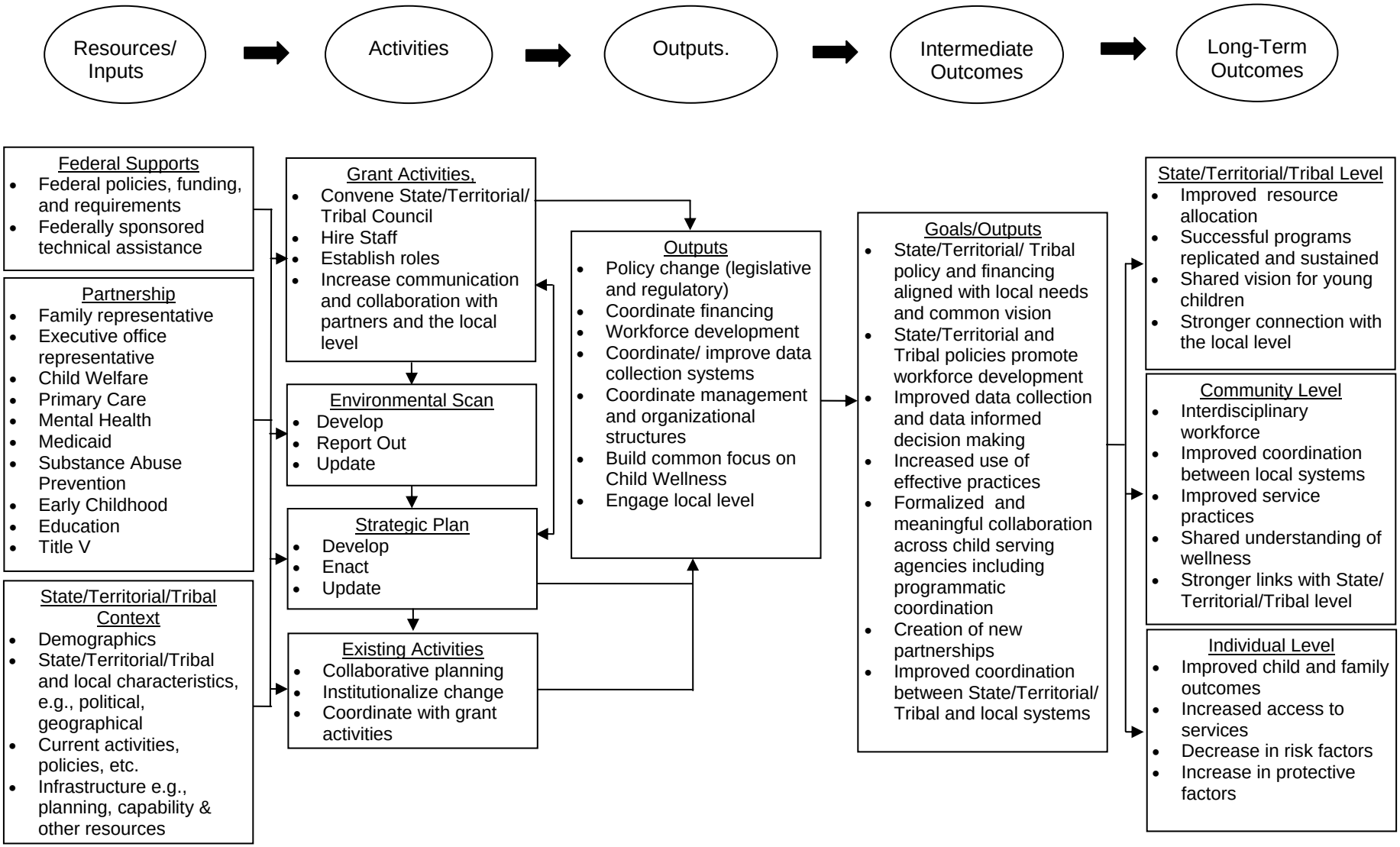
Sample Local Logic Model - Services

Resources (Inputs)	Program Components (Activities)	Outputs	Intermediate Outcomes	Long-Term Outcomes
People: • Staff • Volunteer Funds: • Grant funds • Operating budget • Partner funds • State/Territorial/Tribal funds • Private funds Other resources: • Facilities • Equipment • Community Services • Local Partnerships • Technical Assistance	Interventions: • Mental health consultation • Home visitation • Family support Training: • Parental skills • Social skills • Enhanced child care Other program activities: • Developmental assessments • Referrals • Outreach • Social marketing	• Number of children participating in child care, early education and primary care settings with mental health consultation • Number of families and children served through home visitation and family support programs • Number of staff trained in parenting skills, social skills, and enhanced child care programs: - Per month - Per child or family/month • Number of children receiving developmental assessments • Number of children or caregivers referred to services though grant supported activities • Number of children and caregivers participating in services as a result of referral • Number of children accessing services after early identification of developmental issues • Number of families accessing services as a result of outreach efforts	• Fewer children expelled from child care and early education settings. • Reduced incidence of behavior problems in child care and early education • Improved staff understanding of behavioral health issues in child care, early education and primary care settings • Positive change in caregiver practices • Improved caregiver understanding of healthy parenting practices • Improved child behavior • Improvement in caregiver-child relationship Reduced family conflict • Positive changes in knowledge, attitudes and behavior in staff across programs	• More children demonstrating social and emotional competence • Improved family functioning • Improved child care practices in formal child care settings Improved child social functioning • Increased awareness and knowledge among parents/ caregivers/general public of issues around child wellness

Sample Local Logic Model – Infrastructure, Coordination, and Planning

People: • Staff • Community Leaders • Partner representatives Infrastructure: • Policies and Practices • Funding streams • Partner Agencies • Other Related Agencies • Community Groups • State/Territorial/Tribal connection	• Local Council on Young Child Wellness • Cross- Agency Training • Service Coordination and Planning • Policy Review and Reform • Financing Review and Reform • Development of Environmental Scan (to be updated over life of project) • Development of Comprehensive Plan (to be updated over the life of the project)	• Formal meetings to coordinate programs across systems established • Training programs implemented • Lessons learned shared across systems working toward common understanding of wellness • Formal Policy Review Process established Formal Financing Review Process established	• Increased number of referrals made across agencies • Improved communication between system partners • Staff implement lessons learned from training • Local policies updated • Improved coordination of funding streams	• Increased number of referrals made across agencies • Improved coordination between programs • Local workforce developed with common understanding and increased knowledge of early childhood wellness • Improved system functioning and institutionalized policy review process • Flexible funding enables integrated programs

Sample State/Territorial/Tribal Logic Model



Appendix E – Logic Model Resources

Chen, W.W., Cato, B.M., & Rainford, N. (1998-9). Using a logic model to plan and evaluate a community intervention program: A case study. *International Quarterly of Community Health Education*, *18*(4), 449-458.

Edwards, E.D., Seaman, J.R., Drews, J., & Edwards, M.E. (1995). A community approach for Native American drug and alcohol prevention programs: A logic model framework. *Alcoholism Treatment Quarterly*, *13*(2), 43-62.

Hernandez, M. & Hodges, S. (2003). *Crafting Logic Models for Systems of Care: Ideas into Action*. [Making children's mental health services successful series, volume 1]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. http://cfs.fmhi.usf.edu or phone (813) 974-4651

Hernandez, M. & Hodges, S. (2001). Theory-based accountability. In M. Hernandez & S. Hodges (Eds.), *Developing Outcome Strategies in Children's Mental Health*, pp. 21-40. Baltimore: Brookes.

Julian, D.A. (l997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning*, *20*(3), 251-257.

Julian, D.A., Jones, A., & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. *Evaluation and Program Planning*, *18*(4), 333-341.

Patton, M.Q. (1997). *Utilization-Focused Evaluation* (3rd Ed.), pp. 19, 22, 241. Thousand Oaks, CA: Sage.

Wholey, J.S., Hatry, H.P., Newcome, K.E. (Eds.) (1994). *Handbook of Practical Program Evaluation.* San Francisco, CA: Jossey-Bass Inc.

Appendix F – Confidentiality and Participant Protection

1. Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

- Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

- Explain the reasons for **including or excluding** participants.

- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

- If applicants plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be

the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $20.

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Appendix 2, "Data Collection Instruments/Interview Protocols,"** copies of <u>all</u> available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: **If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of** Title 42 of the Code of Federal Regulations, Part II.

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.
- State:
  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Appendix 3, "Sample Consent Forms",** of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?
- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

Applicants may also have to comply with the Protection of Human Subjects Regulations (45 CFR 46), depending on the evaluation and data collection procedures proposed and the population to be served.

Applicants must be aware that even if the Protection of Human Subjects Regulations do not apply to all projects funded, the specific performance assessment design proposed by the applicant may require compliance with these regulations. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA Web site, under "Applying for a New SAMHSA Grant," http://www.samhsa.gov/grants/apply.aspx.

Applicants whose projects must comply with the Protection of Human Subjects Regulations must describe the process for obtaining Institutional Review Board (IRB) approval fully in their applications. While IRB approval is not required at the time of grant award, these applicants will be required, as a condition of award, to provide the documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP) and that IRB approval has been received prior to enrolling any clients in the proposed project.

General information about Protection of Human Subjects Regulations can be obtained on the Web at http://www.hhs.gov/ohrp. Applicants may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (240/453-6900). SAMHSA-specific questions related to Protection of Human Subjects Regulations should be directed to the program contact listed in Section VII of this RFA.

Appendix G – Funding Restrictions

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.

- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).

- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)

- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)

- Pay for housing other than residential mental health and/or substance abuse treatment.

- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.

- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to $20 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to $20 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow up. This amount may be paid for participation in each required interview.
- Food is generally unallowable unless it's an integral part of a conference grant or program specific, e.g., children's program, residential.

- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.

- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

Appendix H – Sample Budget and Justification (no match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE. WITH GUIDANCE FOR COMPLETING SF 424A: SECTION B FOR THE BUDGET PERIOD

A. Personnel: an employee of the applying agency whose work is tied to the application

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Executive Director	John Doe	$64,890	10%	$6,489
Coordinator	To be selected	$46,276	100%	$46,276
			TOTAL	$52,765

JUSTIFICATION: Describe the role and responsibilities of each position.
The executive director will provide oversight of grant, including fiscal and personnel management, community relations and project implementation and evaluation. The coordinator will coordinate project services and project activities, including training, communication, data collection and information dissemination.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form SF424A) **$52,765**

B. Fringe Benefits: List all components of fringe benefits rate

FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	$52,765	$4,037
Workers Compensation	2.5%	$52,765	$1,319
Insurance	10.5%	$52,765	$5,540
		TOTAL	$10,896

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF424A) **$10,896**

C.Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
Conference (be as specific as possible)	Washington, DC	Airfare	$200/flight x 2 persons	$400
		Hotel	$180/night x 2 persons x 2 nights	$720
		Per Diem (meals)	$46/day x 2 persons x 2 days	$184
Local travel		Mileage	3,000 miles@.38/mile	$1,140
			TOTAL	$2,444

JUSTIFICATION: Describe the purpose of travel and how costs were determined.
Cost for two members to attend a grantee meeting in Washington, DC. Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on agency's privately owned vehicle (POV) reimbursement rate.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF424A) **$2,444**

D. Equipment: an article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit – federal definition.

FEDERAL REQUEST (enter in Section B column 1 line 6d of form SF424A) **$ 0**

E. Supplies: materials costing less than $5,000 per unit and often having one-time use

FEDERAL REQUEST

Item(s)	Rate	Cost
General office supplies	$50/mo. x 12 mo.	$600
Postage	$37/mo. x 8 mo.	$296
Laptop Computer*	$900	$900
Printer*	$300	$300
Projector*	$900	$900
Copies	8000 copies x .10/copy	$800
	TOTAL	$3,796

JUSTIFICATION: Describe need and include explanation of how costs were estimated.
Office supplies, copies and postage are needed for general operation of the project. The laptop computer is needed for both project work and presentations. The projector is needed for presentations and outreach workshops. All costs were based on retail values at the time the application was written. *Provide justification for purchases, especially if they were requested and purchased under a previous budget.

FEDERAL REQUEST (enter in Section B column 1 line 6e of form SF424A) **$ 3,796**

F. Contract: generally amount paid to non-employees for services or products. A consultant is a non-employee who provides advice and expertise in a specific program area.

FEDERAL REQUEST (Consultant)

Name	Service	Rate	Other	Cost
To be selected	Coalition Building	$150/day	15 days	$2,250
	Travel	.38/mile	360 miles	$137
			TOTAL	$2,387

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
This person will advise staff and coalition members on ways to maintain, increase membership, and develop a Strategic Prevention Framework for the local coalition. The rate is based on the average consulting rate in this area. Consultant is expected to make up to 6 trips (each trip a total of 60 miles) to meet with staff and the coalition. Mileage rate is based on POV reimbursement rate. A request for proposal will be issued to secure a competitive bid before final selection is made.

FEDERAL REQUEST (Contract)

Entity	Product/Service	Cost
To be selected	1.5 minute Public Service Announcement (PSA)	$2,300
To be selected	Evaluation Report	$4,500
	TOTAL	$6,800

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
A local media outlet will produce a 1.5-minute PSA from the youth drug awareness video for the local television market. Tasks will include cutting and editing the tape, preparing introductory statement, inserting music and/or narrative, and synchronizing the sound track. A local evaluation specialist will be contracted to produce the year-end results of the coalition efforts. A request for proposal will be issued to secure a competitive bid before final selection is made.

FEDERAL REQUEST (enter in Section B column 1 line 6f of form SF424A)**$ 9,187**
(combine the total of consultant and contact)

G. Construction: NOT ALLOWED – Leave Section B columns 1&2 line 6g on SF424A blank.

H. Other: expenses not covered in any of the previous budget categories

FEDERAL REQUEST

Item	Rate	Cost
Rent	$15/sq.ft x 700 sq. feet	$10,500
Telephone	$100/mo. x 12 mo.	$1,200
Student Surveys	$1/survey x 2784	$2,784
Brochures	.89/brochure X 1500 brochures	$1,335
	TOTAL	$15,819

JUSTIFICATION: Break down costs into cost/unit, i.e. cost/square foot. Explain the use of each item requested.
Rent and telephone are necessary to operate the project. The monthly telephone costs reflect the % of effort for the personnel listed in this application. Survey copyright requires the purchase of the ATOD surveys. Brochures will be used at various community functions (health fairs and exhibits).

FEDERAL REQUEST (enter in Section B column 1 line 6h of form SF424A) **$ 15,819**

Indirect cost rate: Indirect costs can only be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement.

For information on applying for the indirect rate go to: samhsa.gov then click on Grants – Grants Management – HHS Division of Cost Allocation – Regional Offices.

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF424A) **$5,093**
8% of personnel and fringe (.08 x $63,661)

BUDGET SUMMARY:

Category	**Federal Request**
Personnel	$52,765
Fringe	$10,896
Travel	$2,444
Equipment	0
Supplies	$3,796
Contractual	$9,187
Other	$15,819
Total Direct Costs*	$94,907
Indirect Costs	$5,093
Total Project Costs	$100,000

* TOTAL DIRECT COSTS:

FEDERAL REQUEST (enter in Section B column 1 line 6i of form SF424A) **$94,907**

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A) **$100,000**

Appendix I – Position Descriptions

Young Child Wellness Expert

This position will serve as Project Director for the cooperative agreement and is responsible for providing coordination of State/Territorial/Tribal-level young child wellness efforts through work with the State/Territorial/Tribal Council on Young Child Wellness and serve as a liaison to other State/Territorial/Tribal officials and agencies positioned to support young child wellness. With the Council, the Young Child Wellness expert will support the development and implementation of a comprehensive strategic plan addressing young child wellness. These efforts will include working to establish interagency involvement in the initiative's structure and process by developing and/or changing interagency agreements and other public policies relevant to goals of the project. The position will also serve as the bridge between the State/Territory/Tribe and the funded community by working in close coordination and providing technical assistance to the Local Child Wellness Coordinator. The Young Child Wellness Expert must have expertise in the public health approach and early childhood development. They will serve as the official responsible for the fiscal and administrative oversight of the cooperative agreement and will be responsible and accountable to the funded community for the proper conduct of the cooperative agreement. If applicants are not able to find a person with the requisite background, applicants may consider two persons to share the position as long as justifying documentation is provided.

Local Child Wellness Coordinator

Working in close coordination with the Young Child Wellness Expert, the Local Child Wellness coordinator will be responsible for overseeing the development and implementation of a local-level component of the comprehensive strategic plan for developing, implementing and sustaining infrastructure and programs addressing young child wellness; establishing the organizational structure; hiring staff; and providing leadership in all local facets of young child wellness efforts, including guiding the establishment of interagency collaborations with other community-based, child- and family-serving public agencies. This key position should be staffed by one individual with knowledge of early childhood development across physical, mental, social, emotional and behavioral domains and related service systems, with demonstrated experience in mobilizing service systems, management, policy analysis and strategic thinking; leadership experience; and, demonstrated ability to foster collaborative relationships. This position should be staffed by an individual who represents the cultural and linguistic background of the population to be served. This is a full-time equivalent position.

APPENDIX 5: STATE/COUNTY STRATEGIC PLAN

THE DISTRICT OF COLUMBIA EARLY CHILDHOOD COMPREHENSIVE SYSTEMS INITIATIVE IMPLEMENTATION PLAN FOR FY 2006 THRU FY 2008

A COLLABORATIVELY-DEVELOPED PLAN FOR COMPREHENSIVE SERVICE DELIVERY FOR YOUNG CHILDREN AND THEIR FAMILIES

PREPARED FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Submitted by

DC DEPARTMENT OF HEALTH
THE MATERNAL AND PRIMARY CARE ADMINISTRATION

July 9, 2007

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- **Vision and Guiding Principles**
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ACKNOWLEDGMENTS

Numerous people, organizations and planning groups contributed to the development of the District's ECCS Plan. This process would not have succeeded without their involvement and effort on behalf of children and families. While the Maternal and Primary Care Administration has been the convener of all ECCS activities, we have been grateful to benefit from many leaders and champions from every major organization and agency in the District of Columbia. Over 100 people have made time in their busy day, often on more than one occasion, to spend an hour or two discussing their programs and perspectives. While they are too numerous to list here we gratefully acknowledge their input and commitment.

A sincere thanks and heartfelt appreciation goes out to members and participants on the ECCS Steering Committee. They have been the stakeholders most actively guiding the project's vision and approach.

ECCS Steering Committee

Lindsey Allard, *Early Care and Education Administration (ECEA), Head Start State Collaboration Office*

Bobbi Blok, *Georgetown Endowment for Children*

Joyce Brooks, Department of Health (DOH) *Maternal and Primary Care Administration (MPCA), Children with Special Health Care Needs Bureau (CSHCN)*

Suzie Cambria, *DC Action for Children*

Dr. Carlos Cano, *DOH, MPCA*

Julia Castillo, *Washington Child Development Council*

Sylvia Cobbs, *Medical Assistance Administration*

Dr. Felicia Dehaney, *SPARK DC*

Cheryl Durden, *Child and Family Services Agency*

Ellen Yung-Fatah, *ECEA*

Barbara Ferguson Kamara, ECEA

Loren Ganoe, (CFSA)

Dr. Robert Gundling, *DC Department of Parks and Recreation*

Debbie Hall, *Big Momma's Child Care Center, Washington Association of Child Care Centers*

Dr. Beverly Jackson, *ECEA*

Dr. Heather McCabe, *DC Office of the Chief Financial Officer*

Dr. Jaqueline Morris, *Chair, Children with Special Health Care Needs Advisory Board*

BB Otero, *CentroNia*

Barbara Parks, *DC Department of Mental Health*

Michelle Sermon, *DOH, MPCA, CSHCN*

Karen Shaw, *District of Columbia Public Schools (DCPS), Medicaid*

Theresa Shivers, *United Planning Organization*

Dr. Carol Strickland, *DC Children and Youth Investment Trust Corporation*

Dr. Cheryl Roberts, *DCPS, School Readiness & Early Childhood Programs*

Maurice Sykes, *Early Childhood Leadership Institute*

Joyce Thomas, *Center for Child Protection and Family Support*

EXECUTIVE SUMMARY

Prior to the commencement of the Early Childhood Comprehensive Systems Initiative, the District of Columbia lacked a broad and comprehensive DC-wide multi-agency plan for early childhood. At the same time, there were and remain systemic, financial, and cultural challenges affecting the public, private, and nonprofit sectors regarding service delivery for families and children from birth through age eight. The Early Childhood Comprehensive Systems Initiative (ECCS) has been designed to address these issues, providing a vehicle for District stakeholders to plan, develop, and now implement collaborations and partnerships that support children and families in order to ensure that *all children are healthy and ready to learn at school entry and beyond.*

Early childhood developmental programs provide a critical link between academic success, health, and general well-being. The determinants of a child's healthy development are predominantly found in the interaction of biology and their family, social, and community environment. These elements exert a powerful influence on a child's readiness to learn and succeed in school, both antecedents to health outcomes in later life. Over the past three years the ECCS initiative has been guided by two basic goals:

1) To develop within the District cross service systems integration partnerships to enhance children's ability to enter school healthy and ready to learn; and
2) To begin building an early childhood service system in the District that addresses the following priority areas: access to health and medical homes; mental health and social-emotional development; early care and education/child care; parent education; and family support.

The process for addressing and achieving these goals has been overseen by an ECCS Steering Committee comprised of a diverse array of District stakeholders collectively representing the experience and contributions of every major facet and component of early childhood systems. Their input and guidance, together with feedback from over 100 additional program officers and administrators, has been instrumental to the development of this plan. In addition, the planning activities conducted under the banner of the ECCS Initiative have been informed and influenced by the work of many organizations and collaborative activities across the District.

Over the next sixteen months of implementation and in the years to follow, it is expected that the hard work to pull together the fragments of the system of early childhood will yield systemic changes and the empowerment of system planners, service providers, and children and families. Through an environmental scan, a system mapping and resource mapping effort, and the adoption of guiding principles and practices, the ECCS Initiative has developed three core recommendations designed to precipitate improved outcomes for children and families across the District:

- Create multiple points of access for early childhood services through the use of early childhood consultants;
- Create a technological infrastructure of resource information for parents and families; and
- Establish an early childhood brand for the District and initiate public awareness campaigns.

PROFILE OF THE DC DEPARTMENT OF HEALTH, MATERNAL AND PRIMARY CARE ADMINISTRATION (MPCA)

Mission

The mission of the Maternal and Primary Care Administration is to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members.

The Administration includes the following bureaus and offices:

- **Perinatal and Infant Health Bureau**

The purpose of the Perinatal and Infant Health Bureau is to improve perinatal outcomes for high-risk pregnant and parenting women, and improve the health and development of their infants into early childhood. Its overarching goal is to reduce infant mortality and perinatal health disparities in the District of Columbia primarily through a home visiting approach.

- **Children with Special Health Care Needs Bureau**

The purpose of the Children with Special Health Care Needs Bureau is to improve the health outcomes for this population group by facilitating access to coordinated primary and specialty health care and other services in partnership with their families and community organizations.

- **Nutrition and Physical Fitness Bureau**

The purpose of the Nutrition and Physical Fitness Bureau is to provide food, health and nutrition assessments and intervention, education and referral services to District families, infants, children, and seniors to affect dietary habits, foster physical activity, decrease overweight and obesity rates and thus improve health outcomes among the population.

- **Child, Adolescent and School Health Bureau**

The purpose of the Child, Adolescent and School Health Bureau is to improve the health and well-being of all District pre-school and school-age children and adolescents. Primarily the group seeks to enhance access to preventive, dental, primary and specialty care services for all pre-school and school-age children, and contribute to the development of a coordinated, culturally competent, family-centered health care delivery system for this population.

- **Communicable Disease Control Bureau**

The Bureau of Communicable Disease Control is charged with the task of controlling and preventing the spread of communicable diseases in the District of Columbia. This is accomplished through both active and passive surveillance, timely case and outbreak investigations and providing interventions such as preventive medications and vaccines. The

Bureau also provides recommendations and consultations to other District agencies and private healthcare providers. The Bureau consists of five (5) major areas: 1) Immunization Program, 2) Tuberculosis Control Program, 3) Refugee Health Program, 4) Sexually Transmitted Disease Control Program and 5) Communicable Disease Surveillance and Investigation Program.

PROFILE OF THE DC DEPARTMENT OF HEALTH, MATERNAL AND PRIMARY CARE ADMINISTRATION (MPCA) CONTINUED

- **Cancer and Chronic Disease Prevention Bureau**

The purpose of the Bureau of Cancer and Chronic Disease Prevention is the integration and coordination of various chronic disease programs activities such that they are focused and targeted. The Bureau of Chronic Disease and Health Promotion comprises the following programs: Asthma Control Program, Breast and Cervical Cancer Early Detection Program (BCCEDP) also called Project WISH (Women Into Staying Healthy); the District of Columbia Cancer Registry; the Comprehensive Cancer Control Program; State Based Cardiovascular Health Program; Diabetes Control and Prevention Program; Prostate Cancer Control Program and the Cancer Prevention / Tobacco Control Program.

- **Pharmaceutical Services Bureau**

The purpose of the Pharmaceutical Services activity is to provide medication acquisition and drug information support services to District residents and eligible pharmacies so they can have timely access to life saving medications. The services that comprise the activity include: medication acquisition services, medication distribution services, formulary management services, drug information support services, medication storage services and emergency preparedness support.

The following bureaus and offices are presently being formed:

- Lead and Environmental Hazards Bureau
- Office of Health Care Access and Clinical Services
- Office of Program Support Services
- Office of Grants Monitoring and Program Evaluation

I. OVERVIEW OF THE ECCS INITIATIVE IN THE DISTRICT

This project was originally intended to "address the needs of all children from birth through five" in the District. However, through discourse of the ECCS Steering Committee and with feedback from other stakeholders in the District, it was decided that the target population for the ECCS grant initiative should be all children from pre-birth through to eight years of age and their families. While ECCS stakeholders deliberately selected an age cohort that applies the process to children through 3rd grade, thereby further engaging the school system, the overall focus of the initiative remains "to create a more unified and comprehensive child development system that helps children in all of the District's eight Wards—regardless of race, ethnicity, socioeconomic status, and development and behavioral needs—to be healthy and ready to learn when they enter kindergarten."

Over the past several decades, the District of Columbia has focused more resources on infants and young children. Before receiving the ECCS Planning Grant, the foundation for the early childhood system in Washington had benefited from several historic changes. First, Mayor Marion Barry had made child development a major educational and health priority of his administration. This was apparent in the establishment of the Mayor's Advisory Committee on Early Childhood Development (MACECD) in 1979 and its revamping in 1988. Second, Mayor Anthony Williams also affirmed commitment to the District's children reflected in the focus on maternal, infant, and child health in the District's *Healthy People 2010 Plan: a Strategy for Better Health* (2000) and its *Healthy People 2010: Annual Implementation Plan* (2002). And third, several District agencies have become vocal and effective advocates for more comprehensive services on behalf of young children, particularly the DC Department of Health and the DC Department of Human Services. Most recently, the induction of a new Mayor, Adrian Fenty, in January 2007 has again reinforced the District's attention to the needs of its most vulnerable population – infants and children. In fact, in the Mayor's release of his 100 Day Plan and his administration's accomplishments to date, many references have been made to improving access to quality services, developing effective ways to share child data amongst collaborating agencies, and supporting the Mayor's Advisory Committee on Early Childhood Development (MACECD) to be the vehicle to bring forth systems recommendations; all of which can have positive impact on the outcomes for children and families in DC.

Over time, the DC DOH Maternal and Primary Care Administration and the DC Department of Human Services, Early Care and Education Administration have developed public/private partnerships and public/nonprofit partnerships to provide children with access to needed health care services and early childhood education. When grant funds were available, this work had been integrated in part through Healthy Child Care America. Since receiving the ECCS Grant, however, some additional efforts have been brought about that have amplified the gains made previously in each of these quarters and now stands as a truly fundamental shift and systemic change in the planning, management, implementation, effectiveness, efficiency, sustainability and accountability of the efforts within early childhood. A recent change in Mayor, the effectiveness of efforts to secure funding for Pre-K programs, substantial investments in quality improvement for child care providers, a new Early Childhood Mental Health Task Force, and other developments have provided an opportunity for ECCS to support, inform and benefit from enhanced commitment and engagement among stakeholders.

II. UNDERSTANDING EARLY CHILDHOOD SYSTEMS

The Early Childhood Comprehensive Systems (ECCS) Initiative was inspired, in part, by the landmark Institute of Medicine Report: *From Neurons to Neighborhoods* released in 2000. *Neurons to Neighborhoods* concluded that:

- A child's brain development can be optimized by high quality experiences very early in life
- The early years and experiences set the foundation for learning throughout life
- Too many children are entering school without the competencies and traits needed for success
- Mental health and social-emotional development in the early years is as important as their cognitive development
- Current early learning systems in the U.S. are not adequately organized to promote optimal child development and readiness for school

As the findings above suggest and as other research has reinforced, closing the gap between what children and families need and what they currently experience will require significant deliberate investment and effort on the part of many actors, public and private. Partnerships between entities that have responsibility for health, educations and developmental outcomes for young children are one critical piece of the puzzle. A coordinated, efficient and effective system is born of these partnerships because the needs of young children overlap across so many organizations and service sectors.

Fundamental to the systemic bridge-building required for ensuring all children have what they need to be successful in school and in life are core principles that should be shared among all stakeholders in a child's development. Among these principles are:

- **Families are central to a child's development and health**. Parents, siblings and extended family and community relationships have the greatest influence on children. Epidemiological studies reveal strong correlations between optimal parenting ad optimal outcomes for children.
- **Families with children can benefit from guidance, training and support**. Regardless of racial, ethnic or socioeconomic background, all families have the potential to benefit from external assistance and supports, no matter how formal or informal. With higher risk populations, these supports become ever more important to a child's development. In the end, however, support for families should be accompanied by expectations of shared responsibility and leadership from parents. They are the parties ultimately responsible for their children.
- **Healthy child development and readiness for school can and should be accessible outcomes for all children**. Research has shown conclusively that all children benefit from high quality supportive learning environments.
- **A child's developmental outcomes can be viewed as a shared public responsibility**. No child or family is fully alone and a broad multi-sector engagement, from the general public as well as businesses, community organizations, and governmental agencies, is important to ensuring a system that optimizes child outcomes and school readiness.

- **Systems should be held accountable for outcomes**. With shared responsibility, whether formally acknowledged and embraced or not, comes accountability. Focusing on the performance of all system components ensures children will have access to the kinds of services and supports at their different developmental stages (from birth and infancy through adolescence and into adulthood).
- **A complex and diverse society requires culturally appropriate and diverse approaches to early childhood systems**. The imbedded role of culture and socio-economic background necessitate child-rearing practices that accommodate a variety of cultural preferences and norms within individual families and across groups of constituencies. Since parents and families are at the core of a child's development, addressing parent concerns and needs in ways sensitive to their background and disposition is essential to successfully engaging them as their child's first teacher and the larger role they will play in their family and community life.

The components of an early childhood system are many and reflect the complex and diverse array of institutions and informal entities that impact children, youth and families. The ECCS initiative is designed to address each of these components (see list to the right in the figure below) as a way of ensuring that each of the services and supports a child's needs are reflected by and commensurate with the response to those needs.

An Early Childhood System Model *(Figure 1)*

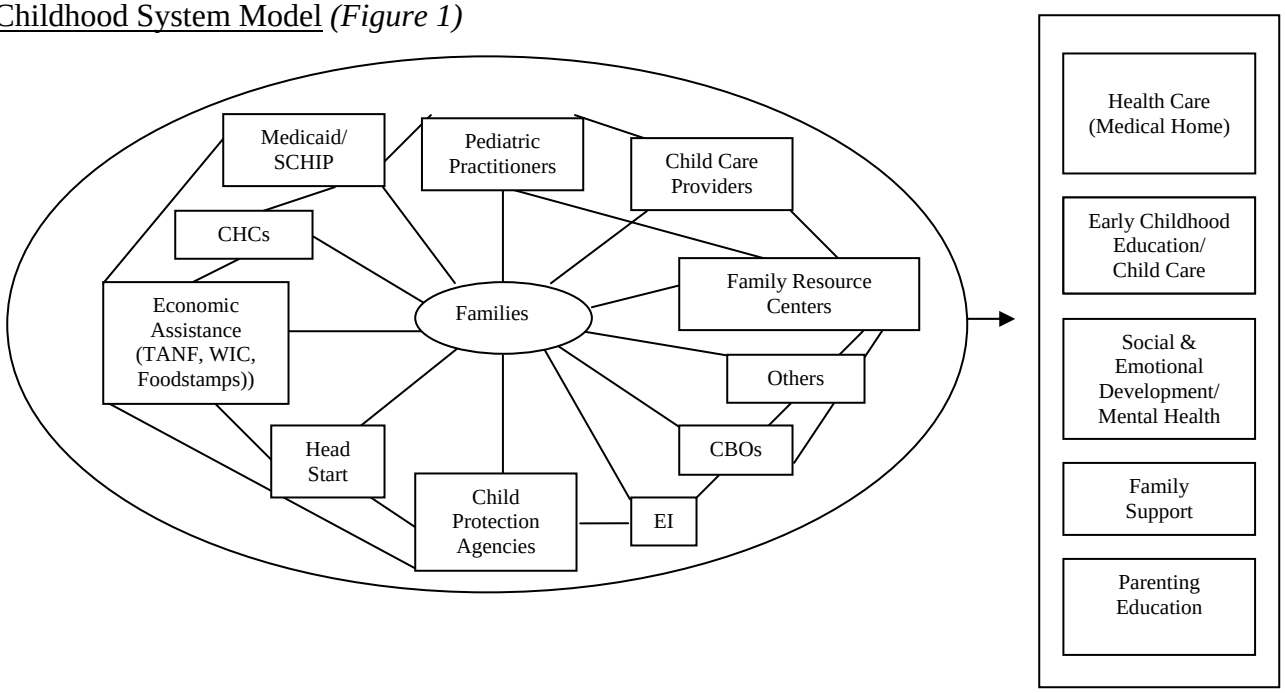

Figure 1above provides a contextual frame of reference for identifying the various programs and entities that can affect a child. Appropriately, the family is at the center, for that is where the majority of child-rearing and development occurs. However, independently of the family, there are numerous public and private services and supports, each operating with varying levels of performance, cultural design, financial health, isolation, inter-dependence, political support and

investment in child outcomes. The advantages of these systems and individual services can include: accessibility to children and families with straight-forward needs, specialized services and professionals, manageable size and complexity of internal programs, and, in a collective sense, a diverse array of approaches for helping children. Disadvantages of these components and systems can include: service gaps and unmet needs, lack of assignable accountability for child outcomes, confusing and frustrating access to more dynamic services, administrative supplication and inefficiency, competition for scarce resources and funding, legal and jurisdictional issues that create boundaries between providers and agencies, and fragmentation of systemic collaboration and communication for service delivery to children and families.

The most important overarching issue in assessing the contributions a system makes to a child's development is whether, in the end, a child or parent that is in need of a service or support is able to receive such in a manner that advances a child's development and leads to better outcomes for the child and family. The extent that the District of Columbia meets this standard is central to our plan.

III. PROFILE OF THE DISTRICT OF COLUMBIA

In recent years many major indices of children's well being have improved in the District. After decades of population decreases, the District's population continued to level off in 2004, and the number of children increased slightly. Figures released last year by the U.S. Census Bureau put the District's total population at 553,523 in 2004, a decrease of less than 1 percent since 2003. While the number of adults has declined over the past four years, the number of children increased by less than 1 percent between 2003 and 2004.

Although the share dropped slightly, from 75 to 72 percent of all children, between 2000 and 2004, almost three-fourths of children living in the District in 2004 are African American. The shares of Hispanic, Asian, Native American, and non-Hispanic youth of two or more races did not change appreciably since 2000.

Births increased by 2 percent in 2003, driven mostly by increases in the northwest sections of the District and births to white mothers. In 2003, 7,616 births were recorded for the District, bringing the number of births back to 2001 levels. While the overall number of births has not markedly increased, the distribution of births throughout the city has changed. In the northwest quadrant of the city, births are on the rise, while the areas with historically high levels of births, the east and southern quadrant of the city, saw a decline.

Extracts from the DC Action for Children

"KidBits" report released in March 2007

Only 39%, or 132, of the 339 child development facilities participating in the Child Care Subsidy Program and as a result the *Going for the Gold!* tiered rate reimbursement system are at the high quality, or Gold, level. This means that 61%, or 207, are of lesser quality. It also means that too few children have access to high-quality care which has been demonstrated to have significant short- and long-term effects. But as also indicated by the data, since 1997, the number of programs accredited by the National Association for the Education of Young Children (NAEYC) has dramatically increased, by 250% in fact, from 32 programs to 112.

The data also shows that the District's EPSDT screening has fluctuated from a low of 60% in FY 2002 to the recent high of 84% in FY 2005, above the federal mandate of 80%. This means that the majority of children ages 0-5 are receiving at least one of the required screens in a given year. It also means that some children are receiving more of the required screens than others. The EPSDT/Health Check schedule for infants in their first year of life includes eight visits, toddlers (13 - 24 months) three visits in one year and from three to five years of age, the schedule calls for one visit per year.

Poverty

In 2005, 32% or 35,292 of related children and youth in the District under age 18 were in poverty. *This is the highest rate in the country.* (www.nccp.org)

• In 2005, more young children were poor proportionally than older children. Just over 34% of children under 5, or 12,939 of 35,692, were poor in 2005.

• Female-headed family households experienced poverty at five times the rate of married couple families, 30.6% compared to 5.7%, over a one-year period as reported in 2005.

• More than 39% of female-headed households with children under 18 were poor some time in the past 12 months as reported in 2005. The percentage jumps to 48.7% for related children under 5 years of age. (2005 American Community Survey)

• Concentrated poverty more than doubled between the 1990 census and the 2000 census, from 10 to 24 census tracts. The majority of these tracts are where large numbers of children live. (http://www.brookings.edu/es/urban/publications/jargowskypoverty.pdf)

Socioeconomic Data

The District's population and economy showed some signs of improvement and resiliency, although not everyone is benefiting from the economic strength of the region. The modest increase in births, particularly in the northwest sections of the city, along with slight increases in the number of children, is good news for the District. Continued job growth also pointed to an improved economic situation. However, the fact that relatively high unemployment for District residents persisted suggests again that positive trends exhibited among higher income residents, located disproportionately in the northwest area, are not always shared by those of lower income, located predominantly in the north- and south-eastern areas of the city.

While the total number of jobs located in the District continued to rise in recent years, a wage gap exists between high- and low-paying jobs. Lower paying jobs have experienced slow growth or even a decrease in wages, while higher paying jobs set a fast pace of growth.

The number of District residents who were employed continued to decline slightly in 2004, suggesting that the decrease in employment means that many new jobs are going to suburban commuters rather than to District residents. The District's estimated unemployment rate increased a full percentage point to 8.2 percent in 2004. The unemployment rate in the District has been gradually rising since 2000 and continued to exceed the national rate of 5.5 percent by a considerable margin. In comparison, the Washington metropolitan region's unemployment rate in 2004 was 3.3 percent, lower than both the national and District rates.

In 2004, the poverty rate for DC children under 21 years of age was 30.6 percent (±3.2 percentage points). This was a decrease of between 1.0 and 10.8 percentage points since 2003, a statistically significant difference. However, the number eligible for Medicaid increased by almost 2 percent in 2004, the fifth consecutive year of increase. The total number of children and youth under age 21 in families enrolled in Medicaid as of June 2005 was 73,314. Thus, the overall number of children and youth participating in the program has risen 15 percent since June 2000, a positive outcome of efforts to increase enrollment and usage.

- More than two-thirds of DCPS students received free or reduced-price lunches in 2004
- The number of children served by subsidized childcare rose in 2005.
- In 2003, 54 percent of all births in DC were to single mothers, marking this as the seventh consecutive year that births to unwed mothers declined.

Risk Factor Data: Child Abuse and Neglect

In December 2006, the Child and Family Services Agency provided a specially requested report to the DC Council to assess child abuse and neglect in the District. Entitled "*The Assessment of District Programs to Prevent Child Abuse and Neglect*," the report soberly and succinctly summarizes the magnitude of child abuse and neglect, the resources for prevention, the gaps in services and recommendations for improving the system. The following is excerpted from this report:

> "Families in the District face a myriad of challenges in raising children. Nearly 17% of the District's families live below the poverty level. When compared with the rest of the United States in the 2005 American Community Survey, the District of Columbia had the highest rate of children living below the poverty level (32.2%). This is a 24% increase since 1990. If this trend remains consistent, children will potentially make up the largest share of the District's poor by the next census in 2010.
>
> A November 2006 analysis by the DC Fiscal Policy Institute linked the District's persistently high rate of poverty to social problems such as violent crime rates, poor school performance (as measured by standardized tests), high teen birth rates, and child abuse and neglect[i]. According to the study, nearly half (45.5%) of the District's substantiated child abuse and neglect cases originate from the poorest fifth of DC neighborhoods. Specifically, the analysis found that:

- In FY 2004 and in the first half of FY 2005, there were 980 substantiated reports of child abuse and neglect in the poorest fifth of DC neighborhoods. This represented a rate of 28.1 substantiated reports per 1,000 children.

- There were 343 substantiated reports of child abuse and neglect in DC's middle-poverty neighborhoods, or 18.4 per 1,000 children.

- In the fifth of District neighborhoods with the lowest poverty rates, there were 62 substantiated reports of child abuse and neglect, or 3.9 per 1,000 children, in FY 2004 and the first half of FY 2005.

Those District families that become involved with CFSA due to allegations of child abuse and neglect face a particularly daunting set of obstacles and barriers to raising strong and safe families. In 2003 and 2005, CFSA completed assessments of the local child welfare system in order to better align services with client needs. The final reports revealed important findings on how many families enter the child welfare system.
Through surveys, focus groups and reviews of existing literature, the *Needs Assessments* identified several factors that place District families at risk of coming into the child welfare system. The *2003 Needs Assessment* identified the following:

- Socioeconomic barriers- including poverty and related issues (e.g., unemployment, lack of adequate housing, and lack of education)
- Family environment- including poor parenting skills and learned helplessness
- Lack of knowledge- including lack of information around child welfare policies, appropriate parenting behaviors, and availability of services and supports
- Lack of support- including family, friends, and community supports
- Size of family units- including more children in the household for whom one parent can reasonably care
- Co-occurring problems- including substance abuse, mental health issues, and domestic violence.

Similar themes emerged from the *2005 Needs Assessment Report*, including socioeconomic barriers, co-occurring issues, and lack of social support. Additional challenges to families were identified, including:

- Lack of community resources - community-based prevention programs
- Lack of access to services for substance abuse and mental health treatment
- Lack of parenting support and/or education - parenting classes, assistance with children's behavioral issues, knowledge of child welfare policies, and education

Additionally, in the *2005 Needs Assessment*, many social workers commented on the lack of community-based prevention services for families. They believe there are limited resources in the District. Both social workers and parents reported a lack

of mentoring/tutoring services, and a lack of quality counseling for children. Other examples of challenges identified both by social workers and parents include a lack of community-based General Educational Diploma (GED) programs, job training programs, childcare, after-school services, and on-going activities for children."

Service Utilization Data

Major trends affecting children and families in the District in recent years:

- The percentage of mothers who received adequate prenatal care dropped very slightly in 2003
- Low-weight births continue to decline to their lowest level in more than a decade.
- It had been perceived that infant mortality continued a general downward trend in 2003 but newly released hospital data shows an increase

In the DC government, there are two major agencies with specific programs for pre-school children: The DC Department of Health (DC DOH) and the DC Department of Human Services. The DC Department of Health designs public health systems, diagnoses and investigates health threats, develops public policy, provides education and disease prevention, and administers the Medicaid insurance program and the Health Care Safety Net. Early childhood programs are directed by its Maternal and Primary Care Administration and the Department of Health also maintains a child care regulatory arm through the Health Regulation Administration's Child and Residential Care Facilities Division.

The DC Department of Human Services sets policy and provides social services for rehabilitation and self-sufficiency for DC residents, including childhood development, youth services, public assistance, disability, and rehabilitation programs. It's Early Care and Education Administration focuses on child development and early education services, and houses the Child Day Care Subsidy Program and the DC Early Intervention Program. The Early Care and Education Administration received the Healthy Child Care America grant to enhance the District's early child care and education systems, but it is now lacking funding and needs ECCS to help perpetuate its impact on children and the system of care.

As stated in the 2007 Kids Count Data Book:

> ***Immunization rates have been steadily rising since 2000, and they continued for a second year in a row to exceed the national average.***
>
> *The federal Centers for Disease Control and Prevention conducts a survey each year to determine rates of immunization for major childhood diseases in all states and the District of Columbia. The U.S. National Immunization Survey tracks the coverage of several vaccinations. The vaccination most commonly given to young children is called "3+DTP" and protects against Diphtheria, Tetanus and Pertussis (whooping cough). It is generally given in three or more doses to children from 19 to 35 months of age.*
>
> *The District's vaccination rate for 3+DTP had historically been a percentage point or more below the national level. In 2000, however, it fell more substantially behind. Each year since, however, the District has made steady gains on the national average. In 2003, the District's rate surpassed the national average by half a percentage point, rising to 98*

percent in 2004, 2.1 percentage points above the national average. The District's immunization rates for 3+DTP continued to surpass other central cities in 2004—similar to 2003. In both years, the District's rate was higher than rates in New York, Chicago, and Philadelphia.

Several factors may explain the improvement in immunization rates for children in the District. While D.C. Public Schools have always required that students be vaccinated before starting school, the school system has recently become more vigilant in enforcing this policy. In addition, in June 2004, the Mayor launched a child health assessment and immunization campaign to increase compliance with age-appropriate vaccinations, among other preventive care services. Uninsured families are provided with free immunizations at neighborhood clinics and larger facilities. Furthermore, the D.C. Department of Health also provides express immunization clinics where appointments are not necessary.

From the National Center for Children in Poverty: District of Columbia Early Childhood Profile

Trends

The District of Columbia has the highest income eligibility criteria for child care subsidies allowable by federal law (85 percent of the state median income, or 242 percent of the poverty level in D.C.). This is a slight increase in eligibility since 2001. Access to health insurance has remained steady at 200 percent of poverty since 2001, but working parents have a slightly higher income eligibility at 207 percent of poverty. The District offers free pre-kindergarten to all 4-year-olds, although the demand for pre-k currently exceeds the supply.

Recent Developments

The District of Columbia 2006 budget increased funding for child care subsidies by $16.5 million to eliminate the waiting list, serve an additional 1,000 children, and raise child care provider reimbursement rates for the first time since 1998. An additional increase of $5.1 million supported a variety of child care quality initiatives. The 2007 budget increased funding for pre-kindergarten by $3.1 million.

Sources: The following sources were consulted to write the state summary: Karen and Helen Blank, *Child Care Assistance Policies 2006: Gaps Remains, with New Challenges Ahead,* National Women's Law Center, September 2006.

W. Steven Barnett, Jason Hustedt, Kenneth Robin, and Karen Schulman, *The State of Preschool,* National Institute for Early Education Research, 2005.

Donna Cohen Ross, Lauren Cox and Caryn Marx, *Renewing the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and SCHIP in 2006,* Kaiser Commission on Medicaid and the Uninsured, January 2007 *http://www.kff.org/medicaid/7608acfm (*accessed January 30, 2007*).*

"In 2005, nearly 5,896 District children enrolled in preschool or pre-kindergarten, helping them to prepare for future schooling.

The District offers Head Start, pre-school (age 3), and pre-kindergarten (age 4) classes for all children of all income levels to prepare them for kindergarten, which is mandatory for all

children age 5. Research shows that children who attend preschool and pre-kindergarten are better prepared for elementary school and consistently perform better as they progress through school."
Source: 2006 Kids Count Data Book:

Table 1 Number of Children Enrolled in Preschool and Pre-Kindergarten by Ward, School Year 2005-06, District of Columbia

Number of Schools			Number of Students Enrolled		
Ward	Preschool	Pre-K	Ward	Preschool	Pre-K
1	12	16	1	229	459
2	5	11	2	96	158
3	1	9	3	9	171
4	9	19	4	259	594
5	10	19	5	260	625
6	12	19	6	194	423
7	13	22	7	314	712
8	16	22	8	514	784
Total	78	139	Total	1,913	3,983

Sources: DCPS, PCSB and BOE
Note: A small number of students could not be matched to a ward because of missing addresses or geo-coding problems

Table 2 Subsidized Child Care Programs in DC 2000-2005

Program Area	2000	2001	2002	2003*	2004	2005
D.C. Public Schools After Care for All						
Number of children served	**7,000**	**12,350**	**10,000**	**7,040**	**7,145**	**7,617**
Number of school sites	56	100	130	62	61	60
Early Care and Education Administration						
Number of children served	**7,653**	**11,451**	**11,947**	**11,396**	**10,001**	**14,060**
Number of family child care homes	112	124	140	144	124	129
Number of child development centers	216	222	235	231	228	148
Number of in-home providers	15	14	7	9	3	5
Number of relative providers	34	31	33	53	52	53
Total number of children served	**14,653**	**23,801**	**21,947**	**18,736**	**17,146**	**21,677**

Source: Department of Human Services, Early Care and Education Administration
** December 2003-does not include summer program*

Feedback from ECCS Interviews

The ECCS Mapping and Environmental Scan process led to interviews of over 100 stakeholders throughout the District. In addition to information regarding their programs, participants were asked to comment regarding their perceptions of what:

1) the District must do to have an "ideal system for children and families;"
2) the areas of greatest challenge and potential for improving the lives of children and families

3) the areas they see the District agencies and/or their own program must improve in order for them to manifest their own ideal programmatic impact

A few randomly selected excerpts of their responses follow below to provide a sense of the type of feedback we heard from stakeholders external to the ECCS process:

Ideal Service System for Children and Families	Areas of Greatest Challenge and Potential Improvement	Areas of improvement for your organization
Need a more centralized (one-stop) service system - it can take an adult 28 stops to visit all the different facilities to receive social services available.	People in general don't know or understand the system. To some, it may look threatening and there is no kindness in the navigation of the system. Could be better communication between the client and public agencies, maybe through a 3rd party facilitator	Training - learning the system and the work in general. Need employees to learn to navigate the social services system. More community outreach by public agencies, strengthen our advocacy.
Continuity of care for 0-21 at the very least, seamless in transition from one system to the next. A system that provides the services they say they are providing and serves all who are eligible	Transitioning from early intervention to regular schools, especially for parents that have children with special education requirements. We need continuity of curriculum and continuity of level of care	Getting people to understand the impact of disabilities and special education on the continuity of care, there is no streamlined system. Funding needed to adequately pay good people.
Should include in addition to a focus on enrichment activities that improve the conditions of children - wrap around services that include services for child protection, domestic health family well-being, mental health, etc.	Changing the paradigm from handouts to empowerment. We have a tremendous wealth of services in DC but we need to refocus these services so they are a partnership with parents and not a handout.	1. Strengthen the relationship with teachers. 2. Parent Leadership - expanding leadership opportunities and desire to demonstrate leadership capabilities outside of the program environment, especially with in the community.
All District residents should receive/be offered home-based support services	Obtaining sustained funding, particularly consistent District funding. Not receiving money from the D.C. government in a timely fashion makes it difficult to do business.	Continuous advocacy and education to government officials regarding research-based home visitation support and the ideal of prevention strategies for positive outcomes for the District's children.

Early childhood programs that have a strong relationship and collaborations with organizations that can provide a wide-range of services. Need high quality home language service.	Health and Mental Health Services. Services and collaboration around children with special needs - identification and service providing. And that the services be provided in home language.	Continuing to provide services. Our organization does not provide clinical services around the various categories of need. We need to develop relationships with those organizations - affordably.
Dental services for Medicaid eligible, low income, and uninsured children is a funding problem. Many dentists opt out of Medicaid because of low reimbursement.	Mental health services. The system of care is far too fragmented. DMH is starting to improve relationships with stakeholders, but DMH hasn't made clear what they do and where children need to go for services.	The system is fragmented. It is not a priority in broad city planning to bring everything together. There isn't a systematic approach for the Mayor's Office and City Council.

IV. DC-ECCS PLANNING PROCESS

Research shows that children who receive high-quality health care, child care, preschool and parental involvement are better prepared for elementary school and consistently perform better as they progress through school. The ECCS Process began with the goal of being responsive to the needs of families and ensuring the District is effectively preparing our youngest citizens to be successful in school and life. The ECCS Steering Committee, with a great deal of thought, has based this early childhood initiative on a number of principles it believes are critical to a child's journey. The early childhood systems initiative was envisioned as being part of a dynamic process with many stakeholders and avenues for inclusion. In setting our guiding principles, the Steering Committee conveyed that the ECCS process should:

- Address the status of ALL children and families in the District, not just those at risk or in the public systems;
- Be used for management decisions that cut across agencies and organizations;
- Identify the status of well-being of children and families;
- Support accountability;
- Have relevance to each individual Ward in the District;
- Be easily understood and made accessible to the community and our collaborative partners;
- Inform the development of the early childhood learning system;
- Identify gaps and strengths of the systems and communities;
- Assets and protective factors play a critical role to the achievement of our goal;
- Support the collection of sector-specific information and perspectives;
- Facilitate the collection of information regarding the District's resources; and
- Develop an efficient and effective system of supports for ALL children and families in the District.

As a central task for accomplishing the objectives above, the ECCS planning process sponsored a System Mapping initiative to address priority areas within child development systems: access to health care and medical homes; mental health and social-emotional development; system access and quality assurance; community development; early care and education; parent education and family support. In order to understand and therefore *manage* these priority areas, stakeholders wanted to document the existing services and resource delivery across agencies and organizations to capture the experience of the system contributors and end clients (children and families), providing a dynamic but fact-based means for stakeholders to achieve integrated, sustainable, appropriate, effective and efficient service delivery – the ultimate goal of any system. This process involved research, interviews, site visits, and collaborative sessions all geared toward mapping the system of early childhood and its programmatic and institutional resources and challenges.

Goals for the System Building Initiative

- Define the roles, responsibilities and resources of all major providers and partners
- Identify and align resources in ways that highlight their contributions to the achievement of school readiness outcomes
- Provide an elegant and comprehensive documentation of the child systems

- Develop a clear view of the system that is useful to public and private stakeholders alike

Outcomes of the System Building Initiative

- A clear articulation of the relationship between federal-District-local resources
- Provide stakeholders with a summary of programs and initiatives at work across the District
- Yield greater efficiency and effectiveness of programmatic and financial management
- Empower stakeholders to make informed policy and program changes in order to facilitate systems integration and the alignment of populations, services, accountability and outcomes

This process also sought to establish a common language for stakeholders to use in describing the child development systems – often a challenge when conducting any form of strategic planning or program coordination. Child development covers a broad array of issues and plays host to a diverse variety of stakeholders: administrators, child care providers, social workers, public health professionals, nurses, practitioners in special education, etc. Establishing a common frame of reference, easily understandable and accurately reflective of how child development *works* is a challenging but necessary endeavor for creating lasting and meaningful improvements to the management and sustainability of an effective system. As such, the ECCS process provided an opportunity for both immediate and long-term benefit.

Governance

This process, overseen by the ECCS Steering Committee but informed by many other groups, was intended to identify and leverage information, partnerships and resources. Four major activities were conducted in order for the project to be a success: meeting facilitation, environmental assessment, system mapping and resource mapping.

MEETING FACILITATION AND OVERSIGHT: MPCA staff and consultants worked with the Steering Committee to schedule and facilitate meetings, develop work plans, and otherwise guide and assist in their accomplishing the goals and objectives of the ECCS initiative. Participants captured and shared an operational understanding of the District's early childhood systems and facilitated the application of that knowledge for the purposes of this plan.

The Maternal and Primary Care Administration supports the citywide strategic priority area of Strengthening Children, Families, and Elders. MPCA's major programmatic work is to provide health screenings, wellness promotion, nutrition and fitness health education, and information, counseling health screenings, health outreach, interventions, referrals and support services to District of Columbia women, infants, children (including children with special health care needs), adolescents, families, and senior citizen residents and visitors so they can minimize their chances of illness and live healthier lives.

The organizational and managerial structure of this project has been oriented toward actively engaging other partners in the development of a more unified and comprehensive child development system. For example, the District's Vision Statement, Service Delivery Themes, and accompanying materials on the following pages were developed, edited, modified and

amended with the active consultation of the following groups: The SPARK DC Leadership Team, Mid-Atlantic Early Education Network, Early Childhood Comprehensive Systems Steering Committee, The Universal School Readiness and Out-of-School Time Stakeholders Meetings, The Mayor's Advisory Committee for Early Child Development, The Early Learning Opportunities Act Grant Steering Committee, and the DC Education Compact. Select listings of planning groups, a description of the collaboration with ECCS, and highlighted activities during the planning process are included below.

Collaborative Group	***Brief Description of Collaboration***	***Highlighted Activities During the Planning Process***
The SPARK DC Leadership Team	ECCS staff have met with, presented, and planned activities with the SPARK team since a joint Retreat was convened in January of 2004. During 2004 and 2005, ECCS was a regular contributor to SPARK's policy agenda and SPARK was one of the vehicles for securing funding for a $15 million Pre-K Pilot project in DC. Several SPARK members have served on the ECCS Steering Committee.	• Joint planning of school readiness outcomes/activities • Collaboration on External Environmental Mapping of resources/funding • Collaboration on public engagement and education • Helped secure $15 million for Pre-K Initiative
DC Education Compact	During 2005 ECCS staff actively participated in the Healthy Kids and Families Workgroup of the Education Compact. The Compact utilized the ECCS Vision Statement and the Five Service Delivery Themes as the headers for its strategic plan related to healthy outcomes.	• Joint planning of school readiness outcomes/activities • Assistance with External Environmental Mapping of resources/funding • Collaboration on public engagement and education
The Universal School Readiness and Out-of-School Time Stakeholders Meetings	In addition to regular participation and presentations, in 2004 ECCS staff conducted a 2 hour session with the USR group including five breakout groups to address the Vision Statement and each Theme – over 50 stakeholders attended. Several USR participants serve on the ECCS Steering Committee.	• Joint planning of school readiness outcomes/activities • Collaboration on External Environmental Mapping of resources/funding • Collaboration on public engagement and education

The Mayor's Advisory Committee for Early Child Development	ECCS staff have presented before the Mayor's Advisory Committee on several occasions, most recently March, 2007. MACECD formally adopted the Vision Statement ECCS had drafted and is an active partner in all ECCS activities. Several MACECD members serve on the ECCS Steering Committee.	• Adoption of DC Vision for Children and Families • Assistance with External Environmental Mapping of resource/funding • Collaboration on public engagement and education

Through the above collaborative groups, individual meetings and consultations, and it's own Steering Committee, the ECCS process also involved a strong contingent of the members and leadership of the Early Childhood Mental Health Initiative, National Infant and Toddler Child Care Initiative; the (former) Early Childhood Collaborative of DC; Healthy Kids DC (Healthy Child Care America Grant); Head Start WORKS; the Parent Educational Collaborative; DC Dept. Parks and Recreation; the Deputy Mayor for Children, Youth, Families and Elders; The University of the District of Columbia's Early Childhood Leadership Institute; The DC Children and Youth Investment Trust; The DOH/MPCA Children with Special Health Care Needs Advisory Board; the Superintendent of Schools (DCPS); the Department of Mental Health; the DC Child and Family Services Agency; the Commission on Mental Health Services; the DC Dept. of Human Services' Early Care and Education Administration; the National Black Child Development Institute; and other public and private entities with a stake in children.

ENVIRONMENTAL ASSESSMENT: A successfully conducted environmental assessment provides valuable information regarding the strengths, weaknesses, opportunities and threats (SWOT) encountered by the clients of the District's early childhood system (i.e. the "demand" for services) as well as those institutional resources providing services as part of the system (i.e. the "supply" of programs and services). The first priority of the environmental assessment was to understand and identify the needs, challenges and human resources of the client populations within the District. The process to address this aspect of the environmental assessment included:

- Participation and attendance at over 30 non-ECCS planning group meetings covering early care and education, health care, family support, mental health, access to a medical home, children with special health care needs, system access and quality assurance, and any other area deemed to affect children and families;
- Research on socioeconomic and early childhood issues particular to the District; and
- Interviews with over 100 service providers and stakeholders serving children and their families (information on their programs as well as their perspectives on population needs and challenges).

There are many distinct programs that serve children and families in the District. Each of these programs and services was treated as a source of information for the environmental scan and other system building efforts. As such, we made outreach to these organizations to not only

secure information on their programs, perspectives on their needs, and feedback on priorities and solutions, but also to ensure their commitment and "buy-in" to the system building process itself. The level of this outreach and the identification of individual organizations with whom this process engaged was pursued primarily through guidance from the ECCS Steering Committee members.

The products developed through the environmental assessment included an executive summary of a full SWOT analysis (**See Appendix D**). This summary articulated the major challenges perceived by the stakeholders involved and was organized into the following subject headings:

- ***Systemic Challenges*** (data sharing, programmatic coordination, client experiences navigating services, etc.)
- ***Financial Challenges*** (public and private funding issues, accounting and financial management, sustainability, dependence on external investment, etc.)
- ***Management Challenges*** (governance, coordination, collaboration, lines of authority and accountability, etc.)
- ***Cultural Challenges*** (to include social attitudes and norms, morale, racial and ethnic issues, languages, etc.)

Highlighted Findings from the Environmental Assessment:

Systemic Challenges. The District of Columbia currently has deep silos and fragmentation of services across the city. This fragmentation is found both within DC agencies and among the group of private sector service providers often contracted by these agencies. The District also has the added challenge of having deep silos of programmatic activity because private sector service providers are often not diversified in their funding sources. Their services are determined by the contractual arrangements they forge with the District's agencies and, even though these agencies and their providers share populations, contractors often function as individual islands of programmatic implementation, making the experience of common populations of children and families highly varied. These factors are compounded by the relative lack of standards for services and the lack of uniform levels of quality among service providers, adding to the degree of variation. In short, there is no system and even the perception of a "system of systems" yields mixed assessments of their performance and responsiveness to the needs of populations across the District.

Management Challenges. The lack of a unified and easily understandable system of early childhood in the District has been both a cause and an effect; what Peter Drucker referred to as the Three Allocations of Management: Responsibility, Authority and Accountability. In the District, despite significant accomplishments to further consolidate early childhood systems in recent years, there remain unclear lines of responsibility, authority and accountability across the public and private sectors. For the most part, public agencies have the authority and the funds to contract services for children but it is the group of contractors who are responsible for implementing those services in an accessible, appropriate, efficient and effective way. With exceptions such as the DC Department of Mental Health, most public agencies have very little, if any, responsibility for directly providing services to children and families. This falls upon their contractors and sub-grantees. However, even though an agency may not have responsibility for

implementing services, they are still held accountable for the results, or lack of results, of their contractor's performance.

Cultural Challenges. The DC DHS and DOH, within the last few years has experienced numerous changes in leadership. Without exception, there has not been a sense of continuity within the programmatic functioning of public agencies when leadership turns over, and this has had ripple effects across the city in terms of morale, transparency, collegiality, trust and commitment for interagency efforts. As a related problem, many stakeholders suffer from "planning fatigue" because frequent changes in leadership has often resulted in a failure to implement or adopt strategic plans in ways that yield real changes. The ECCS process has not altogether overcome this perception, but it is being addressed head-on by the Steering Committee and the ECCS Team.

Financial Challenges. The Environmental Scan and the Resource Mapping effort have gathered information on the status of the funding and financing of early childhood activities in the District. In recent years, many service providers have gone out of business and still others have struggled to remain operational. Part of the challenge this process has uncovered is related not only to the amount of total funding but the speed and efficiency with which it is distributed. The substantial, though yet to be fully quantified, amount of funding that flows through public agencies to their contractors moves too slowly, too late or not at all. Across the District this Environmental Scan found that the problems noted above are not an isolated phenomenon. There are many stories like it – and over time they have indiscriminately claimed victims and created a disincentive to take financial risks or to trust the ability of a governmental agency to deliver on promises. Hence the obstacles to an effective system of early childhood are not solely confined to the system's design, practices, or populations, but relate integrally to systemic issues beyond its purview. The ECCS team is therefore making an effort to deal with such challenges as may be appropriate.

The System Mapping and Resource Mapping processes (described below) provided a lens through which resources, conditions, challenges, and trends were analyzed and assessed. Primarily a "snapshot in time," the Maps provide a framework for managing child development activities in the District for years to come. With the mapping process setting the stage for understanding the basic issues surrounding early childhood systems, additional collaborative work and analysis was secured from ECCS Steering Committee members at a 6-hour retreat on November 28th, 2006. In parallel with the activities of the ECCS Steering Committee, a SWOT analysis was conducted driven by feedback gained from members of the ECCS Steering Committee as well as individual stakeholders interviewed as part of the mapping and outreach effort. As such, this process sought to embrace all perspectives and viewpoints, allowing each an opportunity to see the light of day but ultimately handing responsibility for determining the content of the analysis to the ECCS Steering Committee overseeing the process.

The following headers – System Mapping and Resource Mapping– are fluid aspects of the Mapping and Analysis work but provide greater depth to the process.

<u>SYSTEM MAPPING:</u> A System Map provides a high-level overview of the relational pathways in service delivery and function across multiple organizations and programs. It simultaneously

articulates the "supply and demand" issues pursued as part of the environmental assessment described previously. System maps are defined by the experience of the system contributors and end clients (through review of program eligibility), providing a unifying expression of how partners can coordinate and collaborate to provide seamless service delivery.

Children, youth and family-based services cover an enormous array of issues and programmatic functions. System Mapping helped identify expertise that can be shared across programs and furthered the analysis of community assets as part of the environmental assessment. Since this project addressed several distinct population types and services, the system mapping process sought to be inclusive of all resources and populations. As a result, the System Map product itself provides a "30,000 foot view" of the system and all its most critical elements. This breadth of information is then complemented and detailed through the Resource Mapping process described below. Within the System Map (S**ee Appendix B**) the following is conveyed in a one-page schematic:

- ***Who is Served?*** (who enters system/what funds follow them/eligibility requirements)
- ***Access Points*** (where and how they access services)
- ***Programs/Services Provided*** (what they receive and from whom)
- ***Funding sources*** (federal, DC, private, fee-for-service, etc.)

RESOURCE MAPPING: To the extent possible, the ECCS process set out to identify and analyze the existing resources in child development by program type, population and ages served, program capacity, access points, funding and revenue sources, Ward-specific impact, and other variables. To provide detailed programmatic information was the primary focus of the mapping process. The goal was to obtain detailed program information for use in assessing the net economic impact of early childhood resources, understand the programs and services available to District residents, identify gaps and linkages between the variety of providers (health, early care, education, family support, system support, etc.) and assist stakeholders in the conducting strategic planning activities central to this endeavor. This was one vital component of our larger efforts to create a more *unified and sustainable high-quality child development system* for the District of Columbia.

The ECCS process sought to further three major tasks within the Resource Mapping effort:

1. **Collaborative Process Structures**
   Map the "collaborative processes" across the District to identify the lines of communication and programmatic and management linkages between and among the various planning bodies (**See Appendix C**). The goal was to understand the role and contributions made by the many collaborative processes underway, and what aspects of the ECCS service delivery themes (Health & Safety, Early Care & Education, Family Education & Support, Community Development, and System Access & Quality Assurance) were being addressed through these collaborative processes.

2. **Resources for Service Delivery**

ECCS contributed to a process partially conducted through our 211 "Answers Please" phone and internet resource directory as well to expand the information regarding programs and services affecting young children and their families. This process began to document District resources with a particular emphasis on tracking funding streams, access points for receiving direct services, and the programmatic capacity of service providers. Our goal was that the mapping of resources would, by documenting the programmatic capacity of all providers, enable estimates that show the total number in the District that receive that particular type of service or program (e.g. the number of parents participating in parent mentoring or training during 2005). However, we found it difficult to obtain detailed information from all service providers. There was a great degree of variation in their ability to report on their programs. As such, this particular outcome of the mapping process, while useful for revealing larger themes and priorities, is limited as a source of information for any and all services to children.

3. **Identify expertise that can be shared across programs**
   By conducting interviews and site visits while identifying resources and performing system analyses, this effort enhanced the process of building capacity for non-profit organizations and other service providers, setting a course for making "the whole greater than the sum of the parts." As information about "who does what" continues to become available, we envision the creation or re-alignment of committees and planning groups to facilitate the exchange of knowledge and information beyond the influence of ECCS.

THE DISTRICT OF COLUMBIA VISION AND GUIDING PRINCIPLES

The District of Columbia's First *EVER* Vision Statement for Children and Families

According to many stakeholders who possess a great deal of knowledge and experience in the history of child development efforts in Washington, the District had never had a formally adopted Vision Statement for Children and Families that cuts across organizations, the Mayor's Office, and various collaborative groups. In recognition of the fact that there are many ongoing initiatives and organizational programs at work in Washington that possess their own distinct Mission and/or Vision for the city and its children, the stakeholders steering the ECCS process placed the establishment of ONE UNIFYING VISION for the District as an immediate priority and action step (see statement below). A small workgroup was then formed to draft the Vision Statement and presentations with requests for feedback were made before several collaborative groups, including the Mayor's Advisory Committee for Early Child Development, the Universal School Readiness Stakeholders Group, the Supporting Partnerships to Assure Ready Kids (SPARK) Leadership Committee, and the Deputy Mayor for Children, Youth, Families and Elders in order to obtain feedback and buy-in to the statement. The statement is as follows:

The District's Vision for Children and Families

All children and families will have access to a continuum of comprehensive, high-quality early childhood programs and services that promote child well-being and school readiness and ensure that all children are healthy, ready to learn and have safe passage through the early years.

As mentioned, in establishing this agreed upon Vision Statement, several Mission and Vision Statements from the collaborative partners to the ECCS Initiative were utilized. The ECCS Team gathered together these statements and the stakeholders that subscribe to them in order to harness and direct everyone toward a Vision Statement they could all subscribe to without losing the distinct identity of their own visions and missions. This joint vision statement has since been formally adopted by the Mayor's Advisory Committee on Early Childhood Development (MACECD), the Universal School Readiness stakeholder group (USR), and recently included in the Deputy Mayor for Education's Comprehensive Education Plan.

EARLY CHILDHOOD SERVICE DELIVERY THEMES: GUIDING PRINCIPLES

In addition to, and as a component of, the development of the vision statement above, the ECCS process in Washington has also initiated a new and comprehensive conceptualization of the system of early childhood. Stakeholders have identified five key themes of child development in Washington and these are being used to unify the means by which all planning, committees, evaluations, public engagement, mapping, financing, and programmatic service delivery is conducted. The ***five critical components for early childhood systems development*** identified by HRSA (Access to Health Insurance and Medical Homes; Mental Health and Socio-Emotional Development; Early Care and Education/Child Care; Parent Education; and Family Support) are included within the larger themes for the District so that the entire local system can establish ONE AGREED UPON SET OF ORGANIZING PRINCIPLES FOR EARLY CHILDHOOD.

Service Delivery and Access Themes: These are the organizing categories for all services and programs related to child development across the District of Columbia. The five themes enable organizations and agencies to perform a thorough mapping of resources to clarify the role and function each organization plays in their geographic area of impact. This process and product is designed to trigger questions and research about the various contributions organizations make, their funding sources, programmatic capacity, the ages served, and the socioeconomic background of the target population. The first three themes listed; Health and Safety, Early Care and Education, and Family Education and Support are directly relevant to the development of children and the services and opportunities most geared to serve them. The fourth theme, Community Development, is also a direct service category but refers to the broader elements that create the environment that makes healthy and successful families and children possible. The fifth theme, System Access and Quality Assurance, applies to the resources that support, inform and empower those providing services directly to children and families.

Within each theme is a Glossary, a Description and a list of Subtopics. The Glossary is used to define what is meant by the theme and what relevance it carries for the system. The Description is a highly abbreviated means to add additional background to the glossary and to ensure that the information conveyed is appropriate, adequate and sufficient. The Subtopics ensure that stakeholders are able to be as specific as possible in managing components of the system.

Service Delivery and Access Theme Headers for Early Childhood

Theme	*Glossary, Description and Subtopics*
Health and Safety	**Glossary:** Programs and services that promote health, provide a medical home, ensure access to a continuum of care, and maximize the physical and mental well-being of children and the chances for them to grow up healthy, ready to learn and free from preventable circumstances that compromise their ability to pursue their full potential. Description: Taken in two parts, Health refers to the overall health and development of each child from pre-birth through eight years old. Safety refers to the child's learning environments (classrooms, child care, playgrounds, communities) and home environment such as domestic abuse, substance abuse, neglect, and other forms of personal abuse. Subtopics: Pregnancy, Nutrition, Health Promotion, Medical Care and Medical Home, Oral Care & Hygiene, Insurance, Child Well-Being, Consumer Safety, Special Health Needs: Mental Health, Violence, Substance Abuse, Neglect, Personal Abuse (in-home and out-of-home).
Early Care and Education	**Glossary:** Programs and services that are economically responsive, culturally competent, and committed to ensuring that children develop emotionally, socially, physically, cognitively and in other ways ready to succeed. Description: Child care, schools and curriculum and non-curriculum-based early learning programs are at the heart of the child development system. Developmentally appropriate settings and environments are keys to the readiness and success of all children and cut across many Themes (Health & Safety, Family Education & Support, and Quality Assurance). Subtopics: Child Care (center-based, home-based, kith & kin, Head Start), Transition Practices, K-3rd Grade Instruction, Home Schooling, Family Involvement, Cultural Competence, Early Intervention, Special Education, and School Readiness across the domains of Social & Emotional Development; Intellectual/Cognitive Development; Language, Literacy & Communication; Physical Development; Schools Ready for Children. (Note: these latter "School Readiness" subtopics are subject to change)
Family Education and Support	**Glossary:** Programs and services that involve all parents and families (traditional, non-traditional, at-risk families) in the development of their children, often providing counseling, training, mentoring, nurturing and bonding, leadership opportunities, information, resources and/or materials for successful parenting. Description: Several programs include family involvement and skill development (such as family literacy and parental empowerment) as a central aspect of their approach. These issues are part of the condition for establishing and nurturing a healthy learning environment for children and often serve to infuse values, ethics and morals. Subtopics: Parental Education & Training, Family Literacy, Child support, Family Stability, Foster Care, Adoption, Respite Care, Teen Pregnancy, Faith-based Institutions.
Community Development	**Glossary:** Children growing up in homes and communities where essential needs are met to ensure positive growth and development through services such as social and emergency support, job training and other means to achieve self-sufficiency. Efforts that ensure the community is safe for and supportive of children and families. Description: Of critical need across the District are financial and social supports to families in low to moderate income categories. The challenges of affordable housing, health care, education needs, transportation, and other factors often undermine a healthy and supportive environment for children. Subtopics: Financial/Emergency Assistance, Economic Development, Housing, Public Safety, Employment and Job Training, Entrepreneurship, Work Readiness, Workforce Development, Adult Education, Reentry and incarceration, Self-Esteem and Positive

Theme	*Glossary, Description and Subtopics*
	Development, Mental Health, Counseling, Inter-generational Relations, Transportation.
The fifth theme, System Access and Quality Assurance, applies to the resources that support, inform and empower those providing services directly to children and families. This is to be distinguished from the prior four themes due to its special nature in building their capacity and evaluating and advocating for their effectiveness.	
System Access and Quality Assurance	**Glossary:** Institutions, services and programs that impact the lives of children and families through system improvement, institutional alignments, and by supporting those who care for and work with children and families directly. Description: These are the organizing categories for the stakeholders and programs contributing to the development of partnerships, public education, advocacy efforts, research, evaluation and monitoring, program enhancements, and other means to build capacity, align and integrate systems, and ensure that resources to address the needs of children and families are adequate, appropriate, effective and sustainable. Subtopics: Capacity-Building, Supporting Providers and Parents, Public Education, Developing Programmatic Linkages, Strategic Planning and Coordination, Resource and Referral, Research, Advocacy, Professional Development, Evaluation and Monitoring, Outcomes, System Linkages, Communications, Information and Knowledge Management.

The Definition of an Early Childhood System

During a retreat for the ECCS Steering Committee on November 28th, 2006 the question was posed to members: "What is a system?" Their responses varied but each conveyed a common message: a system is some combination of services, resources, and agencies that works together and is accessible to children and families. Some also preferred to define their *ideal* system rather than simply what a system is:

An ideal family education and support system involves a continuum of services and agencies that provides a seamless flow of options and access (to concrete supports) to enhance child development and well-being of children 0-8 years old and their families.

Taking the definition of a system again, the phrase "works together" is critical to the ideal. Each resource must work together with others to collaborate, share info, solve problems, share resources, provide feedback and act to address needs of the community. Feedback and guidance from numerous sources, most directly but not limited to the ECCS Steering Committee, led to recommendations and strategies for achieving the District's "ideal system" for children and families.

V. CORE RECOMMENDATIONS AND STRATEGIES FOR ACHIEVING SYSTEMS INTEGRATION AND COORDINATION

The proposed activities for ECCS implementation are aligned with the District's Vision for Children and Families. The Core Recommendations and their associated activities are listed below and include connections to the ECCS service delivery themes, the ECCS steering committee recommendations, as well as linkages to Mayor Adrian Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia."

Core Recommendation 1:
Create an early childhood "brand" for all District stakeholders to rally behind and develop a corresponding marketing and public outreach campaign to promote early childhood programs/services.

Core Implementation Activity 1:
Develop a "brand" for early childhood in DC through the use of public awareness campaigns

Core Recommendation 2:
"Create multiple points of access for services and resource information" through the creation of a "technological infrastructure consisting of a comprehensive database of resources";

Core Implementation Activity 2:
Use the early childhood resources information gathered through ECCS to populate and update the Mayor's citywide social service resource center 211 Answers Please! This function is web-based and accessible via telephone.

Core Recommendation 3:
"Create multiple points of access for early childhood services and resource information"

Core Implementation Activity 3:
Reinstate the use of early childhood consultants to provide multidisciplinary training and on-site supports to early care and education programs and the families they serve; revitalize relevant components of the now defunct Healthy Child Care America Initiative.

Sources for Recommendations: The following compiled list of recommendations are organized according to the ECCS-developed categories for all services and programs related to child development across the District of Columbia. The sources of this information are numerous and include ECCS-lead focus groups, site visits and interviews conducted with stakeholders and service providers across the District. Utilized also were existing reports and studies including the "Road Map to Universal School Readiness in the District of Columbia," "A Vision for DC Youth: The Task Force for Evidence-based Programs," " No Time to Wait: Ensuring a Good Start for Infants and Toddlers in the District of Columbia" report from the MACECD Task Force

on Strategic Planning for Infant and Toddler Development, reports and briefings from the DC SPARK (Supporting Partnerships to Assure Ready Kids) Initiative, reports from the Universal School Readiness Stakeholders Group, community forums and strategic planning activities of the DC Education Compact process, reports from the DC Child and Family Services Agency, and others.

NOTE: In recognition that all recommendations and good ideas may be beyond the financial capacity or legislative authority of the ECCS Initiative, the selection of the activities for the implementation plan which follows were based on what was most feasible for the ECCS initiative to implement and what would yield the greatest return on investment. However, there are other systems building activities being pursued throughout the District and ECCS will continue to support them. Many of the recommendations below originated with ongoing planning groups collaborating with the ECCS process. Many of these recommendations will be pursued in partnership with, but not under the mandate of, the ECCS Implementation Plan.

Recommendations for Improving DC's System of Early Childhood

Theme	***Recommendation***
Health and Safety	Description: Taken in two parts, Health refers to the overall health and development of each child from pre-birth through eight years old. Safety refers to the child's learning environments (classrooms, child care, playgrounds, communities) and home environment such as domestic abuse, substance abuse, neglect, and other forms of personal abuse. ❖ Dedicate local funds to provide early intervention services to more infants and toddlers. ❖ Assure access to mental health services by increasing the organizational commitment and resources of the Department of Mental Health to early childhood development ❖ Opportunities to build community linkages through partnership to ensure that programs are efficient and effective ❖ Planned expansion of various job training programs ❖ Develop customized training through partnerships with private and public leading entities ❖ Expand the recruiting outreach of community-based programs ❖ Facilitate partnerships with education providers ❖ Conduct periodic **asthma** screening for black and Latino children as part of annual exams ❖ Better reporting mechanisms for the Department of Health to receive information on incidence of new diagnoses of **asthma** ❖ **Oral health** providers should be encouraged to participate in Medicaid through a better Medicaid reimbursement rate ❖ DCPS should create an office of Special Health Services that would report directly to the Superintendent ❖ Change school health rules to correspond with updated technology. Ex: diabetic school-aged children can self-administer insulin instead of going to the nurse's office ❖ Encourage teachers to understand, diagnose and act upon school-aged student health issues

Theme	*Recommendation*
	❖ Access to a Medical Home o Opportunities to build community linkages through partnership to ensure that programs are efficient and effective o Advocacy for funding and grant opportunities through an infrastructure of strategic partnerships, identification of service gaps and unmet needs o Minimize the time involved in accessing services by providing customers with detailed up-to-date program information, registration requirements, and other prerequisites o Even distribution of referrals to accommodate each organization's capacity o Facilitation of community planning through comprehensive program information searchable by service category, target population and geographic area ❖ Mental Health and Socio-emotional Development o One location to access information on community services and mental health training. o Equip school nurses with greater psychological counseling and assessment training to deal with violence, depression and suicide o Get child care providers access to mental health resources o Expand the services at schools to include behavioral, social and emotional development o Providing incentives to schools to implement proven and appropriate programs and curriculum to prevent violence and substance abuse and promote mental health o Expanding school based mental health to all DCPS and Charters through mixed funding from schools, local grants and Medicaid o Involving parents and families as active partners in the selection of and planning for treatment
Early Care and Education	Description: Child care, schools and curriculum and non-curriculum-based early learning programs are at the heart of the child development system. Developmentally appropriate settings and environments are keys to the readiness and success of all children and cut across many Themes (Health & Safety, Family Education & Support, Quality Assurance). ❖ Create a network of early childhood development programs and two comprehensive service centers, particularly in neighborhoods with poor performing schools and high concentrations of poverty. ❖ Opportunities to build community linkages through partnership to ensure that programs are efficient and effective ❖ Increase in the quality and community ownership of child care providers ❖ Increase in the funding for capacity building and long-range planning ❖ Early identification and better and earlier intervention to prevent the need for Special Education ❖ Encourage teachers to understand health issues ❖ Use more play activities and encouragement of parent habits and skills to stimulate child cognitive development ❖ Aligning curriculum and instruction standards and priorities from Pre-K and

Theme	*Recommendation*
	Kindergarten, then Kindergarten to 1st grade ❖ Cross-training programs for educators would ensure that training doesn't occur in a vacuum
Family Education and Support	Description: Several programs include family involvement and skill development (such as family literacy and parental empowerment) as a central aspect of their approach. These issues are part of the condition for establishing and nurturing a healthy learning environment for children and often serve to infuse values, ethics and morals. ❖ Expand and better coordinate home visiting services to families. ❖ Provide core funding for the Home Visiting Council to coordinate existing home visiting programs, to provide training and evaluation so programs meet high standards of quality, and to ensure families receive appropriate home visiting services. ❖ Increase funding for home visiting services. Currently, fewer than 10 percent of at-risk families in the District receive a home visit. ❖ Establish a universal screening and referral process for all parents of newborns who are District residents. Universal assessment and referral will ensure that families who receive home visiting programs are those that most need support, that families are referred to the home visiting program that best meets their needs, and that home visiting programs have the public and private partners to provide those families the resources that they need to achieve the best outcomes for themselves and their families. ❖ Opportunities to build community linkages through partnership to ensure that programs are efficient and effective ❖ Establish one location to access information on parent education and family support programs ❖ Greater support and implementation for the five goals for parent education in DC: 1. parents empowered to take better care of children; 2. quality early childhood and education programs; 3. effective parent ed programs; 4. funding for parent ed; 5. parent ed training programs
System Access and Quality Assurance	Description: These are the organizing categories for the stakeholders and programs contributing to the development of partnerships, public education, advocacy efforts, research, evaluation and monitoring, program enhancements, and other means to build capacity, align and integrate systems, and ensure that resources to address the needs of children and families are adequate, appropriate, effective and sustainable. ❖ Provide parents of newborns and infants and toddlers with parenting information and support. ❖ Invest in a continuum of proven practices* (evidence-based) of prevention, early intervention, and treatment programs. ❖ Empower a collaborative of City child serving agencies, education leaders (DCPS and Charter Schools), researchers and families to work together to plan a comprehensive system. ❖ Divesting in failed practices that have no evidence base and those which are not a best fit; (i.e. paid mentoring, residential treatment and out-of-state placement) ❖ Reinvesting in a continuum of proven practices in natural settings--- home, community, and school-based services

Theme	***Recommendation***
	❖ Building multi-agency collaboration and high-level accountability structures to City leadership ❖ Building quality programs that can be accessed by children and families regardless of point of entry (i.e., No Wrong Door) ❖ Support the professional development of infant and toddler child care providers ❖ expansion of the following types of service: o Infant (0-3) Child Care Centers o Early Care and Education for Children with Special Needs o 24 Hour Child Care/Non-traditional child care (to accommodate parents that work off-hours or late-night shifts) o Parent Education and Support o Respite Care (both drop-off sites and in-home services). ❖ Quality and Accessibility: While childcare is widely available, efforts need to be made to ensure that high quality, affordable and community-based care is available throughout the District. ❖ Single Point of Access for Early Childhood Services: The major institutions that are responsible for early child care and education (DHS, DCPS, DPR) should collaborate to establish a single point of access for information about and access to services. ❖ Expansion of various training programs for professionals working with children ❖ Reduce programmatic silos for categorical programs ❖ Increase awareness of the full range of services and opportunities available ❖ Create a uniform case management system that ensures effective coordination, smooth transitions, dissemination of information to families and city agencies, and enables efficient budgeting and resources ❖ Develop a formalized community-based infrastructure to further integrate services offered to overlapping populations ❖ Prevent the need for the more expensive costs associated with challenges in youth and young adult populations. ❖ Improve coordination of services across public and private institutions working with children by identifying or creating a central point of accountability for early childhood outcomes ❖ The Executive and City Agency Leadership should develop the organizational structure needed for a City-wide shift to a continuum of proven prevention, intervention and treatment practices. Organization structure must: ❖ Be directly accountable to the Mayor and City Administrator ❖ Involve researchers, parents, and providers ❖ Tie closely to Citi-Stat system ❖ Support a results-based culture shift ❖ Build on proposed Integrated Services Fund

All proposed activities below are aligned with the ECCS vision of "ensuring access to comprehensive, high-quality early childhood programs and services that promote child well-being and school readiness and ensure that all children are healthy, ready to learn and have safe passages through the early years". Activities, action steps, and justification are listed below and include connections to the ECCS service delivery themes, 2006 ECCS steering committee recommendations, as well as linkages to Mayor Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia".

ECCS Core Recommendation 1:
Create an early childhood "brand" for all District stakeholders to rally behind and develop a corresponding marketing and public outreach campaign to promote early childhood programs/services.

Core Implementation Activity 1:
Develop a "brand" for early childhood in DC through the use of public awareness campaigns

Anticipated Outcomes:

- A unified message expressing the importance of early child development
- Greater collaboration across different services sectors (health, safety, child care, parent education, etc.) under the banner chosen
- Improved understanding and support on the part of the general public and civic, business and governmental leadership regarding the benefit of investing in children

Rationale/ Linkages:
To develop an effective early childhood system requires community support and understanding of how to use the system – but the District has many systems and feedback suggests the public and many inside government are confused as to the role, function, and vision for early childhood services in the District. This recommendation addresses the need for public engagement efforts to ensure that all constituencies participating in and accessing the early childhood systems understand and are capable of articulating the system in a clear and concise manner. The District has adopted a vision for children and families. Our next step is to create a single brand that crystallizes that vision and provides a vehicle for gaining momentum for improving outcomes for children. Public engagement activities help establish and reinforce the brand and provide the key language that defines the early childhood system and its action plans to mobilize key stakeholders, communication plans to share information and dissemination, and advocacy work to build and sustain the early childhood system

Service Delivery Theme:

District of Columbia ECCS Implementation Plan

This activity addresses the ECCS service delivery areas of parent education and family support, health and safety, community development, access and quality assurance, and early care and education.

Mayoral Priority*:*
None Identified.

Action Steps	Responsible Parties	Target Date/Status
• Meet with DME to determine if any brand has been developed or is being planned	• ECCS	• July 31, 2007
• Research pre-developed public awareness campaigns such as those created by the "Born Learning Initiative" at the United Way	• ECCS	• Some research conducted in 2006 • Additional efforts by August 30, 2007
• Develop public/private partnerships to support public awareness efforts—ex, "Fairfax Futures"	• ECCS • DME • DCPS	• November 30, 2007
• Strategize ways in which to connect an early childhood brand or public awareness campaign to the *Pre-K Now! Initiative, DC Play Blocks*, and others • Expand efforts of Pre K for All to include Early Childhood (birth-8)	• ECCS • Pre-K Now! • DC Play Blocks Initiative	• January 2008
• Invite representatives from North Carolina Smart Start to provide technical assistance regarding their efforts to build the Smart Start "brand"	• ECCS • MACECD • Deputy Mayor for Education (DME)	• ECCS has a standing commitment from Gerry Cobb and Karen Ponder to provide TA • March 31, 2008

• Launch DC early childhood brand and public awareness campaign	• ECCS • MACECD • DME • Public and private partners • DC Metro system • Local radio, TV and print media	• September 2008

ECCS Core Recommendation 2:
"Create multiple points of access for services and resource information" through the creation of a "technological infrastructure consisting of a comprehensive database of resources";

Core Implementation Activity 2:
Use the early childhood resources information gathered through ECCS and DOH's Health Information Response Team (HIRT) to populate and update the Mayor's citywide social services resource center, *211 Answers Please*!

Anticipated Outcomes:
- An enhanced ability for the District of Columbia to provide accurate, current and appropriate referrals to programs and services affecting children and families
- Improved strategic planning and partnership infrastructures for public and private organizations across the District
- Improve Ward-specific referrals and service coordination

Rationale/ Linkages:
Several co-occurring resources in the District are gathering and providing information through databases and other information systems. With the possible exception of child care information and referral, part of the challenge for the District, among early childhood stakeholders and parents alike, has been a shortage of good, accurate and up to date information regarding the programs and services available to children and families. While several agencies and organizations maintain their own databases of information on resources, in recent years great progress has been made to establish the Mayor's *211 Answers Please* line as the leading and universally accessible database of social services resources in the District. The system and resource mapping process conducted through ECCS utilized other databases such as the 211 system in identifying resources relevant to

children and families but then expanded upon the information 211 typically maintains. As such, the ECCS information has the potential to add helpful information to the 211 and other referral databases for use by both policy-makers, system stakeholders and the general public.

Service Delivery Theme:
Addresses the ECCS service delivery areas of parent education and family support, health and safety, community development, access and quality assurance, and early care and education

Mayoral Priority*:*
Pg 7 of Mayor Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia" plan - "accelerate the implementation of a unified student tracking and data sharing system"; and
Pg 14 – "create a plan for cross public agency data sharing"

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Contact 211 Administrators and technicians at OCTO to discuss in detail the capacity for varying degrees of systems upgrades	• DHS • ECCS • HIRT	• Initial conversation conducted February 2007 • July 31, 2007	• Review with OCTO the capacity and potential for the 211 line
• Review information currently available inside "211"	• ECCS • Department of Human Services (DHS)	• Initial review conducted in fall of 2006. • Submit updated information for inclusion into 211's system by July 31, 2007	• Examine the depth, breadth and accuracy of 211 information on individual programs and services

• Review "211", ECCS for accuracy	• DHS	• August 31, 2007	• Examine at least 100 program records of 211 information on individual programs and services
• Encourage DMH's access help line, DOH's information command center, and Washington Child Development Center (WCDC) to update "211" with early childhood resource information	• ECCS • DMH • ECEA • WCDC	• October 30, 2007	• Broker a more active relationship and collaboration between 211 information management and DMH, MPCA and WCDC
• Educate "211", DMH, and DOH resource line staff on the information provided to them (staff and training program)	• MPCA • DHS/ ECEA/Head Start Collab • DMH	• February 28, 2008	• Provide at least three orientation for frontline staff regarding the substance and status of program information

ECCS Core Recommendation 3:
Improve early identification of children with developmental needs to minimize the likelihood of placement in special education programs.

ECCS Core Implementation Activity 3:
Through participation in the National Academy for State Health Policy's (NASHP) Assuring Better Child Development (ABCD) Screening Academy, explore standardization of developmental screening tools used amongst providers enrolled in DC's Medicaid Managed Care Program.

Anticipated Outcomes:

- Improve early identification of children with developmental delays.
- Increased identification of mothers suffering from maternal depression.
- Improved system of tracking and measuring health outcomes amongst vulnerable populations.
- Enhanced quality assurance measures improving appropriate referrals and follow-up care.
- Statewide implementation of a standardized screening tool to identify developmental delays, social emotional needs, and/or maternal depression.

Service Delivery Theme:
Addresses the service delivery areas of Health & Safety, Early Care and Education, Quality Assurance, and Systems Access.

Mayoral Priority:
Pg 7 – " Explore strategies for reducing special education costs by minimizing the need for special education through effective early intervention".
Pg 14 – "Develop a system of early identification of child and adolescent mental health issues…".

Action Steps	Responsible Parties	Target Date/Status
• Jointly apply for participation in the ABCD Screening Academy	• DOH/ECCS, DOH/Medicaid, DC AAP	• April 20, 2007
• Identify potential partners to participate in ABCD • Develop core leadership team and advisory stakeholder group	• DOH/Medicaid, DOH/ECCS	• May 31, 2007
• Identify an appropriate tool for use in Medicaid managed care settings	• Core leadership Team/ Advisory Group	• July 30, 2007
• Identify barriers to statewide standardized screenings and prioritize potential solutions	• Core leadership Team/ Advisory Group	• July 30, 2007

• Identify or create a system for tracking referrals and providing feedback to physicians on outcomes	• Core leadership Team/ Advisory Group	• December 31, 2007	•
• Test an identified screening tool and optimal referral process at 3 pilot sites	• Core leadership Team/ Advisory Group	• February 28, 2007	•
• Assess impact of changes at pilot sites	• Core leadership Team/ Advisory Group	• July 31, 2008	•
• Implement the use of a standardized tool amongst all providers enrolled in the Medicaid managed care system	• Core leadership Team/ Advisory Group/American Academy of Pediatrics	• December 31, 2008	•

ECCS Core Recommendation4:
"Create multiple points of access for early childhood services and resource information"

Core Implementation Activity 4:
Reinstate the use of early childhood consultants to provide multidisciplinary training and on-site supports to early care and education programs and the families they serve; revitalize relevant components of the now defunct Healthy Child Care America Initiative.

Anticipated Outcomes:

- At least 75 childcare providers in the District of Columbia will host early childhood consultants by 2009.
- Increase by 15 percent the total number and tracking of referrals to comprehensive early childhood services for children in childcare settings.
- Expand the internal capacity of childcare providers to conduct health and child wellness services through formal and informal training and technical assistance.
- Hire, train, and deploy at least 30 early childhood consultants.
- Expand access to mental and socio-emotional health services by 20 percent for children in childcare.

- Expand by 15 percent the number of children receiving dental, vision, and hearing screens in childcare settings.

Rationale/ Linkages:
A cornerstone of District of Columbia's strategy for children and families is the availability of comprehensive, high quality early care and education services that sufficiently meet the needs of children. Ensuring healthy environments for children in early care and education settings, and ensuring children and families have access to a variety of developmental and health care services are therefore high priorities. From 2001 until 2005 the District was a recipient of grant funds from HRSA to support the recruitment, training, placement and management of child care health consultants – a specially trained group of professionals who visit child care providers and render a comprehensive array of services to children at the facility. As a result, the Transitioning of Healthy Child Care America to a coordinated Early Childhood Comprehensive System via the ECCS grant is a citywide priority. This activity adds value to DC's ECCS systems improvement process by increasing the capacity for education and training to child care programs, DCPS staff, health professionals, and other community-based and faith-based providers that work with young children.

Service Delivery Theme:
Addresses the ECCS service delivery areas of parent education and family support, health and safety, community development, access and quality assurance, and early care and education

Mayoral Priority:
Pg 13 of Mayor Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia" plan - "explore expanding home visitation and early intervention programs to reduce infant mortality, child abuse and neglect, youth violence, and to support mental health and wellness…"; and
Pg 14 - "develop a system for early identification of child and adolescent mental health issues and for providing needed care locally".

Action Steps	Responsible Parties	Target Date/Status	
• Create concept paper detailing the rationale for and purposes of this program	• Early Childhood Comprehensive Systems Initiative (ECCS) • Early Care and Education Administration (ECEA) of the Department of Human Services (DHS) • Head Start State Collaborative Office • Department of Mental Health (DMH)	• July 31, 2007	•

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• Find consultants who have been trained in DC and convene them	• Head Start Web Page (Beverly Jackson) • MACECD Health Promotion Subcommittee • DHS Early Care and Education Administration (ECEA) • MPCA • Department of Mental Health (DMH)	• July 31, 2007	•
• Work with a multidisciplinary team (including organizations currently involved in home visiting projects) to draft components of a pilot initiative	• ECCS • ECEA • Maternal and Primary Care Administration (MPCA) of the DC Department of Health (DOH) • Department of Mental Health (DMH) • Head Start State Collaborative Office	• September 30, 2007	•
• Identify the models for early childhood consultants (ECC) • Research successful models of health care consultant programs (NC) • Research successful models of mental health consultant programs • Create a working definition of early childhood mental health • Create a working definition of early childhood mental health consultation (lay person and clinicians) • Find commonalities amongst models and merge appropriate components to create a usable model for DC	• MACECD • Head Start State Collaboration Office • ECCS • DMH • DCPS	• September 30, 2007	•
• Identify means of deploying consultants to accredited child care centers and Head Start Sites	• ECEA • MPCA • Head Start State Collaboration Office • DCPS • MACECD	• January 31, 2008	•

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• Define roles/responsibilities of early childhood consultants. Anticipate challenges to meeting public demand for consultants (recruitment, training, salary, placement)	• Mayor's Advisory Committee for Early Child Development (MACECD) • Network Support Center (NSC) - TA • ECCS • DMH • DCPS • Head Start State Collaboration Office	• January 31, 2008	•
• Establish an MOU between core agencies to sustain commitment for trainers/consultants	• DCPS • DOH • DHS • DMH	• January 31, 2008	•
• Utilize existing funds from ECEA, ECCS, and seek out new funding opportunities from Johnson & Johnson, Inc. to support this activity	• ECEA • ECCS	• February 28, 2008	• •
• Expand number of consultants with an optimal target of 30. Ensure cross-training availability and cross-agency deployment and utilization of consultants to address mental health, oral health, victimization and child abuse/neglect issues, culturally and linguistically appropriate skills, etc.	• Head Start Web Page (Beverly Jackson) • MACECD Health Promotion Subcommittee, • DHS Early Care and Education Administration (ECEA) • MPCA • Department of Mental Health (DMH) • DCPS	• September 30, 2008	• • •
• Establish a strategy and infrastructure for the consultants to bill Medicaid for services to eligible children	• DOH Medical Assistance Administration (MAA) • Maternal and Primary Care Administration (MPCA – formerly the Maternal and Family Health Administration) • ECCS	• December 31, 2008	• •
• Identify other funding sources to support early childhood consultants (ECC) and their training for five years (e.g. Robert Wood Johnson)	• MACECD	• February 30, 2009	•

The following activities are termed "supporting" as they provide opportunities for the ECCS initiative to directly support ongoing and already established functions or activities lead by agencies mostly outside of the Department of Health and the authority of ECCS Implementation funds. They share a clear link to the ECCS vision and ideals, though most are not directly tied to implementation recommendations provided either by the ECCS steering committee or through the Mayor's 2007 Action Plan. Instead, they are

activities in which system building will be achieved through continuing and strengthening existing partnerships.

Supporting Implementation Activity 1:
Consolidation of early childhood planning groups/ determining ways to more effectively link them to one another

Anticipated Outcomes:

- A reduction of the total number of planning and advisory groups in the District that are free-standing entities lacking budgetary, regulatory or programmatic authority over more than one program or early childhood issue
- Enhanced collaboration and integration among and between stakeholder groups
- Identify and confirm the termination or merging of unnecessary, defunct, and/or inactive planning groups

Rationale/ Linkages:
There are many planning and advisory groups in the District of Columbia and it has been historically difficult for stakeholders to participate in any or all of the groups that may cover interests overlapping with their responsibilities. Furthermore, very few of the planning groups in the District have budgetary or program oversight authority. As such, while they may provide value to their participants as a forum for discussion early childhood issues, sharing often valuable program information and perspectives, and framing potential courses of action, these groups often lack the ability to manifest systemic changes. This activity addresses the ECCS service delivery areas of access and quality assurance, health and safety, and early care and education.

Mayoral Priority:
Pg 6 of Mayor Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia" plan – "Reaffirm commitment to using the existing Mayor's Advisory Committee on Early Childhood Development (MACECD) to drive systemic quality improvement".

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Identify groups and revise the existing ECCS DC Planning Group Map to provide an accurate picture of existing and thriving early childhood planning groups	• MACECD • Deputy Mayor for Education (DME) • ECCS	• A revised Map was provided in January, 2007 • Next revision: December, 2007	• A comprehensive, accurate and updated map of collaborative groups in DC • Involvement by and support of the Mayor's Office in the identification of planning groups and their status

• Meet with MACECD Chairperson to discuss possible options	• ECCS	• February 28, 2008	• Successfully schedule a meeting and open conversation with MACECD leadership regarding a potential structure and plan for coordinating collaborative activities
• Convene planning group coordinators to discuss the feasibility of merging or more effectively linking with other early childhood related planning groups	• ECCS	• June 30th, 2008	• Involvement of key DC stakeholders and collaborative groups in the discussion of the structure and options for modifying the status and integration of collaborative groups • Identification of at least three structurally appropriate mergers or realignments of planning groups
• Link groups to MACECD and its subcommittees	• MACECD • DME • ECCS	• December 31, 2008	• Restructuring and potential consolidation of early childhood planning groups under the potential header of MACECD or a series of other convening bodies • Restructure/realign at least two MACECD subcommittees

Supporting Implementation Activity 2:
Create health indicators and benchmarks for children aged 0-8 in DC

Anticipated Outcomes:

- A single set of early childhood indicators for use by multiple agencies in documenting the status of child and family health, development, and support
- Cross-agency collaboration to track and monitor child outcomes
- An annual report card disseminated to the general public and District leadership highlighting trends in early childhood

Rationale/ Linkages:

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This activity addresses the ECCS service delivery areas of health and safety, early care and education, and access and quality assurance. Indicators will ultimately serve as the measures by which the success of the ECCS initiative will be applied in the long-term.

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Connect with groups who are currently working to develop citywide child indicators such as the Children's Advocacy Roundtable Group and the MACECD Health Promotion Subcommittee	• ECCS • MACECD • ECEA • DCPS	• September 30, 2007	• Meetings and collaborative discussions with advisory groups across DC • Number of meetings held to discuss indicators • Number of stakeholders offered an opportunity to contribute to the creation of the indicators
• Rely on guidance from the Healthy People 2010 Initiative in initially developing benchmarks	• ECCS	• January 31, 2008	• Incorporation of Healthy People 2010 in the discussion for developing indicators
• Review indicators used by Safe Passages Report in 2002 and assess feasibility of adaptation to current application	• ECCS • DME • ECEA • MACECD	• January 31, 2008	• Review Safe Passages indicators • Convene a conversation with the Mayor's office and interested agencies and advisory groups to discuss inclusion of Safe Passages indicators and methods

• Unveil indicators and solicit feedback during 2008 Universal School Readiness Conference	• ECCS	• April 2008	• Completion and adoption of a single set of indicators • Secure an opportunity to discuss indicators with a broad audience

Supporting Implementation Activity 3:
ECCS to co-sponsor Universal School Readiness (USR) 2007 Annual Conference

Anticipated Outcomes:

- Secure opportunities to discuss early childhood issues covered by the ECCS Initiative
- Increased education of early childhood stakeholders (child care providers, agency representatives, child care monitors, etc.) on current issues, updates, and best practices related to the 5 ECCS service delivery areas.

Rationale/ Linkages:
The overall goal of this conference is to provide education, training, and resource support to teachers, parents, health professionals, child care providers, and others who work with or have impact on children's readiness to learn and succeed upon entering school.
This activity addresses the ECCS service delivery areas of health and safety, parent education and family support, early care and education, and systems access.

Action Steps	Responsible Parties	Target Date/Status	Indicators
• ECCS coordinator will serve as a member of the planning body for the annual conference	• ECCS Coordinator • Early Childhood Learning Institute (ECLI)	• Ongoing through 05-28-07	• Participation in the conference planning group by ECCS representative

• ECCS coordinator will organize the creation of at least 6 child health-related workshops	• ECCS Coordinator/ MPCA Staff	• Workshops completed - May 2007	• At least 5 child/maternal health related workshops sponsored through ECCS/MPCA • Number of participants attending workshops • Number of continuing education credits awarded through sponsored workshops
• ECCS will be a conference sponsorship partner	• ECCS Coordinator	• Ongoing through 05-28-07	• ECCS/MPCA recognition and involvement as a conference sponsor and organizer

Supporting Implementation Activity 4:
Provide input regarding early child care professional development needs, requirements, criteria, and activities for FY 08 and FY09

Anticipated Outcomes:
- Greater coordination of stated child care worker professional development needs among DC planning and training organizations
- Improved coordination of training opportunities and professional development standards

Rationale/ Linkages:
To provide quality services that will have the best outcomes for children and families, it is important that the staff providing the services are knowledgeable about their jobs, early childhood development, and the impact that they can have on positive outcomes for the development of young children. One part of the Recommendation is to reinforce core competencies that allow individuals to move laterally across disciplines as well as up in their own discipline as a way to develop a cross trained and integrated work force and to offer more opportunities for early childhood staff. This activity is aligned with ECCS service delivery areas of community development, access and quality assurance, early care and education.

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Members of the ECCS state team will participate in an annual three series planning session sponsored by the Early Care and Education Administration. The areas of interest range from Education, Early Childhood, Health, Mental Health, Systems Design, and Organization Development	• ECCS/MPCA • ECEA	• Y1 Session 1: January 2007 • Y1 Session 2: March 2007 • Y1 Session 3: TBA 2007 • Y2 Session 1-3: January 2008-August 2008	• Participation by ECCS State Team in professional development planning sessions • Inclusion of ECCS recommendations and findings in the design and planning of professional development efforts

Supporting Implementation Activity 5:
Facilitate conversations that lead to linkages to the newly developed Medicaid health information database

Anticipated Outcomes:

- Improve coordination of health care services and outcomes for children eligible for Medicaid
- Enhance the sharing of information between Medicaid (EPSDT) and DCPS, ECEA and MPCA regarding trends in maternal and child health
- Improved data entry and accessibility to ensure Medicaid-eligible children receive high quality services
- Reduced duplication of administrative costs associated with health care services and records for Medicaid-eligible children
- Optimization of Medicaid usage by eligible populations

Rationale/ Linkages:
The new Medicaid database is based upon information gathered through the EPSDT forms. From 2002-2005 the District developed a Universal Health Screening Form to be used by child care providers, before- and after-school programs, DC Public Schools and

others for assuring health and immunization compliance and records for all children and youth. However, the EPSDT form used by Medicaid are not part of the Universal Health Screening Form and these forms are likely to remain separate. Part of the purpose for this implementation activity will be to assess the information tracked by both of the databases associated with each of these forms to ensure that information useful to any and all parties, as permitted by law, can be accessed and available. For those accessing these databases, obtaining information regarding EPSDT and vaccination information is important, but currently only basic or incomplete information is available on most children's medical charts. An outcome of this activity should be improved data entry and accessibility that limits duplication of services to children and families, promotes collaboration between variant service providers, and creates a system of monitoring that ensures children and families are receiving high quality services. This activity addresses the ECCS service delivery areas of Health and Safety (Access to a Medical Home); and System Access and Quality Assurance.

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Include special needs children as part of database development and implementation	• MCPA, CSHCN • HSC, Inc	• May 2008	• Utilization of Medicaid database to assist MPCA's Division of Children with Special Health Care Needs and HSCSN, Inc. to track and monitor services to these children • Enhanced coordination of services to special needs children
• Identify stakeholders to participate in conversation	• Medicaid • ECCS	• June 2008	• Involvement of departmental leadership from key agencies and organizations • Timeliness of discussions and time to complete planning effort

• Clarify the purpose of the databases, who its users are, how children and families will ultimately benefit from implementation	• ECCS	• September 30, 2008	• Clear lines of responsibility and accountability for data entry, data integrity, confidentiality and services to children • Involvement of Medicaid providers in the discussion of any changes to the inputting of data and the systemic expectations for its quality and use
• Determine the services Medicaid provides and the data available in their system	• MPCA • MAA • ECCS	• September 30, 2008	• Identification of major health services provided through EPSDT and their correlation to information gathered through the Universal Health Form and standard practices at the Early Intervention Program and Children with Special Health Care Needs Bureau • Assessment and improvement of any difficulties associated with data entry and compliance by Medicaid providers

District of Columbia ECCS Implementation Plan

• Determine capacity for linkages with childcare facilities and Head Start sites	• ECCS • ECEA/Head Start Collab Office • MAA	• February 2009	• Identification of major health services provided through EPSDT and their correlation to information gathered through the Universal Health Form used by child care and Head Start providers
• Provide an orientation to all early childhood stakeholders who might serve Medicaid children and partners for education and solicitation	• ECCS • ECEA/Head Start Collab Office • MAA	• March 30, 2009	• At least two orientations (one on a weeknight) to child care providers, health care practitioners and others serving Medicaid-eligible children • Use MACECD and USR monthly meetings as a vehicle for orientations • Participation of at least thirty providers in orientations

• A minimum of 15 site connections to be launched	• ECCS • ECEA/Head Start Collab Office • MAA	• August 30, 2009	• Include at least 15 child care and Head Start sites in the Medicaid database integration discussion • Assess capability and appropriate access to Medicaid information by a piloted group of providers – and select appropriate providers

Supporting Implementation Activity 6:

Increase access to appropriate care and education by initiating "Head Start First" - increase access to appropriate and affordable childcare by first requiring enrollment in Head Start before using child care slots delineated by other sources of funding.

Anticipated Outcomes:

- Maximization of the Head Start funds and available slots in the District
- Increase the public's knowledge of Head Start and its utilization
- Increase the percentage of Head Start-eligible children participating in the program
- Non-duplication or redundancy of early care and education services to children 3-4 yrs old who are eligible for Head Start
- Demonstrate effective and efficient programmatic coordination between pre-k providers and Head Start

Rationale/ Linkages:

Public awareness of the availability of Head Start is mixed and some child care providers do not refer children eligible for Head Start to Head Start. While competition between programs is a barrier/struggle, the District must bring together parties to ensure cooperation, not competition. This activity addresses the ECCS service delivery area of access and quality assurance and early care and education.

Mayoral Priority:

Pg 19 of Mayor Fenty's "100 Days and Beyond: 2007 Action Plan for the District of Columbia" plan - "Develop a strategy to transform child care, Head Start, and pre-kindergarten programs into a coordinated system that assures school readiness by age 5".

District of Columbia ECCS Implementation Plan

Action Steps	Responsible Parties	Target Date/Status	Indicators
• Determine barriers to enrollment in Head Start	• ECEA • DCPS • Charter schools • DME	• July 31st, 2007	• Convene a group of Head Start and child care providers to discuss and identify barriers to enrollment
• Develop a plan to address enrollment barriers (i.e., stigma, dual eligibility, protocols)	• UPO • Head Start State Collaborative	• December 30, 2007	• Timely development of a DC-wide strategy and campaign for ensuring enrollment barriers are minimized

District of Columbia ECCS Implementation Plan

• Implement/evaluate plan	• Head Start • UPO	• Commence implementation by May 2008 • Evaluate progress June 2009	• Number and penetration of public education and child care provider outreach campaigns to ensure Head Start First • 0% of child care providers not receiving Head Start funds will provide services to Head Start-eligible children • Selection of an external evaluator to assess progress
• Educate health care and Social Services providers about Head Start First	• UPO • DCPS • ECEA	• May 30, 2008	• Provide a minimum of two presentations to health care and social service providers who serve child care and Head Start facilities • Link Head Start First to the Early Childhood Consultant corps

District of Columbia ECCS Implementation Plan

• Develop strategies to educate and encourage parents to enroll their children in Head Start (get statistics)	• UPO • DCPS	• May 30, 2008	• Development of public education campaigns • Market penetration of advertisements, public service announcements • Dissemination of pamphlets and brochures to families likely to be eligible for Head Start
• Educate child care and head start provides to ensure eligible children are in H.S., not C.C.	• ECEA • Washington Child Development Council (WCDC) • DCPS	• First round: May 30, 2008	• Provide a minimum of three presentations to child care provider stakeholder groups • Make presentations and announcements at USR meetings and conferences • Involvement of child care subsidy Monitors in the education and monitoring of child care providers to ensure their referral to Head Start for all eligible children

• Establish protocol and provide training	• Head Start State Collaborative	• May 31, 2008	• Provide at least three training opportunities to child care providers • Equip child care providers with Head Start enrollment forms to pre-screen potentially eligible children

Org Name		
Family and Maternal Health Administration	**The D.C. Children With Special Health Care Needs Advisory Board** meets six times a year to advise the CSHCN Division of the FMHA. Meetings include community leaders, members of the advisee organization, and occasional guests.	
Healthy Families Thriving Communities Collaboratives	**The Georgia Avenue/Rock Creek East Family Support Collaborative** links urban families with regional assets and opportunities, builds on existing strengths, and expands involvement in local programs. The Collaborative provides case management services to 140 at-risk families, as well as information and referral services, support groups for fathers and other caregivers, community grants, and partner development.	Local residents
Office of Early Child Development	**The D.C. Early Intervention Program** participates in the following planning groups: **The Interagency Coordination Council,** CSHN Advisory Committee, Developmental Disabilities Council, State Policy Council on Family Support, Infant Mortality Review Committee, Fetal Alcohol Syndrome Steering Committee, DC HEARS, and the Early Head Start Committee.	
South Washington Collaborative	**The South Washington / West of the River Family Strengthening Collaborative (South Washington Collaborative)** develops and/or coordinates resources and services in our community (e.g. residents, churches, schools, businesses, non-profit agencies and civic groups) to build the capacity of our residents and organizations, to reduce the conditions leading to child abuse and neglect by supporting and promoting the social, emotional, physical, spiritual and economic growth and stability of our children, youth, and families.	Residents who live in Ward 6 and are parenting children under the age of 18.
The Healthy Families, Thriving Communities Collaboratives	**The Healthy Families, Thriving Communities Collaboratives** are a network of seven community based organizations providing intensive family-centered services to low income children and families.	Low-income children and families

			$2.1 million from OECD office
	140 in case management		
			$25,000 from the Meyer Foundation for the Client Information Database
	Over 1,600 family cases managed		$12,000 for parent groups $15,000 for children's programs

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
	Programs and services that promote health, provide a medical home, ensure access to a continuum of care and maximize the physical and mental well-being of children and the chances for them to grow up healthy, ready to learn and free from preventable circumstances that compromise their ability to pursue their full potential.	*Description of the children and families the program seeks to affect, including eligibility criteria*	*Ages of children*	*# children eligible/served*	*Physical doors of entry (On-site and Home Visitation)*	*Total annual programmatic budget*
Children's National Medical Center	Launched in September 1992, the Children's Health Project of D.C. seeks to serve the primary care medical needs of children living in some of Washington, D.C.'s most impoverished communities usine mobile medical units. The project's model of finding local solutions to national problems and staying community-directed has allowed the program to be replicated by nonprofit clinics within Washington, D.C. and by academic institutions throughout the nation. The Children's Health Project of DC is organized as a satellite of the Diana L. and Stephen A. Goldber Center for Community Pediatric Health.	The project serves permanently-housed families in the Anacostia region of southeastern Washington, D.C. Serves constituents up to 21 years of age, including neglected, abandoned, physically abused children (30% of kids need a referral to social services f	from birth to age 21.	About 300 patient visits are conducted per month aboard two mobile units and a fixed site clinic. Since Oct 1992, there have been more than 44,000 patient visits. In last year, 3,300 vistis to the mobile clinic, and 3,200 to DC General clinic.	40 clinical sites completed paper surveys, 14 had on-site surveys.	$1,800,000.00

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Department of Health	**Maternal and Family Health Administration (MFHA)**'s mission is to plan, promote, and coordinate a comprehensive system of care for families, women, children, and adolescents, including children with special health care needs in the District of Columbia. In addition, the Administration is charged with designing a system of care that impacts positively on maternal and child health issues such as infant mortality, teen pregnancy, metabolic disorders, and disabilities, as well as address access barriers to appropriate health services.			14,777 children <1 yr, 3,246 children age 1-4		
Department of Health / Maternal and Family Health Administration	**Newborn Initiative:** This program enables nurses to refer children to Healthy Start, Healthy Babies, CFSA, collaboratives, and others as appropriate. Services, including home visitation, are available to anyone who requests them, and HEALTHLINE staff members are available for non-English speakers.	Any newborn's parents who request them; substance abuse (a child with trace element is to be visited in home by CFSA. They look at child first time. A DOH nurse does a visit w/ CFSA caseworker. Some children stay in hospital for detox.	Newborns		Home visitation	
Horton's Kids	**Horton's Kids** provides comprehensive services to the underserved children of Anacostia's Wellington Park housing project, including services to meet fundamental needs, such as health care, food, and clothing.	Children in Anacostia's Wellington Park housing project in Ward 8				

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Latin American Youth Center	**Latin American Youth Center's Freddie Mac**: social service program specifically designed to provide services to young adolescents and adults who are part of the Foster Care Program or who are in danger of becoming homeless or runaway. The programs goals include: Rebuild supportive relationships between youth and their biological families, and seek family reunification when possible. Reduce incidence of prostitution and drug use among homeless and runaway youth by providing shelter and referrals to safe housing alternatives, including family reunification. Reduce clients long-term dependency on social services; build clients self-sufficiency in areas including housing, language skills, etc. Empower clients to develop effective interpersonal skills needed to maintain housing and a job. Provide minors with homes headed by competent caregivers.	All programs described above target at risk youth in danger of becoming or who are homeless or under the care of the DC CFSA. Together, these programs serve a 0 to 21 age cohort.				
Martha's Table, Inc.	**Children, Youth & Family Learning** provides meals and snacks, interactive learning, health education, recreational activities, day care, after-school and summer camp programs, developmental screening, and parent training and education classes.	Children, teens, and parents who come to Martha's Table; Ward 1	3 mo. - 4 yrs in day care, 5-18 years for other programs		On-Site	
Mary's Center	**Mary's Center for Maternal and Child Care** established in 1988 with joint funding from the DC Mayor's Office on Latino Affairs and the DC commission of Public Health to address the need for Spanish speaking maternal and pediatric services in the predominantly Latino areas of Ward One. The center now serves a multi-cultural population residing in every ward of the city with a focus on families who work in jobs where health insurance is not available.	All families with children who work, but have no access to health insurance through their employers. 52% of clients are eligible for medicaid;40.3% for DC Health Care Alliance;6.4% for private insurance and 1.3% for no insurance. 91% of the clients are Hispanic.	0-6 year olds; 7-12 year olds;13-18 year olds; 19-22 year olds.	2600	On site and mobile health clinic "The Mama and Baby Bus" at six DC sites in wards 1,2,4,5 in collaboration with March of Dimes. A school-based health center at Brightwood Elementary school.	$8,000,000.00

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Office of Early Child Development	**OECD's Program Development Division** implements the Head Start State Collaboration Project, designs and implements child care program expansion and improvement efforts, provides consumer services, and coordinates professional development initiatives for early care and education providers. It also implements the Quality Child Care Initiative (QCCI), Healthy Child Care DC and the Child Care Health Consultant Corps. In 2003 all Healthy Child Care America Projects were asked to include a SIDS training initiative.	All children	Birth to 21		Child care centers	

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Office of Early Child Development	The **DC Early Intervention Program** is part of the Department of Human Services Office of Early Childhood and Development and serves as a single point of entry for the Districts infant/toddler program. The program seeks to identify and serve infants and toddlers with developmental delays. Delays may occur in one or more of the following areas: physical development, cognitive deelopment, language and speech development, social/emotional development, and adaptive/self-help skills. For eligibility, a child must be 50% or more delayed in one of the areas. Services include: assistive technology, hearing evaluations, evaluations and assessments, occupational therapy, physical therapy, service coordination/case management, special instruction, speech-language therapy, transportation and related costs, and vision therapy. DCEIP also actively involves the parents in the child's care through family centered services, and offers transition assistance for when the child reaches three years of age.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	Direct Services: Children's National Medical Center, Columbia Lighthouse for the Blind, Easter Seals, Edward P. Mazique Parent Child Center, Lt. Joseph P. Kennedy Institute, Mary's Center, Multicultural Rehab Services, Out Came the Sun, Phoenix Therapeutic Services, Rosemount Center, Abilities Network, Metropolitan Area Community Services, Rehab Plus, The River School. Evaluations: Multicultural Rehab, Children's National Medical Center, Georgetown Univ. Child Development Ctr., Little Feet & Hands, Out Came	
Progressive Life Center	**DC NIA Therapeutic Foster Care**: The provision of therapeutic foster parents, case management, mentoring, and therapy services.	Children ages 2-20 years of age				

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Rosemount Center	**Rosemount Center**'s mission is to prepare children and families for their future by providing comprehensive early childhood education and family support programs in a bilingual multicultural setting. All Rosemount Center programs offer and coordinate a range of multilingual comprehensive services including: Bilingual instruction, Individualized Curriculum Education Plans, Quarterly progress reports, Weekly thematic lesson plans, Mental Health services, Immunizations assistance, Medical referrals, Nutritional services, Social Services, Speech and Language Therapy, Physical Therapy, Occupational Therapy, Developmental, hearing, vision and dental screenings, Monthly parent meetings, trainings and family socializations, English-as-a-Second-Language classes, Home visits, Parent/Teacher Conferences	Low-income families living at or below poverty line. Families must enroll their child (pregnant mother - 5 years of age) in our Early/Head Start program.				
The Center for Child Protection and Family Support Inc	**The Center for Child Protection and Family Support** was co-founded in 1987 and its mission is to ensure that all children particularly inner-city disadvantaged children have an opportunity to grow up within a safe and nurturing family and community structure. Their work consists of direct delivery of services, training and technical assistance and national leadership on cultural competency.	Child victims			On site (at least 2 locations)	

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Georgia Avenue Rock Creek East Family Support Collaborative	The **Family Stabilization program** provides direct services to families including intensive case management, housing support, financial assistance, information and referral services. Family stabilization services involves the provision of interventions across the service continuum aimed at resolving immediate crisis, identifying and linking to needed resources, and/or providing the support and supervision necessary to achieve permanency goals and family wellbeing. The purpose is to provide neighborhood-based service intervention to families to prevent abuse and/or neglect of children. The objectives of this program are: To update and maintain a resource database or resource manual for use by Collaborative staff, community partners, and families in the target area To provide adequate and appropriate referrals based on the needs of families and children To prevent children from entering the child welfare system. To increase the stability and capacity of families to nurture and maintain their children within their homes and communities. To provide comprehensive case management and services to at-risk families. To support CFSA in their efforts to stabilize and reunify families with open cases in the child welfare system. To ensure children living with their families	For the Family Stabilization Program: Families with minor children 18 and under living in Ward 4, Families referred by CFSA, Youth involved in the foster care system referred by CFSA. For the Capacity Building Program: Parents, Children and Youth				
The National Center for Children and Families	**The J.C. Nalle Community School** is a full service community school program. Students and their families have access to the following: extended academic enrichment program; after school care; social, creative, and cultural clubs for applied mastery; health care services; mental health services; parental involvement; information and referral to community resources; free summer enrichment programs; and social services and counseling.			150 children, 108 adults, 125 families		
Valley Place Family Transitional Apartment Program	**Family Transitional Apartment Program**: The Coalition For The Homeless provides 18 fully equipped apartment units to provide Transitional Housing for 18 familes who have become homeless. Services include 24 hour residential housing, general social services which include: (food stamps, TANF, child care, etc.) case management, substance abuse counseling, assess medical/mental health needs and make appropriate referrals.					

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Pregnancy						
Department of Health	**DC Healthy Start** seeks to reduce infant mortality in wards 5, 6, 7, and 8 through outreach and recruitment, case management and coordination, facilitation services such as transportation to medical facilities, and education and training. The program is voluntary, and home visitation plays a central role.	All pregnant women in wards 5, 6, 7, and 8	Prenatal to two years	335 + 125 through Healthy Babies	on site, home visits and nurse visits.	Wards 7 & 8: $2,350,000 FY03; Wards 5&6: $1,350,000 FY03
Breastfeeding Center for Greater Washington	**Lactation Consults and Breastfeeding Classes** provides comprehensive free lactation education and supports program for women, their partners and other significant family members. Hands-on assistance and instruction in use of breastpumps and breastfeeding supplies. Skilled technical management of lactation related problems. Our goal is to increase breastfeeding satisfaction and duration for expectant parents and families.	Expectant and breastfeeding mothers and families in the DC Metro area from VA,MD, and DC.				$125,000.00
Capitol Hill Pregnancy Center	**The Capitol Hill Pregnancy Center** provides support and assistance to anyone facing a pregnancy or experiencing post-abortion stress. Services include ongoing pregnancy support, prenatal and parenting classes, maternity and baby clothing and supplies, post abortion peer support and Bible studies, and medical, legal, adoption, and housing referrals. The center also runs an abstinence teen program.				Five members of the Multidisciplinary Team	
Capitol Hill Pregnancy Center	**Crisis Pregnancy Help**: The CHPC porgrams offer help and support to women, men, gorls and boys who are struggling with a crisis pregnancy. We provide free pregnancy testing, material resources (baby clothes, cribs, strollers, bottles, high chairs and all other items that babies need), free childbirth classes, free parenting classes and one to one mentoring and couseling. Our counselors are trained to look for abuse when meeting with the clents and we encourage conversations that allows the mother and/or father to share their frustrations as parents. We address child abuse in both the childbirth classes and our parenting classes.	Our target is the DC inner-city lower socio-economic population. We work with mostly the mothers and mothers-to-be and encourage them to break the generations of incorrect parenting and etc.				

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Capitol Hill Pregnancy Center	**The Capitol Hill Pregnancy Center** provides support and assistance to anyone facing a pregnancy or experiencing post-abortion stress. Services include ongoing pregnancy support, prenatal and parenting classes, maternity and baby clothing and supplies, post abortion peer support and Bible studies, and medical, legal, adoption, and housing referrals. The center also runs an abstinence teen program.	Anyone facing a pregnancy or experiencing post-abortion stress			On-site	
DC Developing Families Center	**Healthy Babies Project:** This community-based support system for pregnant and parenting women seeks to improve health, education, and parenting outcomes for at-risk mothers, fathers, and infants. Services include pregnancy testing and family planning, risk assessment, case management, home visits, crisis intervention, parent education, smoking cessation, prenatal care, emergency referrals, and mothers' and fathers' support groups.	Parents or expecting parents in wards 5 and 6				
DC Developing Families Center	**The DC Birth Center** provides preventative health services for women, maternity services at two facilities, family planning, STD screening and treatment, pediatric primary care, and help in applying for health insurance.	Pregnant women and mothers, Wards 5 and 6	prenatal and newborns			
Department of Health	**Teen Mothers Take Charge** a home visiting support program for pregnant and parenting adolescents. The program helps teen parents prevent a second pregnancy and stay in school, while encouraging parental involvement by the father. Funded with Department of Human Services, Income Maintenance Administration.	Low-income and TANF eligible teens who are pregnant (with no other children) or first-time mothers	13-18 year olds; children until age 2			$1,195,857 FY04; DHS, Income Maintenance/TANF Administration
Department of Health	**Health Promotion - Maternal and Family Health** provides outreach, assessment, health education, and referral and support services to District women, children, and families.					Total Health Promotion budget: $31,367,345

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Healthy Babies Project, Inc.	**Teen Parent Empowerment Program:** This free program allows pregnant teens and teen parents to partake in programs to lift them out of the cycle of poverty. Programs include health education, counseling, support groups, GED tutoring, and parenting classes.	Mothers or pregnant teenagers, age 12-21		710	Home visitation for every newborn living in DC within 48 hours of hospital discharge at the request of the family.	
Mary's Center	**Community Healthy Start** is a program that targets pregnant women and their families in wards 1,2,4 to encourage healthy pregnancies and positive birth outcomes and a healthy maternal and child bond.	All pregnant women in wards 1, 2, and 4		173 mothers served	on site, home visits and nurse visits.	
Mary's Center	**Teen Mothers Take Charge** a home visiting support program for pregnant and parenting adolescents. The program helps teen parents prevent a second pregnancy and stay in school, while encouraging parental involvement by the father.	Pregnant and adolescent parents.	13-18 year olds	160 teen mothers served	on site	
Maternal and Family Health Administration	**Abstinence Education** campaigns					
Maternal and Family Health Administration	**MFHA** nursing and social work staff coordinate with city birthing hospitals to provide information important to the health and safety of newborns, family planning and city services to new mothers at discharge. Mothers can also request a home visit by a registered nurse, who will assess the home environment, answer questions about infant care, and help to obtain social and health services. A Newborn Discharge Planner is currently being introduced to birthing hospitals in the District. MFHA works in partnership with Children's Hospital as well as the District's HIV/AIDS Administration to provide HIV/AIDS counseling, testing and in other ways prevent/treat the perinatal transmission of HIV/AIDS. MFHA has also established a Perinatal Association.					

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Office of Early Child Development	**The DC Early Intervention Program** provides evaluation and assessment services (physical, occupational, speech-language, vision, etc.) as well as Assistive Technologies, special instruction, service coordination and case management, therapy and transportation supports. Delays may occur in one or more of the following areas: physical development, cognitive development, language and speech development, social/emotional development, and adaptive/self-help skills. For eligibility, a child must be 50% or more delayed in one of the areas.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	14 Direct Services providers, 6 Evaluations providers	$2.1 million from OECD office
The Northwest Center	**The Northwest Pregnancy Center and Maternity Home**: For both the maternity home and pregnancy center programs, the mission of the staff is to promote the dignity of women and a respect for all human life. Accomplishes this goal by offering the loving support and comprehensive aid necessary to enable all women to continue their pregnancies, deliver healthy babies, and care for themselves and their children. The Pregnancy Center Program provides pregnancy testing, short and long term motherhood support, health education, resources referrals including; adoptions, prenatal care, medical assistance, educational, employment and housing resources referrals, material assistance (maternity and baby clothing, diapers, formula, carseats, and Safe Start, Cribs for Newborns vouchers. The Center provides Career Connections Workshops, Parenting Classes, Prenatal Yoga, Motherhood Support Groups and Natural Family Planning Seminars. The Maternity Home Program provides transitional housing for pregnant women and women with infants for up to 18 months.	The program serves low income pregnant and parenting women and families in Washington DC. There are no income or residency requirements for our programs				$1,372,234.00
Department of Health	**Health Promotion - Maternal and Family Health** provides outreach, assessment, health education, and referral and support services to District women, children, and families.					Total Health Promotion budget: $31,367,345

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Capitol Hill Pregnancy Center	**The Capitol Hill Pregnancy Center** provides support and assistance to anyone facing a pregnancy or experiencing post-abortion stress. Services include ongoing pregnancy support, prenatal and parenting classes, maternity and baby clothing and supplies, post abortion peer support and Bible studies, and medical, legal, adoption, and housing referrals. The center also runs an abstinence teen program.	Anyone facing a pregnancy or experiencing post-abortion stress			On-site	
Nutrition						
Bright Beginnings, Inc.	**Transition Services**: In the classrooms children learn the importance of taking care of their bodies, eating well, and getting enough sleep and exercise. Nutritious meals ensure the children receive well-balanced breakfasts, lunches and snacks. Bright Beginnings also realizes healthy parents raise healthy children, and encourages parents to make a commitment to incorporating a healthy lifestyle. Through workshops, seminars, and cooking demonstrations, families learn realistic ways to improve their health through exercise and nutrition.					
Department of Health	**Health Promotion - Nutrition Programs** provides health and nutrition assessments, interventions, education, food, and fitness promotion and referral services to District families, infants, children, and seniors.					Total Health Promotion budget: $31,367,346
Food Research and Action Center/D.C. Hunger Solutions	**Breakfast in the Classroom** aims to expand the utilization of the School Breakfast Program for eligible low-income children.	Initially, students in 30 City public schools, with the goal creating Universal School Breakfast Programs in all D.C. public schools.			School cafeterias	

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Food Stamp Program	**The Food Stamp Program** provides resources for needy families to buy nutritious food. Benefits are scaled to income and the size of the family.	Eligibility is based on pay rate and family size, and applicants must submit to an interview and verification of financial eligibility. Some immigrants are also eligible. Households without elderly or disabled members must have gross incomes below 130% of the poverty level, and all families' net incomes must be below 100% poverty.	Not age-specific.			Total $90,113,910 in DC in FY 2003
Martha's Table, Inc.	**McKenna's Wagon** vans are a mobile soup kitchen, feeding approximately 1,200 homeless and hungry people every day, at nine locations. The program relies heavily on donated foodstuffs.	Hungry and homeless in Ward 1		1,200 per day	Mobile: 9 sites	
Mary's Center	**Women Infants and Children Nutrition Program (WIC)** services provides enrollment, nutrition counseling and breastfeeding support	Pregnant women, new mothers and infants and children.	0-5 year olds	1500 families seen per month	on site	
Maternal and Family Health Administration	**Nutritional Services** are run in a partnership with WIC.					
National School Lunch Program and the School Breakfast Program	**Free and Reduced Price Eligibility** is offered to students at public or non-profit private schools and at all Residential Child Care Institutions. Qualification is based on household income, segmented into *categorical eligibility* , which is based on food stamp or TANF participation, and *income-based eligibility* , which is measured against the poverty level. Homeless children are also covered.	*Categorical eligibility:* any child in public or non-profit private school or in an RCCI, who is receiving Food Stamp or TANF benefits. *Income-based eligibility* : Free meals if income < 130% poverty, reduced price if <185% poverty.	All students in school: 5-21 year-olds	Approx. 24,700 served 2002-2003	Public schools, non-profit private schools, and Residential Child Care Institutions	
Share Our Strength	**Operation Frontline** unites chefs, nutritionists, and other community leaders to volunteer to provide educational services to low income families. The project provides parents with the cooking, nutrition, and food budgeting skills they need to make healthy and economical food choices.	Low-income parents				

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Summer Food Service Program	**The Summer Food Service Program** provides meals to children who would otherwise go hungry because school is not in session. Programs can be offered by local governments, school districts, and non-profits. An organization that only serves those children who are enrolled in its program is eligible if 50% of the children qualify for free or reduced price meals.	Low-income children when school is not in session, and people over 18 enrolled in disabilities programs	5-18 low-income children, 5-21 disabled persons	48,432 children in 186 schools, 41,507 below full price	On average, 171 schools participated 2002-2003	
The Child and Adult Care Food Program (CACFP)	**CACFP** provides reimbursement for meals and snacks served to children and disabled adults. Payments are based on the type of care center and the income level of those receiving the food.	Children in group or family child care, child care centers, Head Start, recreation centers, afterschool programs, and for-profit child care centers using Title XX funding. Also adult day care serving nonresidents and emergency shelters caring for homeless children	Children under 13 at a child care center or in a homeless shelter. Migrant children under 16, and disabled people at any age. Afterschool snacks available to all students through age 18.	FY 2003 average 4,795 children served per day. Total 2,863,230 meals and snacks.	The institution providing care	

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Child and Adult Care Food Program (CACFP) and the National School Lunch Program (NSLP)	**The Afterschool Snack Program** provides reimbursement for nutritious snacks served in afterschool hours. Reimbursement is paid in full to low-income neighborhood sources and is scaled to average income in other neighborhoods. *School-based* programs must be operated under the NSLP. *Community-based* programs are funded through the CACFP and are located in low-income areas.	After-school programs (homework clubs, tutoring, athletics, etc.) may not be selective in eligibility. Community-based programs are operated in low-income areas, where 50% of students qualify for free or reduced-price meals. Students in other areas under the age of 12 can apply individually.	School-based: up to those who turn 19 during the school year. Community-based: all school children in low-income areas, and up to age 12 in other areas.	Approx. 4,048 children daily in FY 2003	School-based programs need not be provided on school grounds. Community-based programs include non-profit public or private organizations.	$42611 spent in FY 2003; Funding provided by CACFP and NSLP
US Department of Agriculture Food and Nutrition Service and the State Education Office	**The District of Columbia School Breakfast Program** serves breakfast to all children and offers reduced costs to those from low-income families.	All children enrolled in participating schools may participate. Reduced price if <185% poverty level, free if <130% poverty.	All students in school: 5-21 year-olds	In 2002-2003, 19,234 daily, 17,414 free or reduced cost	On average, 171 schools participated 2002-2003	$3,850,292 in FY 2003 (down $419,543 from 2002)
US Department of Agriculture Food and Nutrition Service and the State Education Office	**The National School Lunch Program** provides reimbursement for school lunches. About 85% of children served receive free or reduced-price lunches.	All children in a participating school	5-21 year-olds	48,432 children in 186 schools, 41,507 below full price	School cafeterias	Total $14,620,767 in DC in FY 2003

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WIC	**WIC** is a federally funded program that provides healthy foods and nutrition counseling to pregnant women, new moms and infant and children under 5 year olds. In DC Wick offers the following services: Commodity Supplemental Food program; Seniors Farmers Market Nutrition program; Special supplemental Nutrition program for women, infants and children; Food Stamp Nutrition Education Program; WIC Farmers Market Nutrition Program; Loving Support; DC 5-A-Day program Coordination. The program is affiliated with the DC DOH.	Eligible women have demonstrated a medical or nutritional need and meet income guidelines. Families who are enrolled in DC Healthy Families, Medicaid, TANF, and the food stamp program are automatically eligible for the WIC program regardless of income. The WIC population served is 73% black, 23% Hispanic, 3% Asian/Pacific islander.	Pregnant women and new mothers, children ages 0-5	4,187 women, 7706 children and 4479 infants served. Currently serve 55-60% of all eligible participants.	19 clinics ranging from hospitals to an air force base. Vouchers can be redeemed at vendors such as pharmacies and grocery stores. Also offer food stamps at schools. They also have a mobile WIC van offering services	$1.8 Million from District; $13-14 million from USDA, two thirds are used for food the rest for services; Rebates from Gerber $2.4 million from USDA for special project funding for FY2005."Loving Support Grant" of $75,000
WIC	**The Farmers Market Nutrition Program (FMNP)** was established in 2004 and provides reimbursement for fresh produce to women and children enrolled in WIC. The program expands the awareness and use of farmers market to promote the consumption of fresh fruits and vegetables. In the District of Columbia, the FMNP is called "Get Fresh". FMNP operates from May 1 to November 30, annually.	Women and Children who are enrolled in WIC	0-5 year olds		Coupons are received with the WIC payment and can be redeemed at the Farmer's Market	

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Health Promotion						
Alliance for Fairness in Reforms to Medicaid (AFFIRM)	**Managed Care Quality and Access Project:** This project works to improve the access to and quality of health care received by families enrolled in Medicaid, as well as to support ongoing advocacy for children and their parents enrolled in Medicaid. The program also supports an intensive education program about DC's health care system, called *TOUCH: Teaching, Outreach and Understanding While Communicating Health.*	Families on Medicaid	All			Consumer Health Foundation: $35,000
Children's National Medical Center	**The Childrens Healthy Schools Program** is an initiative of Childrens National Medical Center which seeks to improve the health and well being of the children in the District of Columbia. The initiative consists of the President's Council on Physical Fitness and Sports' four-pillar Healthier US model. Its four components: Nutrition, physical activity, immunization/prevention, risky behavior avoidance.	Children in public elementary and middle schools, as well as school nurses, science, and physical education teachers..	elementary and middle school students, as well as school nurses, science, and physical education teachers.		Youth shall be referred from Oak Hill Youth Detention Facility by the Youth Services Administration, the courts, attorneys, parents, and out of state institution.	Receives Non Federal / Non District Funding
Children's National Medical Center	**The Goldberg Center for Community Pediatric Health** is committed to building healthy communities throughout Washington, D.C., focusing on offering comprehensive primary care, including prevention, diagnosis, and treatment of prevalent pediatric health conditions. Intake/assignment procedures: walk-in, school or preschoolreferral, or child welfare agency. Organization places an emphasis on prevention, intervention, and treatment: Do it all, immunization through acute care. Programs: primary care delivery, oral health, WIC, Mobile Medical Clinic, adolescent care, “Generations” (young mom and baby) w/ wrap around services.	Low income, special needs, needs that extend beyond health, domestic violence, school problems, community violence. Ages 0 to 21. Foster children, neglected children, abandonment, physical abuse, sexual abuse, emotional abuse, substance abuse, medicaid el	0 to 21.	In 2005, the program targeted fourth, fifth, and sixth graders in two elementary schools.	A referral is required from DMH Access Helpline. Intake/Assignment procedure is via telephone for referral, court order, and child welfare agency; On-Site	Receives Federal Funding and Non Federal / Non District Funding

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Campaign to Prevent Teen Pregnancy	**How to Talk to Teens about Love, Sex and Relationships:** Research shows that teen pregnancy is less likely when boys and girls feel connected with reliable adults, like parents, with whom they can have comfortable conversations and receive accurate information about love, sex and relationships. Our goal for the How to Talk to Teens about Love, Sex and Relationships program is to help foster parents to talk with their teens about love, sex and relationships. The following is a brief description of the project. This session provides skills and techniques parents will need. Parents learn the following: The importance of using correct language with your teen when referring to the anatomy and teen pregnancy prevention. A discussion about the messages influencing teens and the need for parents to communicate their own values and messages about love, sex and relationships. A discussion of barriers and solutions that lead to more open and comfortable parent/child communication about love, sex and relationships.	Foster Parents				
DC Department of Health	The mission of **Primary Care, Prevention and Planning (PCPP)** is to improve the health and well being of residents by reporting, investigating and controlling communicable diseases, prevention of chronic diseases and their complications, and engaging in health care systems planning to meet the service needs of the population. OPCPP focuses on carrying out the Mayor's initiatives to reorient the health care system toward community-based prevention, primary care, and keeping children and families healthy to reduce unnecessary hospital utilization and diminish the burden of disease in the District's population.					Receives Federal Funding and District Funding
Department of Health	**Health Promotion - Maternal and Family Health** provides outreach, assessment, health education, and referral and support services to District women, children, and families.					Total Health Promotion budget: $31,367,345
Department of Health	**Health Promotion - Nutrition Programs** provides health and nutrition assessments, interventions, education, food, and fitness promotion and referral services to District families, infants, children, and seniors.					Total Health Promotion budget: $31,367,346

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Department of Health	**Health Promotion - Health Promotion and Support** provides wellness promotion, health education, and public information, health screenings, health outreach and referrals, and general prevention and support services to DC residents and visitors.					Total Health Promotion budget: $31,367,347
Department of Health	**Health Promotion - School Health** provides school-based nursing and wellness services to District school students.					$4,702,000 FY03; Total Health Promotion budget: $31,367,348
Georgetown University Center for Child and Human Development	**Home Instruction Program for Parents of Preschool/Supporting Childeren and Families**: Participating families receive a home visit one time per week to role play the curriculum packet with their home visitor. All activities are geared to providing early literacy support to children ages 3-5 years. Families are also provided referrals to community services as needed, and developmental screening is offered to at-risk participants. Child maltreatment is addressed by teaching parents skills to work effectively with their children as their first and best teachers. Home visitors are taught the warning signs of abuse and neglect so families can be referred as needed.	Families in Wards 7 & 8 with children 3-5 years of age.				
Georgetown University Children's Medical Center	**KIDS Mobile Medical Clinic** is a clinic on wheels that provides a medical home to needy families at no cost to them. General care is offered at four sites, and adolescent care at two. Primary care is the focus, but referrals are provided for mental health needs, and some health education takes place. Health education consists of outreach programs to residents on general topics like asthma, immunizations, and nutrition. The program participates in health firs, and immunization campaigns. Outreach offers visibility to potential partners and to recipients of the care.	Low-income families in wards 5, 6, and 8	0-21 years old	2,000 in housing developments, 125 a month in shelters, 1,800 in schools	Mobile unit with six scheduled locations: three housing developments, an emergency shelter, and two public high schools	Georgetown University; Consumer Health Foundation: $22,500

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Healthy Babies Project, Inc.	intensive outreach for pregnant and parenting women. HBP aims to reduce the rates of infant death, illness, low birth weight, and unintended pregnancies and improve the health, education and parenting outcomes for at-risk mothers, fathers and infants. In 2002, we began dedicating our efforts to expanding our outreach to expecting and parenting men as well. We have added services such as childbirth education classes, prenatal yoga classes, prenatal support group, HBP book club, health education classes, and parenting classes, all with the mother and father in mind. All services offered are free of charge. HBP encourages families to accept prenatal care and education, childbirth education and prenatal yoga, home visitation and case management services, family planning education, mental health services, substance abuse counseling and referrals for treatment. We bring expectant mothers and fathers under our wing and many times to their first prenatal care appointments. Clients enrolled are nurtured, educated and maintained as active participants in their own care through the child's third year of life. HBP services each family from a strength-based perspective, accentuating and building on the positive attributes in every family. The overall goals of the HBP are to: Reduce	This program has no eligibility requirements. Areas served by HBP contain a large population of high risk, single income and low-income families. Households in these areas are predominantly African American and headed by women.				$380,000.00
Latin American Youth Center	**The Teen Health Promoters Program** trains Latino high school students to provide health information and counseling to their peers at Mary's Center for Maternal and Child Care's Teen Clinic and Unity Health Care's Upper Carddozo Clinic.	Latino high school students and their peers				Consumer Health Foundation: $50,000
Mary's Center	**ProUrban Youth or Urbanitos Program** is an education and employment program. Adolescents are trained to present health education sessions at high schools and receive work experience at Mary's Center.		13-18 years olds.	355	on site	

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Mary's Center for Maternal and Child Care, Inc.	**Healthy Start Healthy Families:** To partner with families to ensure children are healthy, safe, and ready for school through home visitation, and linkages with community resources. Program Services: Healthy Start Healthy Families services include intensive home visitation, parent activities, and linkages with outside services. All families also receive a home visit from a nurse at least once prenatally and once post-partum, unless medical risk is identified at which time, additional nurse visits are indicated. A mental health provider is also available to provide short-term, in-home counseling and support. Healthy Start Healthy Families staff is crucial to ensure that families access health care, educational support, safe housing, and employment—any service necessary for the health, stability and progress of the parents and their children. Staff becomes caring advocates and facilitators—teaching families to negotiate systemic barriers and challenges, advocating with schools to support teen parents in continuing with their education, identifying alternative school programs that can better meet their needs and coordinating service providers to ensure continuity of care.	Healthy Start Healthy Families' target population are typically difficult to reach families who may face barriers in accessing services, such as language difficulties, transportation, fear of becoming involved in "the system," lack of permanent housing,	parents of children less than five years old.	Approximately 200 families	on site and home visitation and play groups on site	
Maternal and Family Health Administration	**MFHA** develops consumer education and education materials, designs training, executes public information campaigns, and coordinates public-private partnerships to address health issues such as adolescent pregnancy, reproductive health, prenatal care, asthma, smoking cessation, nutrition, services for children with special needs and women's health. In conjunction with other infant mortality reduction interventions, MFHA promotes SIDS Prevention education, focusing on the dissemination of "Back to Sleep" brochures and other materials to health care professionals and service providers, birthing hospital personnel, Healthy Start and WIC workers, as well as community leaders.					SIDS Education Program: $176,302 FY03
Maternal and Family Health Administration	**Lead Poisoning Prevention Program:** this comprehensive program conducts screening and testing in homes, preschools, childcare facilities, and elementary schools, and offers outreach and education.					Childhood Lead Poisoning Screening and Education: $563,000 FY03 ; Title V

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Maternal and Family Health Administration	**The Immunization Program** contracts with nurses who staff clinics, school immunization clinics and health fairs.					Title V
Northwest Church Family Network NCFN	**NCFN**: Our program offers residential, apartment-style living to homeless families. We offer parenting skills developmenet, parent annonyomous support groups, youth enrichment programs, substance abuse prevention groups, healthy living groups focusing on prevention and living with HIV/AIDS/ individual and family therapy sessions	Primary traget population are homeless families. Homeless families are encouraged to contact the Coalition for the Homeless or for those families having a member living with HIV/AIDS, they are encouraged to contact HOPWA for referrals to the program.				
Transitional Housing Corp.	**Partner Arms I and II** is a faith-based non-profit program that provides housing and comprehensive support services to homeless and at-risk families so that they can make transformational changes in their lives and attain self-sufficiency. Parenting workshops are provided on a regular schedule in order to promote nurturing and the proper care of children in a healthy, safe and supportive environment. Best methods in the care of children are also promoted during case management sessions and enhanced via mental health and substance abuse supportive services.	Homeless and families who are at-risk of being homeless are the target population we serve. Due to the lack of affordable housing in the DC region, families with low to moderate incomes are also at risk of becoming homeless. Along with proof of home				$200,000.00
Unity Health Care	**The Community Health Promoter/Outreach Worker** program trains consumers living east of the Anacostia River as community health promoters who reach out to those not receiving primary care, as well as to those who are diagnosed with a disease, in order to assure that appropriate treatment is pursued.	Residents east of the Anacostia River not receiving primary care or diagnosed with a disease				Consumer Health Foundation: $30,000

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Use Your Power! Parent Council	**The Use Your Power! Project** is a citywide parent council that trains and supports parents to be consumer health educators and advocates. Activities include health promotion, prevention workshops, and advocacy pertaining to mental health, substance abuse, heart disease, and asthma. The project is in collaboration with DOH OMCH.					$45,000 from Community Foundation for the National Capital Region

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Medical Care						
Anacostia Health Center (Unity Health Care)	**Anacostia Health Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, case management, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Bread for the City	**Bread for the City** provides medical care to uninsured and low-income DC residents. Staff includes one full time physicians and over 200 volunteers. Medical care includes adult general medicine, pediatrics, OB/GYN, and job physicals. The Southeast Center's medical and dental clinic is operated in partnership with Unity Health Care. Referrals are made for specialty care (mammograms and radiology.)	Uninsured and low-income DC residents	All	The organization can manage up to 200; now at 150 families.	Telephone, walk-in, referral.	
Brentwood Square Health Center (Unity Health Care)	**Brentwood Square Health Center** provides the following medical services: primary medical care (adult medicine, family medicine, pediatrics); specialty care (OB/GYN); health education; laboratory services; and social services (adolescent services, case management). Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Children's National Medical Center	**The Goldberg Center for Community Pediatric Health** is committed to building healthy communities throughout Washington, D.C., focusing on offering comprehensive primary care, including prevention, diagnosis, and treatment of prevalent pediatric health conditions. Intake/assignment procedures: walk-in, school or preschoolreferral, or child welfare agency. Organization places an emphasis on prevention, intervention, and treatment: Do it all, immunization through acute care. Programs: primary care delivery, oral health, WIC, Mobile Medical Clinic, adolescent care, “Generations” (young mom and baby) w/ wrap around services.	Low income, special needs, needs that extend beyond health, domestic violence, school problems, community violence. Ages 0 to 21. Foster children, neglected children, abandonment, physical abuse, sexual abuse, emotional abuse, substance abuse, medicaid el	0 to 21.	In 2005, the program targeted fourth, fifth, and sixth graders in two elementary schools.	A referral is required from DMH Access Helpline. Intake/Assignment procedure is via telephone for referral, court order, and child welfare agency; On-Site	Receives Federal Funding and Non Federal / Non District Funding

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Children's National Medical Center	The **School Health Program** provides basic health services.	All students enrolled in DC public schools and public charter schools		Nearly 15,000 childen participate in Reach Out and Read annually.	Children's Hospital, HSC Pediatric Center	Receives Federal Funding and Non Federal / Non District Funding
Children's National Medical Center	**Children's Bear Essentials**: Primary care is the overarching priority - all families can have their own pediatrician, CNMC's community health centers are a great resource. Family Supports: Information services, public health, public safety (car seats), education, early childhood.	Parents and their children. A majority of the clients are from the suburbs. DC parents typically do not subscribe to Parents magazine. Program serves all children.	0-21 years	2700 served on one case load. All 0 to 21.	Intake/assignment procedure: Walk-ins, school preschool and head start referrals, child welfare agency.	$0.00
Community of Hope	**Community of Hope**'s health clinic provides primary care, outreach, and health education services for the occupants of their transitional housing apartments and residents of the surrounding neighborhood. Pediatric clients comprise approximately 25% of clients. 40% are uninsured and 20% are on Medicaid. Prenatal and pediatric care are provided.	Occupants of transitional housing and residents of the surrounding neighborhood. 60% do not have private insurance.	All	5,300 yearly; approx. 1,325 children	On-site	
Congress Heights Health Center (Unity Health Care)	**Congress Heights Health Center** provides the following medical services: adult medicine, pediatrics, ophthalmology, dermatology, HIV/AIDS services, podiatry, OB-GYN, rheumatology, social services, laboratory service, case management, and surgical services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
DC Developing Families Center	**The DC Birth Center** provides preventative health services for women, maternity services at two facilities, family planning, STD screening and treatment, pediatric primary care, and help in applying for health insurance.	Pregnant women and mothers, Wards 5 and 6	prenatal and newborns			
Department of Health	**The Newborn Home Visiting Initiative** provides a nurse home visit for every newborn living in DC, within 48 hours of hospital discharge at the family's request. The nurse assesses the home environment, provides case management and other support, and ensures that medical appointments have been made.					

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
East of the River Health Center (Unity Health Care)	**East of the River Health Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, case management, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Federal City-CCNV (Ward 1) (Unity Health Care)	**Federal City- CCNV** provides the following medical services: primary medical care for adult men and women, HIV testing/treatment, case management, psychiatric services, social service, substance abuse counseling and referrals, diabetic education, and specialty care (neurology, urology, nephrology, podiatry, orthopedic, ENT, dermatology, TB screenings). Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
First Street Health Center (Unity Health Care)	**First Street Health Center** provides primary care services to dually and triply diagnosed individuals who are referred by the D.C. Department of Health. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.	Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.				
Georgetown University Children's Medical Center	**KIDS Mobile Medical Clinic** is a clinic on wheels that provides a medical home to needy families at no cost to them. General care is offered at four sites, and adolescent care at two. Primary care is the focus, but referrals are provided for mental health needs, and some health education takes place.	Low-income families in wards 5, 6, and 8	0-21 years old	2,000 in housing developments, 125 a month in shelters, 1,800 in schools	Mobile unit with six scheduled locations: three housing developments, an emergency shelter, and two public high schools	Georgetown University

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Good Hope Health Center (Unity Health Care)	**Good Hope Health Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, case management, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Hunt Place Health Center (Unity Health Care)	**Hunt Place Health Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
La Clinica Del Pueblo	**La Clinica Del Pueblo** provides free health services to the Latino community, including primary care, mental health, substance abuse, HIV/AIDS, interpreter service, social services, health education, and outreach.	The Latino community (86% are recent immigrants; over 90% have no insurance and income below the poverty line; 50% have less than 7th grade education; over 90% favor Spanish; 68% from DC, 22% Maryland, 10% Virginia; 62% female, 20% under 20 yrs.		5,500 clients in 31,000 visits	On-site	Consumer Health Foundation: $45,000
Maternal and Family Health Administration	**The Maternal and Family Health Administration** is responsible for the oversight and operation of a School Health Program, providing a minimum of 20 hours of nursing services per school per week in elementary and secondary schools in DC. The program promotes optimal health through direct services and public health education, awareness and prevention, early detection of problems, referral of care, and follow-up. It also is working to establish medical homes for children with special needs who receive health care at selected community sites in Wards 5,6,7 and 8.					

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Maternal and Family Health Administration	**The School Nurse Program and School-Based Screening** are operated under contract with Children's National Medical Center for DC's Public and Charter Schools.	Children in DC Public and Charter Schools			DC Public and Charter Schools	Title V
Maternal and Family Health Administration, Howard University Hospital, GWU Medical Care	MFHA contracts with Howard University Hospital and GWU Medical Center to provide **genetic counseling and testing** and pediatric genetic services and referrals at 6 Unity Health Care Clinics and other sites. This service involves counseling, testing and follow-up for infants and children with sickle cell disease and other genetic disorders, with testing and counseling for parents as well.	Infants and children with sickle cell disease and other genetic disorders, and parents				
Phoenix Health Center (Unity Health Care)	**Phoenix Health Center** provides primary medial and nursing care, social work, nutritional counseling, mental health care, and case management for patients with HIV. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
So Others Might Eat	**The SOME Medical Clinic** provides healthcare services to the homeless and most vulnerable members of the community. Services include HIV care, podiatry, gastroenterology, x-rays, lab work, and diabetes treatments.	Homeless and vulnerable populations		Average 30/day	On-Site	Health Services: $1,214,255. Total: $10,222,810.
So Others Might Eat	**The SOME Dental Clinic** serves the uninsured indigent and homeless populations who would otherwise not have access to dental care. Services include basic care, screening, and restorations. The clinic also conducts outreach services at SOME's housing centers and senior centers.	Homeless and vulnerable populations			On-Site	Health Services: $1,214,255. Total: $10,222,810.
Southwest Health Center (Unity Health Care)	**Southwest Health Center** provides the following medical services: primary medical care (adult medicine, family practice, internal medicine, pediatrics); specialty care (dental services, HIV care, OB/GYN, podiatry, pulmonary medicine, dermatology); health education; laboratory services; and social services (case management). Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Stanton Road Center (Unity Health Care)	**Stanton Road Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, case management, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Upper Cardozo Center (Unity Health Care)	**Upper Cardozo Center** provides the following medical services: primary medical care (adult medicine, family medicine, internal medicine, pediatrics); dental care (restorative dentistry, extractions, dentures, hygiene); specialty care (behavioral medicine, cardiology, HIV care, OB/GYN, pulmonary medicine, rheumatology); adult education, and social services (adolescent case management and WIC). Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Walker-Jones Health Center (Unity Health Care)	**Walker-Jones Health Center** provides the following medical services: pediatrics, cardiology, ophthalmology, dermatology, HIV/AIDS services, podiatry, pulmonary medicine, OB-GYN, rheumatology, urology, social service, laboratory services, case management, and surgery services. Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Woodridge Health Center (Unity Health Care)	**Woodridge Health Center** provides the following medical services: primary medical care (adult medicine, family medicine, pediatrics); specialty care (psychiatry, infectious disease care - HIV & Hepatitis C); health education; laboratory services; social services (adolescent, case management). Unity Health Care provides DC residents with health care regardless of ability to pay. Those who can pay are billed on a sliding scale.					
Oral Care and Hygiene						

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DOH and Head Start	**District of Columbia Head Start Oral Health Campaign**: This 2-year health campaign seeks to educate parents and caregivers, to increase Head Start's capacity to deliver screenings and to contribute in data collection, to train and recruit oral health volunteers throughout Head Start, to better utilize dental hygienists, and to increase reimbursement policies for dentists serving Head Start children.	Children enrolled in the Head Start program	2-5 year olds		Dental offices, proposed mobile van unit at 2 schools	
Maternal and Family Health Administration	**Oral Health Initiative**					$500,000 FY03: $50,000 O.H. Prevention Initiative; $450,000 O.H. Community Development Project
Insurance						
DC Department of Health, MPCA	**Title V Programs**: MFHA uses Title V funds to support managed care health services for immigrant children (including undocumented immigrants) who do not meet Medicaid or CHIPS eligibility criteria due to their immigration status. The program assists these children in enrolling in Medicaid managed care. The Title V Block Grant funds the support of the Information and referral through the 24 hour multi-language and TTY/TTD accessible 1-800-MOM-baby HEALTHLINE, which in addition to providing information to consumers and providers, arranges for home visits for at-risk pregnant women and infants.					1-800-MOM-BABY: $359,970 FY03
Child Well-Being						

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Healthy Families DC	**Healthy Families DC** uses family support workers to teach good parenting skills, prevent child abuse and neglect, and oversee the health care of at-risk babies. It is an intensive home visitation program for overburdened parents. Support workers encourage parent-child interaction, ensure that children get immunizations, begin developmental screens, and track the child's developmental progress.	Overburdened mothers and at-risk babies	0-5 years old		Home visitation. Families referred by a network of seven health clinics	
Latin American Youth Center	**Latin American Youth Centers Foster Care**: The Foster Care Program provides bilingual foster children and adolescents with bilingual case management and room and board services. In addition, the program provides training and licensing services to bilingual families within the Hispanic community in order to ensure that the need for culturally competent foster families is met.	All programs described above target at risk youth in danger of becoming or who are homeless or under the care of the DC CFSA. Together, these programs serve a 0 to 21 age cohort.				
Mary's Center	**Child Development Program** provided education, service coordination, advocacy, psychosocial support, home visitation, and translation services for parents of children with disabilities or developmental delays.	All families with children 0-3 years old with disability or developmental delays.	0-3 year olds.	78 families were served in 2003	on site and home visitation and play groups on site	
Mary's Center for Maternal and Child Care, Inc.	**Healthy Start Healthy Families:** To partner with families to ensure children are healthy, safe, and ready for school through home visitation, and linkages with community resources. Program Services: Healthy Start Healthy Families services include intensive home visitation, parent activities, and linkages with outside services. All families also receive a home visit from a nurse at least once prenatally and once post-partum, unless medical risk is identified at which time, additional nurse visits are indicated. A mental health provider is also available to provide short-term, in-home counseling and support. Healthy Start Healthy Families staff is crucial to ensure that families access health care, educational support, safe housing, and employment—any service necessary for the health, stability and progress of the parents and their children. Staff becomes caring advocates and facilitators—teaching families to negotiate systemic barriers and challenges, advocating with schools to support teen parents in continuing with their education, identifying alternative school programs that can better meet their needs and coordinating service providers to ensure continuity of care.	Healthy Start Healthy Families' target population are typically difficult to reach families who may face barriers in accessing services, such as language difficulties, transportation, fear of becoming involved in "the system," lack of permanent housing,	parents of children less than five years old.	Approximately 200 families	on site and home visitation and play groups on site	

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
North Capitol Collaborative Inc	objectives are to provide a comprehensive Neighborhood Based Family Support and Child Welfare Service Delivery System through the service categories of Family Stabilization, which includes information and referral services, community case management, supportive case management for cases referred from CFSA to NCCI, youth aftercare case management for youth aging out of the foster care system. Further NCCI, will support this objective through the delivery of services in the category of Community Capacity Building, which designed to increase the knowledge of and enhance the capacity of internal and external community resources for the prevention of abuse and neglect. Community Building Services are achieved through the development of initiatives designed to support and enhance a family support network: parent education training, parent support group, youth, and parent-geared activities. Through the development of partnerships with area service providers, board development and trainings and increased staff development; community engagement strategies: hot spot reports, engagement activities with the local ANCs, police departments, roving leaders and other key partners within the community.	North Capitol Collaborative, Inc. services seven neighborhoods in the District of Columbia. On the south side, the neighborhoods are China Town and Mount Vernon, on the West side, Truxton Circle, Bloomingdale, and Ledroit Park, and on the East side, Edgew				$6,600,000.00
The Center for Child Protection and Family Support Inc	Health promotions for infants and toddlers program is funded by the CGS foundation and enhances family support and parenting services through quality health supervision for infants and children.	All families with toddlers.				
Zero to Three	**Zero To Three**'s mission is to support the healthy development and well-being of infants, toddlers and their families. A national nonprofit multidisciplinary organization that advances our mission by informing, educating and supporting adults who influence the lives of infants and toddlers.					
Consumer Safety						

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Maternal and Family Health Administration	**Safe Start: Cribs for Newborns** provided 710 vouchers for cribs to families in FY 03	355 pregnant women, 365 parents of newborns		710		$182,584 FY03; Metropolitan Washington Council of Governments; Title V

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Special Health Care Needs						
Bright Beginnings, Inc.	**Child Development Program** is a developmental child care center for homeless preschoolers whose families are in crisis shelters or transitional housing. Also offered: on-site therapeutic services (speech, occupational, psychiatric), parent involvement, transition support for parents, and family enrichment.	Children at 6 weeks to 5 years of age from homeless families in DC area.		Approx. 100	On-site (undisclosed location)	
Children with Special Health Care Needs Bureau (MPCA) - DOH	**Care Coordination** links children with special health care needs to services and resources.	All children with special needs, and their families, without regard to income.	0-21 year olds		Dental offices, proposed mobile van unit at 2 schools	Receives Federal Funding and Non Federal / Non District Funding
Children with Special Health Care Needs Bureau (MPCA) - DOH	**The Universal Newborn Metabolic Screening Program** requires all hospitals to screen for seven inherited genetic disorders.	All newborns	Newborns		7 birthing hospitals, Hospital for Sick Children, Title V screening programs, vital records.	
Children with Special Health Care Needs Bureau (MPCA) - DOH	**Sickle Cell Disease Program** aids in sickle cell disease surveillance, diagnosis, and management by providing education and training, tracking and referral procedures, follow-ups, and psychological counseling services to sickle cell patients.	Services for children diagnosed with sickle cell anemia, and screening for all infants				Awareness program: $162,775 FY03

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Consortium for Child Welfare	**The Family Ties Project** promotes and preserves the well-being of children, youth, and families affected by HIV/AIDS. Collaborators include case managers, therapists, and attorneys. Subcontractors include the U.D.C. David A. Clarke School of Law, Pediatric HIV/AIDS Care, Inc., and Sasha Bruce Youthwork, Inc.	Children, youth, and families affected by HIV/AIDS				U.S. DHHS, Administration for Children, Youth and Families, Abandoned Infants Assistance Program; Washington AIDS Partnership; Broadway CARES/Equity Fights AIDS
DC Department of Health, MPCA	The **Healthy and Ready to Work Project** coordinates services for up to 60 special needs youth who are aging out of the educational and social services programs and are referred by DC Public Schools. The Interagency Transition Council Steering Committee serves to identify existing resources and services gaps, and is working to institutionalize referral networks.					
Department of Health	The **DC Birth Defects Surveillance and Prevention Program** supports health care training programs and provides advice to families regarding birth defects. The program also provides referral services for children with birth defects and their parents, and conducts a birth defects awareness media campaign.	All children with birth defects			7 birthing hospitals, Hospital for Sick Children, Title V screening programs, vital records.	
Department of Human Services	**Child Development - Early Childhood Intervention** provides therapeutic, developmental, and family support services to families with children under age three with developmental delays, or children at risk of developmental delay.		0-3 years old			Total Child Development budget: $75,932,896

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
HSCSN	**Health Services for Children with Special Needs (HSCSN)** is a unique nonprofit care management organization that provides personalized coordination of health care, social, and education services for infants, children, and adolescents who have disabilities and/or complex medical and/or psychosocial needs. The program uses intensive individual, family, and community-centered approaches to serve children from birth through the twenty-first year who receive Medicaid and Supplemental Security Income (SSI) benefits, or are SSI-eligible.	Infants, childs, and adolescents (0-21) with disabilities, complex medical, or psychosocial needs who receive Medicaid and Supplemental Security Income.		Inpatient Days: 17,291; Outpatient visits: 4,096; School visits: 11,814; Total outpatient visits: 15,910.		Receives Federal Funding and Non Federal / Non District Funding
Mary's Center	**The pediatrics program** provides a medical home for children with special needs which is linked to tertiary care and home health services.	All families with children 0-12 years old	0-12 years old.	unknown	on site	
Maternal and Family Health Administration	**The Newborn Screening Program** conducts early detection and treatment of irreversible disorders that contribute to severe childhood morbidities and developmental delays. The program also provides training to hospital-based providers. The program is currently developing a birth defects registry.					$412,794 FY03; Title V
Maternal and Family Health Administration	**The Healthy and Ready to Work project** coordinates services for up to 60 special needs youth who are aging out of the educational and social services programs and are referred by DC Public Schools. The Interagency Transition Council Steering Committee serves to identify existing resources and services gaps, and is working to institutionalize referral networks.					Title V
National Children's Center	**Child Development Program:** National Children's Center provides educational, social, and clinical services to people with developmental disabilities. The Child Development Program serves infants and children in various settings, including early intervention, home health, preschool and childcare. Children receive either a periodic screening or an initial developmental assessment. Programming includes input from developmental services, nursing, physical therapy, medical social work, occupational therapy, psychological care, and service coordination.	Children and infants with developmental disabilities			Two sites	

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Office of Early Child Development	**The DC Early Intervention Program (DCEIP)** provides services for children age birth through two years who have or are at risk of having a developmental delay or disability. It also provides evaluation and assessment services (physical, occupational, speech-language, vision, etc.) as well as Assistive Technologies, special instruction, service coordination and case management, therapy and transportation supports. Delays may occur in one or more of the following areas: physical development, cognitive development, language and speech development, social/emotional development, and adaptive/self-help skills. For eligibility, a child must be 50% or more delayed in one of the areas.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	14 Direct Services providers, 6 Evaluations providers	$2.1 million from OECD office
Office of Early Child Development's Program Development Division	**Head Start State Collaboration Project** is implemented by the OECD's Program Development division. All Head Start programs have a legislative mandate for a minimum of its service population to include children with disabilities (health, physical, mental).					
Mental Health						

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Adle Lebowitz Center for Youth and Famiiles	**Mothers and Babies Group**: Therapy group for mothers and babies up to one year old. The purpose of the group is to provide an opportunity for mothers and their new babies to learn about themselves and their babies in order to lay a foundation for healthy child development and strong positive relationships between mother and child. The mother infant relationship is often the scene for playing out the mother's unresolved relational conflicts. This often leads to the recreation of the same problematic relational patterns that dominate mother's past and present relationships. This happens through a mother's repsonses to her new baby where she projects onto the child attributes of her own that she cannot tolerate. the purpose of this group is to help break this cycle and creat new patterns of relating. Mothers and their babies will meet weekly with two facilitators whose roles it will be to help mothers observe their babies more closely and follow their babies'leads. This allows an ooportunity for the infant's initiative to change interactions and potentially change the mother infant relational system.	The program is targeting new mothers and babies up to one year old. Mothers need to be able to come to the Center's location in Friendship Heights.				$60,000.00
Columbia Heights Shaw Collaborative	**Family Services** provide comprehensive assessment, resource and referral, and case management and short term therapy when necessary to families experiencing stress or crisis.	All families residing in the target area.				
Community Connections	**Community Connections** is a private, not-for-profit mental health agency in DC. Since 1984, Community Connections has worked with people who have been marginalized to assist them toward stable, integrated community living. Clinical programs, residential and support services, and research projects play roles in achieving this goal.	DC and Montgomery County, MD residents				Receives Federal Funding, District Funding, and Non Federal / Non District Funding

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Campaign to Prevent Teen Pregnancy	**Community Connections Child & Adolescent Services** provides outpatient mental health services, including comprehensive assessments, therapy, community support services, psychiatric assessments/medication management. Our goal is to provide high quality and culturally competent mental health services that are focused on the strengths of each individual child and family.	Our focus is on providing services to underserved children/youth with complex needs who have serious emotional disturbance and demonstrate significant problems in one or more of the following domains: familiy, school, peers and/or community.				
Department of Mental Health	**Parent and Infant Development Program (PIDP):** This is a family-centered mental health program for expectant parents, infants, 0-5 year olds, and their caretakers/parents. The program offers individual or group services, including evaluations of infants and toddlers, assessment of adults, speech and language evaluations, parent-child interactional psychotherapies, family therapy, diagnostic evaluation, and referral to early intervention.	Expectant parents, infants, 0-5 year olds and their caretakers/parents	0-5 year olds	Total of 2,781 children enrolled in DMH		
Department of Mental Health	**The Therapeutic Nursery Branch** serves children ages 3 through 6 who have special emotional problems. The program provides early diagnosis and remediation of learning difficulties. Partners include the Division of Special Education and DC Public Schools.	Children ages 3-6 with emotional problems	3-6 year olds	Total of 2,781 children enrolled in DMH		
FACTS PLLC	**Family Assistance in Coping with Trauma and Stress (F.A.C.T.S.)** is an outpatient mental health facility on Capitol Hill in Washington, D.C. that was founded in 1997 to promote bio-psycho-social health, self + relationship development, and educational + employment success in persons across the life span. F.A.C.T.S. provides confidential, effective mental health care for children, adolescents, and adults in a safe and caring environment.	Age 5-85; trauma surviors and their families				

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Family and Child Services	**Family and Child Services** provides mental health and counseling services, including individual counseling; group sessions on anger management, parenting skills, and domestic violence; and school-based programs that emphasize wellness and structure, discipline and communications between youth and parents.					
Family and Child Services of Washington DC Inc	**Family Counseling / Mental Health**: Objective is to stabilize families and individuals through the use of individual, family and group counseling/therapy; parenting classes; and a domestic violence prevention program	Program addresses individual and families with social and emotional problem significant enough to interupt normal activities				
Free Advice Inc	**Free Advice, Inc. (FAI)** was established to provide information and resources to empower at-risk youth and their families suffering multiple hardships. Fulfills its mission by providing professional therapy services, workshops and programs for specialized populations. Provides in-home and in-school therapy to the victims and family interventions for the household.	The target children ages(3-18 years) who have been victimized and identified by adult caregivers or parents, CFSA, DYRS, these cases ususally are documented by a police report. We will come to the home to provide therapy for the victims and intervention				
Georgetown University Children's Medical Center	**KIDS Mobile Medical Clinic** is a clinic on wheels that provides a medical home to needy families at no cost to them. General care is offered at four sites, and adolescent care at two. Primary care is the focus, but referrals are provided for mental health needs, and some health education takes place. Patients can be referred to the Child Advocacy and Mental Health Coordinator, who assists with access to health insurance, WIC, TANF, employment services, referrals to mental health providers or for developmental evaluations, and early intervention.	Low-income families in wards 5, 6, and 8	0-21 years old	2,000 in housing developments, 125 a month in shelters, 1,800 in schools	Mobile unit with six scheduled locations: three housing developments, an emergency shelter, and two public high schools	Georgetown University
Gospel Rescue Ministries	**Gospel Rescue Ministries**: Helping homeless men and women acheive self-sufficiency, housing, employment, and where applicable, freedom from addictions and debilitating effects of mental illness. We treat many parents and help to correct abuse issues. Our aim is for family reunification whenever it is possible and appropriate.	Homeless and addicted adult men and women in the District of Columbia.				

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
La Clinica del Pueblo INC	**Project Mi Familia**: The program consists of a 16- week Saturday workshops for the entire family. Offers concurrent group therapy for parents, children and adolescents. The purpose of the workshops is to offer a psycho-educational treatment service for the treatment and prevention of child traumatic stress.	The program caters to those in the latino community. The parent workshops are conducted in spanish, as well as the children's workshop. The adolescent workshops are conducted in english and spanish dpending on the needs of those attending. There are no el				$8,000.00
Sasha Bruce Youthwork Inc	**Kindred Connections**: One of the Far Southeast Family Strengthening Collaborative Family Support Centers providing case management, referrals, in-home counseling and other wrap around services on a drop-in basis at our site and also through home-based outreach. The primary objective is to prevent removal of children from homes. The focus in on low-income families in Ward 8 of the District.	Youth and adults living in the Henson Ridge community of Ward 8. Most individuals are referred for case management and supportive counseling by CFSA case workers, but this program also is open to the general public in that community. The focus is on str				
Hearing and Vision						
Department of Health, MFHA, Division of Children with Special Health Care Needs	**Universal Newborn Hearing Screening and Intervention: DC Hears** ensures detection, diagnosis, and intervention for children with hearing loss, and provides support services to the screening locations	Newborns	Diagnosis by 3 mo., intervention by 6 mo.			$171,000 FY03
Department of Health, MFHA, Division of Children with Special Health Care Needs	**Vision Program**: A collaboration with the Lions Club to provide vision screening, which consists of the following: identification, referral for diagnostic evaluation, treatment, education, and follow-up referrals.	All children	1-6 year olds			

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Office of Early Child Development	**The DC Early Intervention Program** provides evaluation and assessment services (physical, occupational, speech-language, vision, etc.). For eligibility, a child must be 50% or more delayed in one of the areas.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	14 Direct Services providers, 6 Evaluations providers	$2.1 million from OECD office
So Others Might Eat	**The SOME Eye Clinic** gives ophthalmologic care to the homeless and extremely poor, at no cost.	Homeless and extremely poor		Average 50/day	On-site	Health Services: $1,214,255. Total: $10,222,810.

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Child Welfare (Violence, Neglect and Personal Abuse)						
Asian American Leadership Empowerment and Development (AALEAD)	**The Family Strengthening Program** includes comprehensive case management and advocacy for parents and families, and guidance to parents on local systems and raising children in the U.S. AALEAD has a two-person Family Strengthening Program staff. The prevention portion of this program is with individual parents or groups of parents discussing child-abuse and child-neglect, and to help parents understand the system. Staff reports cases as needed.					
Casa for Children of DC	**CASA for Children of DC** uniquely provides services to children and youth through five specialized programs. Together these programs serve more than 120 children who are identified as being abused or neglected and in need of intervention services. CASA for Children of DC relies heavily on the contribution of volunteer time and talent, corporate support, private donations, as well as public support.	Children 0 to 21, in Washington DC, economics is not a factor, Children have to be invovled in abuse and neglect system within courts. judge request that a Casa be invovled in case				
Center for Child protection and Family Support	**Far Southeast Youth Violence Prevention and Coalition** has a focus on decreasing incidences of violence among the young people of Anacostia, decreasing delinquent behavior and improving academic performance. The coalition provides networking, resource building and information sharing.					
Center for Child protection and Family Support	**Youth Education and Resilience (YEAR)** collaborates with schools to provide on-to-one mentoring and to ensure that children receive comprehensive services.		10-15 years			
Center for Child Protection and Family Support	**Child Abuse and Neglect Victim Service Center (VOCA)** offers mental health services to abused and neglected children and their families.	over a 100 children per year	4-17 year olds		on site, home visits, accompaniment to courts and hospitals.	Funded by the Office of Victims of Crime, through the DC Grants Management Office

Washington, DC Early Child Development
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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Center for Child Protection and Family Support	**Child Abuse and Neglect Training Initiative (CANTI)** is funded by the DOH and Office of Early Child Development. The program provides expertise training and resources to daycare providers in the District in the area of child abuse and neglect. The Center partners with the Latin American Youth Center and the Asian American LEAD using a cultural competency model to increase providers' knowledge and skills on early identification and appropriate intervention in cases of child maltreatment.			Training and resources to 400 day care providers.		
Center for Child Protection and Family Support, The	**Balancing Employment and Parenting**: Funded by the Department of Health and Human Services Administration for Children and Families, the program focuses on prevention and intervention of child abuse and neglect among predominately African-American TANF mothers with children 0-6 years old who reside in high risk neighborhoods. Balancing Employment and Parenting involves linkage with community agencies such as Head Start and Department of Employment Services to strengthen parenting skills through training of families involved in Welfare-to-Work and TANF job training.		Serves mothers with children 0-6 year olds			
Child and Family Services Agency	**Child Welfare - Intake and Investigation** accepts reports of child abuse and neglect and investigates alleged incidents.					Total Child Welfare budget: $39,399,088
Child and Family Services Agency	**Child Welfare - In-Home and Reunification** provides crisis and ongoing intervention services to at-risk children and families					Total Child Welfare budget: $39,399,089
Child and Family Services Agency	**Child Welfare - Adoption** provides recruitment, placement, and monitoring services to children and families	Anyone facing a pregnancy or experiencing post-abortion stress				Total Child Welfare budget: $39,399,090
Child and Family Services Agency	**Out-Of-Home Care and Support - Interstate Compact for the Placement of Children** provides Legal Inter-Jurisdictional Placement to children in need of placement so that they can have permanent homes.					Total Out-of-Home Care and Support budget: $104,605,024
Child and Family Services Agency	**Out-Of-Home Care and Support - Family Resources** provides recruitment, training, licensing, monitoring, and support services to current and potential foster, kinship and adoptive parents.					Total Out-of-Home Care and Support budget: $104,605,024

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Child and Family Services Agency	**Out-Of-Home Care and Support - Child Placement** provides living arrangement services to children.					Total Out-of-Home Care and Support budget: $104,605,024
Child and Family Services Agency	**Out-of-Home Care and Support - Licensing and Monitoring** provides licensing approval and ongoing monitoring services to operators of private agency foster homes, group homes, and independent living facilities.					Total Out-of-Home Care and Support budget: $104,605,025
Child and Family Services Agency	**Out-of-Hoe Care and Support - Health Services and Clinical Support** provides health and clinical services support to social workers.					Total Out-of-Home Care and Support budget: $104,605,026
D.C. Children's Trust Fund	**The D.C. Children's Trust Fund** provides guidance and support to community-based organizations, schools, and churches to incorporate primary prevention of child abuse and neglect into their activities. Activities include public education and awareness, community outreach and program linkage, and resource development and management.	Recipients of service at community-based organizations, schools, and churches			Community-based organizations, school, and churches	
DC Campaign to Prevent Teen Pregnancy	The **Child Sex Abuse Prevention Task Force** has five goals: 1.Clarify policies and laws 2.Develop standards for professionals and providers on mandatory reporting of child sex abuse 3.Offer training 4.Engage in public education 5.Collect data	Providers, adults and parents.				$16,000.00

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Rape Crisis Center	**Prevention Risk Reduction Program**: Good Touch/Bad Touch (grades pre-k-2): 50 minutes- This presentation explains the differences between good touches and bad or secret touches. Children learn what to do if someone touches them inappropriately. Appropriate/Inappropriate Touch (grades 3-6): 60 minutes- This presentation educates children on the difference between appropriate and inappropriate touches and what to do if they receive an inappropriate touch Multi-Session (middle school-junior high): 3 sessions- This set of presentations helps students understand what sexual harassment is and to identify resources and effective responses to it Peer Education (High School): Year course taught at a local highschool in the District. Students learn the historical and social context of sexual violence during Phase I. They then share what they learned with their peers by conducting close to 60 presentations.	All students in the District of Columbia from pre-K to 12 grade.				$500,000.00
East River Family Strengthening Collaborative	**Family Services Division**: This division provides supportive and preventive services to families living in Ward 7 who are at risk of abuse and/or neglect. The objective is to prevent children from entering foster care. The activities used in working with families include, family team meetings, case management, parenting, information and referral, budget management, housing, visitation, family group conferencing. The Family Assessment Form is used to assess risk factors associated with a family.	Families with children living in Ward 7. Some eligibility requirements are attached to certain programs (housing and emergency assistance)				
Metro DC PFLAG	Provide Support, education and advocacy to keep families together and promote the equality and well-being of gay/lesbian/bisexual/transgender and questioning individuals. Provide parent support groups and work with youth in schools. By promoting parental tolerance and understanding, g/l/b/t/q youth should be safer in their homes.	Parents, families and friends of g/l/b/t/q individuals. No eligibility requirements.				

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
My Sister's Place	**My Sister's Place** is a shelter for battered women and their children. MSP provides safe, confidential transitional housing, as well as a children's program. The children's program allows child victims of abuse to receive counseling and support from trained volunteers and staff members.	Battered women and their children			On-site (undisclosed location)	
Prevent Child Abuse of Metropolitan Washington	**The PhoneFriend Program** is an afternoon and evening support line for children who are at home without adult supervision. The PhoneFriend Community Educator also runs safety workshops for children and parents.	Children who are at home without adult supervision	5-15 years old	8,000 calls per year		
Safe Shores - The D.C. Children's Advocacy Center	**The DC Children's Advocacy Center** provides a coordinated approach to the investigation and prosecution of civil and criminal child abuse cases. The service provides forensic interviews and medical exams, therapy, court appearances, placement resolutions, statistical case tracking, bi-weekly team case reviews, trauma assessments, and pre-trial support for child victims. Through the Victim Services Program, the staff also ensures that children receive care (supervision, meals, clean clothes, crisis intervention) during the investigative process.	While the program's focus is on victims of child abuse, the therapy program also helps parents and caretakers.	3-18 years old		On-site	
The National Center for Children and Families	**The Betty Anne Krahnke Center for New Beginnings** is a 54-bed residential facility for single women and mothers with children who are recovering from family abuse. Assistance is provided by individual therapists and case managers.	Single women and mothers with children who are victims of abuse		141 women, 187 children, 132 families served	On-site (undisclosed location)	
Volunteers for Abused and Neglected Children	**Volunteers for Abused & Neglected Children** recruits, trains, assigns and manages volunteers to advocate for abused and neglected children in court. Volunteers also provide information and recommendations to the judge in the best interests of children.	Target population is children who are in the family court system due to child abuse and/or neglect....largely minority, low income families, often with single parents, siblings, and exhibiting behavioral issues; along with academic deficiencies.		4,500 children are served by the Family Court of D.C. Superior Court.		

Washington, DC Early Child Development
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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Little Blue House	**The Commitment to Hope Program** is a multidisciplinary approach to solving problems of child abuse and neglect within a family where substance abuse is an issue. The program addresses child health needs, which often include developmental delays, speech and language deficiencies, information processing difficulties, and behavioral problems, as well as poor nutrition and lack of medical care. LBH staff coordinates parental visits to the facility, where they participate in the children's daily care.	Neglected or abused children of parents who are substance abusers			On-site	
Substance Abuse and Treatment						
Calvary Womens Services	**Calvary Womens Services** provides housing and support services to homeless women in Washington, DC. We operate three housing programs - Calvary Women's Shelter, Pathways and Sister Circle - that offer a range of housing services from low-barrier shelter to permanent housing. Calvary provides on-site mental health services, case management, addiction recovery groups, life skills classes, and supported employment to the women we serve. While we wouldnt necessarily refer to Calvary as a child abuse and neglect prevention program, we do seek to support women as they re-build their lives and prepare to re-connect in a positive way with their children and families.	Calvary's programs serve single, homeless women.			Exodus House (men) and Maya Angelou House (women)	Health Services: $1,214,255. Total: $10,222,810.
Center for Child Protection and Family Support, The	**Families and Schools Together (FAST)** is funded by the Addiction Prevention Recovery Administration, FAST seeks to enhance family functioning, prevent school failure among youth, reduce day-to-day stressors among parents and families and prevent the use of drugs and alcohol within the family. Fast replicates a national science-based substance abuse prevention model, based on selected research in family therapy, child psychiatry, community development and social support. The FAST structure allows both youth and families to have a voice and role in the prevention process.					$550,000.00
So Others Might Eat	**Addictions Recovery:** SOME's Behavioral Health Services runs two 90-day treatment facilities in West Virginia. Addictions counselors also meet with clients in recovery. 70% of patients graduate from the program.	Substance addicted men and women	Adults			$119,000.00

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
SOME	**Women's Transitional Housing Addiction Program**: Goals: Maya Angelou House (Phase 1) Residential Stability 60% of clients will complete their treatment at Maya Angelou House, the first phase of treatment. 75% of clients that completed the first phase will move on to Harvest House or other transitional housing. Increased Skills or Income 60% of all completers will be employed at least part-time or in job-readiness training within 4 months of completion Greater Self-determination 60% of clients completing the Maya Angelou House program will continue to take personal responsibility for recovery by attending a 12-step meeting program at least once per week at their one-year follow-up. Goals: Harvest House (Phase 2) Residential Stability 75 percentof clients will move into permanent housing upon completion of the program. Performance Measure: Many participants will receive vouchers or subsidies that will assist in clients in finding permanent housing. Increased Skills or Income 70% of all program completers will obtain employment at completion Performance Measure: Income sources will increase due to increased employment as well as increased access to benefits such as SSI and Disability. Greater Self-determination 75% of program completers will maintain	The poor and homeless of Washington DC, inlcluding those with mental and physical disablities and those who are addicted to drugs and or alcolhol.				
Gospel Rescue Ministries	**Gospel Rescue Ministries**: Helping homeless men and women acheive self-sufficiency, housing, employment, and where applicable, freedom from addictions and debilitating effects of mental illness. We treat many parents and help to correct abuse issues. Our aim is for family reunification whenever it is possible and appropriate.	Homeless and addicted adult men and women in the District of Columbia.				
The Little Blue House	**The Commitment to Hope Program** is a multidisciplinary approach to solving problems of child abuse and neglect within a family where substance abuse is an issue. The program addresses the mother's substance abuse, including physical and psycho-social components of addiction. Residential and outpatient treatment is available for mothers. The mother's parenting abilities are assessed and evaluated, and she receives independent living skills.	Neglected or abused children of parents who are substance abusers			On-site	

Washington, DC Early Child Development
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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Planning Groups and Collaborative Processes						
Break the Cycle	**Break the Cycle** is a domestic violence law center that promotes the health and protects the rights of youth. Our comprehensive programs provide positive intervention in the lives of youth as they are forming their first relationships. We encourage youth to take action and mobilize to raise awareness in their communities about domestic violence and its impact on their peers. We are promoting youth as the next generation of leaders in the domestic violence prevention movement. Break the Cycles preventive education program teaches teens about domestic violence, healthy relationships and the legal options and responsibilities of young victims. The interactive curriculum connects students to practical tools and confidential resources for information and advice. We also work to increase awareness about teen dating violence in the community at-large through public awareness campaigns, tabling and our website. Empower Break the Cycle helps young victims, ages 12 to 24, achieve safe, violence-free lives through legal advice, referrals and counsel. Our public policy efforts work to ensure that young people are protected by domestic violence laws and that funding exists to support programs to help youth.	Young people between the ages of 12-24 who are experiencing dating or domestic violence and are in need of free legal services.				
D.C. Control Asthma Now	**The Asthma Collaborative Working Committees** include the Executive Committee, the Education Committee, the Environmental and Occupational Health Committee, the Policy, Planning and Resource Development Committee, the Health Services and Quality Assurance Committee, and the Surveillance, Evaluation and Data Committee. DC CAN is a public health planning initiative designed to determine the impact of asthma on D.C. residents and develop a community-wide strategic plan to reduce asthma's impact.					
Prevent Child Abuse of Metropolitan Washington	**The Partners in Prevention Coalition** is led by five agencies dedicated to eliminating child abuse and neglect in DC. The mission is to raise awareness and increase public involvement in prevention by collaborating and sharing resources. Partners in Prevention coordinates the Child Abuse Prevention Campaign, as well.					

Washington, DC Early Child Development

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Health and Safety						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The DC Home Visiting Council	**The DC Home Visiting Council** is a collaboration of government agencies and community based organizations that provide home visitation. The DC HVC identified best practice standards for training, cultural competency, and universal screening. DC HVC facilitates implementation by providing technical assistance, coordination, training, funding, and other resources to various agencies.					

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Early Care and Education

Organization Name	*Programs and Descriptions*	*Population Served*	*Ages Served*	*Capacity*	*Access Points*	*Funding*
Organization name	*Programs and services that are economically responsive, culturally competent and committed to ensuring that children develop emotionally, socially, physically, cognitively and in other ways ready to succeed.*	*Description of the children and families the program seeks to affect, including eligibility criteria*	*Ages of children*	*# children eligible/served*	*Physical doors of entry (On-site and Home Visitation)*	*Total annual programmatic budget*
CentroNia	**Learning Center:** this program reaches infants to teens through early childhood and school-age/youth development programs. The curricula include poetry, drama, music, dance, chess, fine arts, photography, videography, and computer-generated art, as well as technology instruction.	Wards 1, 2, and 4	infants to junior high	84 0-4 year olds; 60 3-4 year olds before or after school; 120 elementary and junior high students	On-site	$6.3 million CentroNia overall
Community of Hope	**Educational Enrichment Program:** As part of the Family Learning Center, this after-school program serves about 50 children each school day. It provides an after-school snack, homework help, creative arts activities, and "down time." It also provides direct service to children with educational and behavioral challenges.	School-age children from the transitional housing apartments or the surrounding neighborhood		Approx. 50/day	On-site	
DC ParentSmart	**DC ParentSmart** started in April 2004 helps parents take advantage of public education options available to their children. They provide resources, training outreach, and individualized assistance to all DC parents with special attention to those children that attend schools designated "in need of improvement". A program of The Center for Student Support Services DC ParentSmart is funded through a grant from the US Department of Education.	All families with school age children. Targeting wards 1, 7, 8.	0-6 year olds	33000 are entitled to be served.	on site and through outreach and advocacy.	$1.5 million Federal Grant
DC Public Schools	**Office of Early Childhood Programs:**					
Department of Parks and Recreation	**Specialty and Targeted - Educational Services** provides educational, cultural, recreational, and creative arts programming and nutritional support services to both pre-school and school-aged children, including those with special needs.					Total Specialty and Targeted budget: $9,426,489
Horton's Kids	**Horton's Kids** provides comprehensive services to the underserved children in Anacostia's Wellington Park housing project, including: twice weekly tutoring sessions, weekly mentoring activities, tuition assistance and access to community leadership programs, funding for summer camp, and birthday and holiday celebrations.	Children in Anacostia's Wellington Park housing project in Ward 8				

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Lt. Joseph P. Kennedy Institute	**Child Development Center:** This center serve children with and without disabilities, age 6 weeks to 6 years, where they develop positive self-esteem and learn academic readiness skills, good self-care habits, and group participation. Transition coordination into elementary school is provided. Services include traditional day care and preschool services, medical day treatment, physician assessments, nursing and nutrition services, IFSP and IEP development, therapy (occupational, physical, speech, hearing, mental health, and vision), social work and service coordination, and family supports.	Children with and without disabilities	6 weeks to 6 years		On-site	
New Community After School and Advocacy Program	**The New Community After School and Advocacy Program (NC-ASAP)** provides year-round academic and cultural enrichment to children from pre-K to 12th grade. Pre-K to 5th grade after school programs include hands-on learning experiences, tutoring, enrichment activities in reading, math, and other subjects, and special classes. Summer and weekend activities include camps, visits to historical and cultural sites, community service, mentor relationships, and academic and recreational activities.	Children from local schools	pre-K to 12th grade		On-site	
Office of Early Child Development	**The Program Development Division** implements the Quality Child Care Initiative (QCCI), Healthy Child Care DC and the Child Care Health Consultant Corps. It also implements the Head Start State Collaboration Project, designs and implements child care program expansion and improvement efforts, and provides consumer services.					
The National Center for Children and Families	**The J.C. Nalle Community School** is a full service community school program. Students and their families have access to the following: extended academic enrichment program; after school care; social, creative, and cultural clubs for applied mastery; health care services; mental health services; parental involvement; information and referral to community resources; free summer enrichment programs; and social services and counseling.			150 children, 108 adults, 125 families		

Washington, DC Early Child Development

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Child Care (center-based, home-based, kith & kin, Head Start)						
CentroNia	**Learning Center:** this program reaches infants to teens through early childhood and school-age/youth development programs. The curricula include poetry, drama, music, dance, chess, fine arts, photography, videography, and computer-generated art, as well as technology instruction.	Wards 1, 2, and 4	infants to junior high	84 0-4 year olds; 60 3-4 year olds before or after school; 120 elementary and junior high students	On-site	$6.3 million CentroNia overall
Community of Hope	**Educational Enrichment Program:** As part of the Family Learning Center, this after-school program serves about 50 children each school day. It provides an after-school snack, homework help, creative arts activities, and "down time." It also provides direct service to children with educational and behavioral challenges.	School-age children from the transitional housing apartments or the surrounding neighborhood		Approx. 50/day	On-site	
DC ParentSmart	**DC ParentSmart** started in April 2004 helps parents take advantage of public education options available to their children. They provide resources, training outreach, and individualized assistance to all DC parents with special attention to those children that attend schools designated "in need of improvement". A program of The Center for Student Support Services DC ParentSmart is funded through a grant from the US Department of Education.	All families with school age children. Targeting wards 1, 7, 8.	0-6 year olds	33000 are entitled to be served.	on site and through outreach and advocacy.	$1.5 million Federal Grant
DC Public Schools	**Office of Early Childhood Programs:**					
Department of Parks and Recreation	**Specialty and Targeted - Educational Services** provides educational, cultural, recreational, and creative arts programming and nutritional support services to both pre-school and school-aged children, including those with special needs.					Total Specialty and Targeted budget: $9,426,489
Horton's Kids	**Horton's Kids** provides comprehensive services to the underserved children in Anacostia's Wellington Park housing project, including: twice weekly tutoring sessions, weekly mentoring activities, tuition assistance and access to community leadership programs, funding for summer camp, and birthday and holiday celebrations.	Children in Anacostia's Wellington Park housing project in Ward 8				

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Lt. Joseph P. Kennedy Institute	**Child Development Center:** This center serve children with and without disabilities, age 6 weeks to 6 years, where they develop positive self-esteem and learn academic readiness skills, good self-care habits, and group participation. Transition coordination into elementary school is provided. Services include traditional day care and preschool services, medical day treatment, physician assessments, nursing and nutrition services, IFSP and IEP development, therapy (occupational, physical, speech, hearing, mental health, and vision), social work and service coordination, and family supports.	Children with and without disabilities	6 weeks to 6 years		On-site	
New Community After School and Advocacy Program	**The New Community After School and Advocacy Program (NC-ASAP)** provides year-round academic and cultural enrichment to children from pre-K to 12th grade. Pre-K to 5th grade after school programs include hands-on learning experiences, tutoring, enrichment activities in reading, math, and other subjects, and special classes. Summer and weekend activities include camps, visits to historical and cultural sites, community service, mentor relationships, and academic and recreational activities.	Children from local schools	pre-K to 12th grade		On-site	
Office of Early Child Development	**The Program Development Division** implements the Quality Child Care Initiative (QCCI), Healthy Child Care DC and the Child Care Health Consultant Corps. It also implements the Head Start State Collaboration Project, designs and implements child care program expansion and improvement efforts, and provides consumer services.					
The National Center for Children and Families	**The J.C. Nalle Community School** is a full service community school program. Students and their families have access to the following: extended academic enrichment program; after school care; social, creative, and cultural clubs for applied mastery; health care services; mental health services; parental involvement; information and referral to community resources; free summer enrichment programs; and social services and counseling.			150 children, 108 adults, 125 families		

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Assistance with Developmental Disabilities						
National Children's Center	**Child Development Program:** National Children's Center provides educational, social, and clinical services to people with developmental disabilities. The Child Development Program serves infants and children in various settings, including early intervention, home health, preschool and childcare.	Children and infants with developmental disabilities			Two sites	
National Children's Center	**Educational Services:** This program serves children whose unique problems keep them from succeeding in public school. All participants have intellectual disabilities, and many are emotionally troubled, hearing impaired, behaviorally maladaptive, or have language deficits.	Children whose disabilities keep them from attending public school				
The River School	**Infant and Toddler Programs:** The River School runs educational and developmental programs for deaf children, from infants to preschool.	Deaf children			On-site	
K-3rd Grade Instruction						
Everybody Wins!	**The Power Lunch** program matches students and adults for one-on-one reading during the lunch hour. Nearly 100 area businesses provide over 1,300 volunteers.	Students in Title I public elementary schools		3,000 total for EW!	On-site at Title I public elementary schools	
Everybody Wins!	**The Readers Are Leaders** program matches older elementary students with younger children for one-on-one reading during the lunch hour.	Students in Title I public elementary schools (grades 1-6)	Grades 1-6	3,000 total for EW!	On-site at Title I public elementary schools	
Everybody Wins!	**The Story Time Program** brings storytellers and authors into schools to perform for students every month.	Students in Title I public elementary schools (grades 1-3)	Grades 1-3	3,000 total for EW!; 1,100 children, 50 per performance	Intake/Assignment Procedure: telephone, walk-in, referral, child welfare agency, Mary's center (telephone). Org provides referrals.	
For Love of Children	**The Neighborhood Tutoring** program focuses on bringing students up to their grade level in math an dreading. Tutors are local community members. On average, students' reading and math levels advance by 1 year and 3 months.	Students in public elementary schools		550 in 2002		

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
For Love of Children	**Hope and A Home** rents apartments to families for up to three years at far below market rates. Educational success is encouraged by training parents as advocates for their children, a Good Grades Program to encourage student achievement, after-school and summer activities, scholarships for youth and adult education, and tutors and mentors.	Families with limited resources				
Greater Washington Urban League	**After School Tutorial Program**: Provides homework assistance and tutorial serives in reading and math. Additional activities to develop computer litercy/exposure and geography exposure.	Serve children in section 8 housing complex and low to moderate income apartment complexes - domestic violence and one parent incarcerated	6-12		2 office locations; On-Site	
In2Books	**In2Books** motivates students in grades 2-5 to read, think, and write by matching them with adult pen pals. Students are given books and are encouraged to maintain correspondence with their mentors.		Grades 2-5			
Project Northstar	**Project Northstar** provides one-on-one tutoring to homeless or disadvantaged school children. A Case Manager will track the student's progress and meet with the parents. A meal and transportation are provided to ensure attendance. Their comprehensive approach includes field trips and special weekend classes in fine arts.	Homeless or disadvantaged school children	Grades 1 - 12	200		
YMCA of Metropolitan Washington	**Afterschool and Camp Programs** are designed to enhance academic achievement and provide structured wellness opportunities.	Children 3-14 and their caregivers.				

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Charter Schools						
Arts Explorer Performing Arts Conservatory Public Charter School	This conservatory addresses the educational needs of students with outstanding capabilities in acting, dance, visual and media arts, and music.		Pre K - 8th grade	TBD		
Capital City Public Charter School	Founded by leaders of the Phoebe Hearst Elementary School PTA, this new institution uses the Expeditionary Learning Outward Bound model. Teachers use a system called Responsive Classroom to meet individual learning needs. Arts instruction has also been integrated into the curriculum.		Pre K - 8th grade	220		$35,000 from Moriah Fund in 2003
CentroNia: The District of Columbia Bilingual Public Charter School	This school fosters a bi-lingual approach to learning. Its parent organization, the Calvary Bilingual Multicultural Learning Center, shares its philosophy respecting a culturally and linguistically rich environment.	Bilingual children; Wards 1, 2, and 6	Pre K - 5th grade	122		
Children's Studio School Public Charter School of the Arts & Humanities	This community-based arts organization and full-time school uses an Arts ad Education approach to "develop multidimensional thinking in children." It employs a diverse group of artists as teachers.		3-10 year-olds	127		
E.L. Haynes Public Charter School	Named for a remarkable African-American educator, this urban school focuses on mathematics and science.	Mostly children from wards 1, 4, and 5	Pre K - 2nd grade	138		
Eagle Academy Public Charter School	This is a Pre-School and Kindergarten that allows students to develop at their own pace and does not consider advancement to be a measurement of intelligence.		3 - 5 year-olds	116		
Elsie Whitlow Stokes Community Freedom Public Charter School	This is a bilingual school, teaching in English and either Spanish or French.		K - 6th grade	220		
Friendship Edison Public Charter School	These two schools, on Chamberlain Campus and Woodridge Campus, are organized around teaching academies wherein the teachers stay with the same students for several years. Technology is emphasized, and third grade students and above are all equipped with their own computers.		K - 5th grade	1242		
Howard Road Academy Public Charter School	This school's education program features the Direct Instruction curriculum and has recently expanded to seventh grade.	Children in Ward 8	K - 7th grade	550		

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Hyde Leadership Public Charter School of Washington, D.C.	Reading fluency is at the core of the curriculum at this school, where all students are expected to read at or above their grade level. The school is adding one grade per year until it reaches 6th.		K - 3rd grade	231		
Ideal Academy Public Charter School	The curriculum here emphasizes mathematics, science, and technology, and reading skills are developed early with an intensive phonics program. Before and after school programming is included.		Pre K - 8th grade	221		
Latin American Montessori Bilingual Public Charter School	This school uses the Montessori approach to language arts, mathematics, and science in English and in Spanish. One grade will be added every year until the school serves 8 year-olds.	Bilingual children (Spanish and English)	3 - 5 year-olds	TBD		
Mary McLeod Bethune Day Academy Public Charter School	Besides a challenging academic program in a supporting environment, this school emphasizes parental involvement and diversity in its programming.		Pre K - 8th grade	TBD		
Meridian Public Charter School	Programs here include a concept-based curriculum, structured classrooms with assistant teachers, ongoing evaluation, a tutoring/mentoring system, and individualized language studies. The elementary program was designed by Calvert School.		Pre K - 8th grade	475		
Roots Public Charter School	This school offers a learning environment coupled with an investigation of African heritage and culture.		Grades 1 - 8	66		
The Community Academy Public Charter School	Founded by the Urban Family Institute and managed by LearnNow, a subsidiary of Edison Schools, Inc., this school also provides Kids' House, an afterschool program with homework time and tutoring services.		Pre K - 7th grade	508		
The School for Arts in Learning Public Charter School	This education center serves children with learning disabilities, using an interdisciplinary, project-based curriculum.	Children with learning disabilities	K - 6th grade	118		
The SEED Foundation	The SEED Foundation provides funding for the SEED School of Washington, D.C., including operations financing, construction financing, and campus development funds.					
The SouthEast Academy of Scholastic Excellence Public Charter School	This academy provides instruction that can be individually tailored to the student's needs, offering college preparatory or skilled career development programs.	Targets the Southeast section of DC	Grades K - 8	667		

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Tree of Life Community Public Charter School	This school targets African American students performing below their grade levels, emphasizing reading and literacy and seeking strong parental involvement. Family-literacy services are also offered.	African-American children performing below grade levels	Pre K - 7th grade	133		
The Village Learning Center Public Charter School	This school emphasizes reading, writing, mathematics, spelling, and speech, and has adopted a strict moral and discipline standard.		Pre K - 5th grade	227		
Tri-Community Public Charter School	This school will add a grade every year until it reaches grade 12. It focuses on literacy using the America's Choice Performance Standards.	Children in Ward 4	K - 3rd grade	TBD		
Two Rivers Public Charter School	This school uses the Expeditionary Learning Outward Bound model that emphasizes hands-on and interactive project-based learning.		Pre K - 3rd grade	TBD		
William E. Doar, Jr. Public Charter School	This school provides a college-preparatory academic and artistic experience by combining a multi-disciplinary arts program with more traditional curricula.		Pre K - 5th grade	232		

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Assistance with Developmental Disabilities						
Lt. Joseph P. Kennedy Institute	**Kennedy Schools (Lower School)** educates students with developmental disabilities in an un-graded academic program that also offers intensive therapeutic services. Services include individualized instruction, therapy (occupational, physical, speech and language, and social and emotional), after-school programs, transition services and counseling, and family supports.	Children with developmental disabilities	6-13 years		On-site	
Lt. Joseph P. Kennedy Institute	**The School Inclusion Program** assists children with disabilities who are enrolled in other child care centers and public an parochial schools so that they can participate fully. Kennedy Institute's staff provides help to children and support to teachers in general education classes. Services include individualized instruction, therapy (occupational, physical, speech and language, and social and emotional), technical assistance and team teaching, family supports, classroom and instructional accommodations, and training to educators and service providers.	Children with developmental disabilities enrolled in other child care centers and public and parochial schools			Public and parochial schools, and day care centers	
New Community After School and Advocacy Program	**The New Community After School and Advocacy Program (NC-ASAP)** helps families get services for children with special academic and emotional needs, and coordinates regular meetings with teachers in schools that the children attend. The Family Council, of which parents are members, meets monthly to receive training to be advocates for their children, to plan fundraising events, and to receive information and mutual support.	Children from local schools; Ward 2	pre-K to 12th grade		On-site	
The River School	**Primary School-Aged Programs:** This full-time school program teaches deaf students skills in reading, writing, spelling, and creating, and reinforces core values such as responsibility, respect, and appreciation of differences.	Deaf children	Primary School		On-site	
Home Schooling						

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Family Involvement						
Associates for Renewal in Education Inc	**Early Childhood Development**: Provides childcare services to ages 2 months to 4 years of age. In conjunction with providing services to the children provides parenting to the parents of those children. Has programs within two high schools and one middle school. The parents of those programs are required to participate in parenting meetings as well as daily contact with the staff regaridng their child. They must spend their lunch hour participating in the Center with their child.	Teen parents from various socio-economic backgrounds.				
Carlos Rosario International Career Center	**Family Literacy**: In collaboration with Elsie Whitlow Stokes Community Freedom Charter School, Seaton Elementary DCPS and Marie Reed Community Learning Center parents are able to becomemore involved in their child's education and school. Through parent education, children's books distribution and parent/child literacy activities parents strive towards improving reading comprehension and vocabulary building skills. PACT events (Parent and Child Together) occur monthly at each site, providing families with an opportunity to read together. Whether it's parents reading to children or children reading to parents these activities are vital to our families' literacy skills. Through these experiences parents are better equipped to assist their children by actively participating in their education.					
DC ParentSmart	**Call Center** Parents citywide can access individualized help by calling 202-GO-4-DCED . Bilingual staff provide accurate up-to-date information and resources to help parents understand their options and make sound educational choices. Call Center staff members receive calls from parents seeking to transfer their child to another school, access supplemental services or become more involved in their child's education.				Home Visitation	
DC ParentSmart	**Outreach and Advocacy** campaign used to engage parents and empower them to advocate for their child. This is done through trainings and presentations, media outreach, radio commercials, talk show presentations, and advertisements in local and national newspapers to increase community awareness of No Child Left Behind Legislation.					

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Georgetown University Center for Child and Human Development	**Home Instruction Program for Parents of Preschool/Supporting Childeren and Families**: Participating families receive a home visit one time per week to role play the curriculum packet with their home visitor. All activities are geared to providing early literacy support to children ages 3-5 years. Families are also provided referrals to community services as needed, and developmental screening is offered to at-risk participants. Child maltreatment is addressed by teaching parents skills to work effectively with their children as their first and best teachers. Home visitors are taught the warning signs of abuse and neglect so families can be referred as needed.	Families in Wards 7 & 8 with children 3-5 years of age.				
Cultural Competence						
GAP Community Child Care Center	**GAP Center**: Quality multi cultural educational and developmental child development center.	Young parents; families; low income; balck and hispanic.				1.3 million

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Early Intervention						
Office of Early Child Development	The **DC Early Intervention Program** is part of the Department of Human Services Office of Early Childhood and Development and serves as a single point of entry for the Districts infant/toddler program. The program seeks to identify and serve infants and toddlers with developmental delays. Delays may occur in one or more of the following areas: physical development, cognitive development, language and speech development, social/emotional development, and adaptive/self-help skills. For eligibility, a child must be 50% or more delayed in one of the areas.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	14 Direct Services providers, 6 Evaluations providers Direct Services: Children's National Medical Center, Columbia Lighthouse for the Blind, Easter Seals, Edward P. Mazique Parent Child Center, Lt. Joseph P. Kennedy Institute, Mary's Center, Multicultural Rehab Services, Out Came the Sun, Phoenix Therapeutic Services, Rosemount Center, Abilities Network, Metropolitan Area Community Services, Rehab Plus, The River School. Evaluations: Multicultural Rehab, Children's National Medical Center, Georgetown Univ. Child Development Ctr., Little Feet & Hands, Out Came the Sun, Rehab Plus.	$2.1 million from OECD office
Assistance with Developmental Disabilities						

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Special Education						
DC Public Schools	**DCPS Special Education** educates public school children with special needs, both physical and mental. Most eligible children are identified by the age of 5.	Any public school child with a physical or mental disability	5-21 year-olds			
School Readiness						
DC ParentSmart	**Parents as Teachers** through a partnership with Mary's Center has trained home visitors to help families prepare their children below age 6 to enter school. Family support workers and supervisors have been trained in the Parents as Teachers curriculum, a case management-based home visitation program.	All families with children who are in the school age range.	0-6 year old.	Expect to reach 400 children in 2004-5		
Mary's Center	**Healthy Families DC Collaborative** partners with families to ensure children are healthy, safe and ready for school through home visitation and linkages with community resources. The program provides intensive support and home visitation for five years to DC parents identified as overburdened.	All families with children 0-5 years old.	0-5 years old	215 families served	Home visitations and through community outreach	
United Planning Organization	**Head Start / Early Head Start / Early Childhood Development:** Child-oriented educational programs that provide educational, nutritional, health, and recreational activities.		Pre-K			US Dept. of Health and Human Services, DC Dept. of Human Services, CSBG
Social and Emotional Development						
Intellectual/Cognitive Development						

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Language						
Mary's center	**The Bilingual health Access Project (BHAP)** is a DC funded project helping families apply for Medicaid, DC Healthy Families, Food Stamps, and TANF. BHAP translates all the documents for enrollment and helps families complete their applications on time.	Families with children in all age ranges.	0-22 year olds	1145 clients offered services	Outreach at community settings such as day care centers, restaurants, and churches and community centers.	
Literacy & Communication						
D.C. Public Library	**The Reach Out and Read Program (ROAR)** provides an opportunity for over 300 licensed family day care providers to support and encourage literacy. ROAR employs a librarian to provide monthly 30-minute in-home visits to each participating family day care provider. ROAR delivers monthly activity sheets and provides transportation for one annual trip to the nearest library.	Family day-care providers			Home visitation	Federal grant (Library Services and Construction Act) from the Department of Education
Mary's center	**The Even Start Multicultural Family Literacy Program** helps immigrant parents become literate in English and learn computer skills, civic responsibilities and parenting skills while their young children are prepared to succeed in school.	All families with children 0-8 years old.	0-8 year olds	469 parents and children served.	Two locations; on site and Bancroft Elementary school	2 awards from the University of UDC and Adult Education; Grants
Physical Development						
Boys & Girls Clubs of Greater Washington	**The Boys & Girls Club** consists of 25 clubs and 3 summer camps. Programs are in character and leadership development, education and career development, the cultural arts, health and life skills, and sports, fitness and recreation. No child is turned away for being unable to pay for services.	Youths age 6-18, regardless of ability to pay	6-18 years old	Daily average: 4,102. 55% male. Over 35,000 youth annually	23 clubs, a camp in DC, Maryland, and Virginia each.	
D.C. Department of Parks and Recreation	**The Department of Parks and Recreation** operates a number of childcare centers and provides the physical plant needed by other organizations.					

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Early Care and Education						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Schools Ready for Children						
DC ParentSmart	**Partnership Schools Program** works with schools to build collaboration between parents, teachers, administrators and the community using Dr Joyce Epstein's Family and Community Partnerships model. The program provides technical assistance, training, workshops and resources based on evidence-based models of school/parent partnership.					
SPARK-DC	**SPARK-DC** advocates for system change to improve child development processes in DC. It is a study with the goal of aligning systems that apply to the early care and education of children in order to increase the consistency of policies and practices. In three Wards, this study pairs a child development program with an elementary school so that implementation and transition strategies can be followed over time. The initiative's evaluation is managed by Child Trends. Partners: Calvary Bilingual Multicultural Learning Center and Harriet Tubman-Elementary School; Kenilworth-Parkside Recreation Center and Kenilworth-Elementary School; Frederick Douglass II Center and Turner Elementary School.	Elementary school children in Wards 1, 7, and 8	Age 2.5 or 3 to age 5. Five year long study, three cohorts.	420 enrolled per year; est. 1000 at end of study	Elementary schools and partner institutions; SPARK-DC leadership team, NBCDI, OECD, DCPS, DOH MFHA, Parks and Recreation	National Black Child Development Institute (NBCDI)
Planning Groups and Collaborative Processes						
Foundation for Educational Innovation	The **Foundation for Educational Innovation** will support a new learning system, the Virtual Visit, and Technical Learning Centers, using two-way video and teleconferencing technology as a basis for establishing communication environments providing electronic and interactive links to content found in America's museums and galleries; develop a pilot network in the DC public school system; and ensure the participation of minority and at-risk students in the project. Howard University will provide teacher training; program evauation methodologies will be developed based on Department of Energy models. Installation locations include Garrison Elementary School, Coolidge High School,and the Henry Gregory Family Life Center. Each school will be linked to the system via the Internet through interactive multimedia workstations. Museums in New York, DC, and Australia will participate.	Elementary and high school students				Federal $450,000; Non District / Non Federal $743,621; Receives District Funding

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Organization name	*Programs and services that involve all parents and families (traditional, non-traditional, at risk families) in the development of their children, often providing counseling, training, mentoring, nurturing and bonding, leadership opportunities, information resources and/or materials for successful parenting*	*Description of the children and families the program seeks to affect, including eligibility criteria*	*Ages of children*	*# children eligible/served*	*Physical doors of entry (On-site and Home Visitation)*	*Total annual programmatic budget*
Advocates for Justice and Education, Inc.	**Advocates for Justice and Education (General):** The mission statement is to help parents understand their rights and understand their role so they can get involved as a parent.	No specific profile, however work with parents of children with special needs and disciplinary cases at the schools		180 children and 130 families		
Center for Child Protection and Family Support	**Center for Child Protection and Family Support** has been committed to promoting healthy children and families free of violence abuse and neglect. The Center offer programs and services directly to children and families and also provides professional training on various child welfare issues. Services include parent education, school-based programs, therapeutic services, professional training and programs are linked to various DC agencies such as DOH, Child Health and family services, Office of early Childhood development, Addiction Prevention and Recovery Administration and DC Public Schools.	All families with children 0-17 year old sometimes based on geography and referral from specific provider or school. Serves all victims of child abuse and serves children with developmental challenges. See many children with asthma and diabetes and children with developmental concerns. High percentage of clients are eligible for TANF and Medicaid. 90% are African American. Serves clients in wards 8,6, and 7 with greater emphasis on ward 8.	0-17 years olds, but most clients are 6-12 year olds. Also see some babies in the 7-18 and 19-36 month range.	Train 400 providers a year;100 cases of abuse per year; mentor 25 kids per school at three schools; early childhood pre-k program serves 25 children across the city.	on site, home visits, school based programs, community based programs.	Total unknown; Federal grants from HHS, District of Columbia; Grants from foundations and private donors

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
CentroNia	**Family Institute**: Since its formation in 1999, the Family Institute has worked to ensure family strength and well being. By supporting the various programs within CentroNía that serve children and youth, the Family Institute completes the circle of support for the family as a whole. The Institutes mission is to support families within the community in their efforts to achieve their highest potential in education, financial stability, physical and mental health, cultural awareness, leadership and quality of life. The Family Institute's programs are implemented with the goal of furthering CentroNía's four core values of social justice, economic advancement, lifelong learning, and family and child well-being. The Family Institute seeks to aid parents in providing a home environment that fosters each child's ability to reach her/his full potential.	All our children's parents can access all services and workshops available at CentroNia. There are no eligibility requirements. However most of our families are people of color, low income, immigrants. Second Description: Low to middle income families in	15-45+ parents	396 - legal cases, 318 - parents received training, 808 - families utilized the centers	On-Site	$1,017,092.00
DC Department of Human Services	**Affordable Housing and Residential Service** provides stable housing and support services to eligible individuals and families.					
East Capitol Center for Change	**LifeStarts**: The mission of ECCC is to provide mentoring, life skills coaching, support and advocacy for youth & their families residing in the neighborhoods East of the Anacostia River in Washington, D.C. and Prince George's County Maryland. We model the conviction that transformation begins within the heart. It is our purpose to encourage individuals to cultivate change in their own lives and inspire others to do the same.	Youth & their families residing in the neighborhoods East of the Anacostia River in Washington, D.C. and Prince George's County Maryland. Members of any community, no matter what their income level				$14,000.00
Even Start	**William F. Goodling Even Start Family Literacy Program** is a free, federally funded family literacy program designed to empower families to grow toward independence together.	Adults, children from infancy to age eight, parents	childen from infancy to eight, parents			Receives Federal Funding

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Healthy Babies Project, Inc.	Since 1990, **Healthy Babies Project, Inc. (HBP)** has provided intensive outreach for pregnant and parenting women. HBP aims to reduce the rates of infant death, illness, low birth weight, and unintended pregnancies and improve the health, education and parenting outcomes for at-risk mothers, fathers and infants. In 2002, we began dedicating our efforts to expanding our outreach to expecting and parenting men as well. We have added services such as childbirth education classes, prenatal yoga classes, prenatal support group, HBP book club, health education classes, and parenting classes, all with the mother and father in mind. All services offered are free of charge. HBP encourages families to accept prenatal care and education, childbirth education and prenatal yoga, home visitation and case management services, family planning education, mental health services, substance abuse counseling and referrals for treatment. We bring expectant mothers and fathers under our wing and many times to their first prenatal care appointments. Clients enrolled are nurtured, educated and maintained as active participants in their own care through the child's third year of life. HBP services	This program has no eligibility requirements. Areas served by HBP contain a large population of high risk, single income and low-income families. Households in these areas are predominantly African American and headed by women.				$380,000.00
Mary's Center	**Family Support Services** provides intensive case management to Mary's Center clients and their families. Each family's needs are assessed and evaluated and treatment plans are developed to enable clients achieve life stability by enhancing problem-solving, self-direction, and crisis prevention.	All families being served.	0-22 years olds	1663 families served with children 0-22 year olds.	on site	
Perry School Social Services	**Social Services**: Provides social services including counseling, parenting, emergency assistance; family strengthening which includes family mentoring and fatherhood. Previously had a subcontract with a collaborative to provide services to families at risk for being reported to CFSA or supportive services to families who were already involved with CFSA. Employs the same methods used in working with the collaborative.	Our target population are residents of WARD 6 primarily Northwest 1 residents. Some of the residents are on TANF and live in subsidized housing and are from a single parent household. The schools in the immediate area are transformation schools which mea				

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
SPARK-DC	**SPARK-DC** advocates for system change to improve child development processes in DC. It is a study with the goal of aligning systems that apply to the early care and education of children in order to increase the consistency of policies and practices. In three Wards, this study pairs a child development program with an elementary school so that implementation and transition strategies can be followed over time. The initiative's evaluation is managed by Child Trends. Partners: Calvary Bilingual Multicultural Learning Center and Harriet Tubman-Elementary School; Kenilworth-Parkside Recreation Center and Kenilworth-Elementary School; Frederick Douglass II Center and Turner Elementary School. SPARK actively engages parents in support of its objectives.	Elementary school children in Wards 1, 7, and 8	Age 2.5 or 3 to age 5. Five year long study, three cohorts.	420 enrolled per year; est. 1000 at end of study	Elementary schools and partner institutions; SPARK-DC leadership team, NBCDI, OECD, DCPS, DOH MFHA, Parks and Recreation	National Black Child Development Institute (NBCDI)
The National Center for Children and Families	**The CARA House** is a therapeutic parenting education center that helps families avoid unnecessary involvement in the child welfare system. Parents are taught how to nurture healthy children. Services include respite and treatment foster care services in the community, and the KinNet and Nurturing Parent Program support relatives and neighbors in assisting families at risk of separation. Programs include the resource exchange program, individual and group parenting education classes, community parent advocates and mentors, neighborhood-based treatment foster care and respite services, Men-In-Motion Fathers Initiative, and a Youth Committee Advisory for Responsible Empowerment. Other services include conflict resolution skills, therapeutic family camp, and employment and computer skills training.	Ward 7 residents	Birth to adult	233 children, 137 adults, and 138 families	On-site	

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Northwest Center	**The Northwest Pregnancy Center and Maternity Home**: For both the maternity home and pregnancy center programs, the mission of the staff is to promote the dignity of women and a respect for all human life. Accomplishes this goal by offering the loving support and comprehensive aid necessary to enable all women to continue their pregnancies, deliver healthy babies, and care for themselves and their children. The Pregnancy Center Program provides pregnancy testing, short and long term motherhood support, health education, resources referrals including; adoptions, prenatal care, medical assistance, educational, employment and housing resources referrals, material assistance (maternity and baby clothing, diapers, formula, carseats, and Safe Start, Cribs for Newborns vouchers. The Center provides Career Connections Workshops, Parenting Classes, Prenatal Yoga, Motherhood Support Groups and Natural Family Planning Seminars. The Maternity Home Program provides transitional housing for pregnant women and women with infants for up to 18 months.	The program serves low income pregnant and parenting women and families in Washington DC. There are no income or residency requirements for our programs				$1,372,234.00
Parental Education & Training						
Advocates for Justice and Education, Inc.	**Parent to Parent Program:** This program provides parents with a supportive network of peers, offering parents an opportunity to develop leadership skills. Peer supporters are trained in a six-week course that focuses on educational advocacy, the laws supporting special education and related services, and leadership training. Community education for the families of children with disabilities is provided for free. AJE will provide direct service to parents in the form of individual representation, in order to ensure that appropriate services are being made available.				One Parent Training and Information Center	

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Capitol Hill Group Ministry	**Congregation Based Shelter** is a project that assists homeless families in becoming self sufficient utilizing a wholistic approach to family needs. The project addresses the risk factors through prevention, parenting classes and age appropriate expectations. The shelter provides overnight coverage for supervision of the families.	Families that are homeless and at risk to homelessness. Demographical data TANF recipeints, welfare to work and educational issues. Families are deemed eligible for shelter through the Virginia Williams Emergency Shelter program.				$616,142.00
Capitol Hill Pregnancy Center	The **Capitol Hill Pregnancy Center** provides support and assistance to anyone facing a pregnancy or experiencing post-abortion stress. Services include ongoing pregnancy support, prenatal and parenting classes, maternity and baby clothing and supplies, post abortion peer support and Bible studies, and medical, legal, adoption, and housing referrals. The center also runs an abstinence teen program.				Five members of the Multidisciplinary Team	
Capitol Hill Pregnancy Center	**Crisis Pregnancy Help**: The CHPC porgrams offer help and support to women, men, gorls and boys who are struggling with a crisis pregnancy. We provide free pregnancy testing, material resources (baby clothes, cribs, strollers, bottles, high chairs and all other items that babies need), free childbirth classes, free parenting classes and one to one mentoring and couseling. Our counselors are trained to look for abuse when meeting with the clents and we encourage conversations that allows the mother and/or father to share their frustrations as parents. We address child abuse in both the childbirth classes and our parenting classes.	Our target is the DC inner-city lower socio-economic population. We work with mostly the mothers and mothers-to-be and encourage them to break the generations of incorrect parenting and etc.				

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Family Education and Support						
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Catholic Charities, Washington Parent Education Collaborative (WPEC)	**Parent Education Initiative**: This initiative, funded by the Freddie Mac Foundation grant to the Catholic Charities Parenting Program, addresses the challenge of providing city-wide parenting classes and resources. Progress to date includes a directory of parent education, a video collection at the Martin Luther King Memorial Library, monthly meetings of the WPEC, and annual sponsorship of the Family Multicultural Health Festival. Partners include Catholic Charities, D.C. Public Library, UDC, OECD, and WPEC.				Martin Luther King Memorial Library	$375,000 from Freddie Mac Foundation
Catholic Community Services	**Strong Parents Strong Children**: Catholic Community Services Parenting Program seeks to build confident, competent parents and offer guidance to strengthen them in their role of raising a healthy child in today's society. As a leader in the community in this vision, we provide a uniquely designed program with wide resources. Over 40 highly qualified parent educators teach classes in the District of Columbia and several counties in Maryland. In addition to classes, we offer supportive services to other programs and individual parents. Sites for our classes include child development certers, schools, community based programs, shelters, and faith based programs. Our belief that strong parents make strong children is based on our philosophy that parents are the primary decision makers, role models, and authority for their children. We work to accommodate all parents who may need our services, focusing on their needs, identifying their goals, and offering them the tools necessary to succeed.	No Data Entered				total operating budget of the organization FY 2.3 million
CentroNia	**Family/Community Development Institute**: This program supports parents and community members to become lifelong learners, strong and supportive parents, and powerful education advocates. Options include Healthy Families DC, the Family Institute, and the Family Literacy Program. It also provides help with taxes, a food bank, and clothing supply.	Parents and community members; includes 25 teen parents; Wards 1, 2, and 4			On-Site	$6.3 million CentroNia overall

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Children's National Medical Center	**Children's Bear Essentials**: Primary care is the overarching priority - all families can have their own pediatrician, CNMC's community health centers are a great resource. Family Supports: Information services, public health, public safety (car seats), education, early childhood.	Parents and their children. A majority of the clients are from the suburbs. DC parents typically do not subscribe to Parents magazine. Program serves all children.	0-21 years	2700 served on one case load. All 0 to 21.	Intake/assignment procedure: Walk-ins, school preschool and head start referrals, child welfare agency.	Funding comes from the operation revenue of CNMC
Children's National Medical Center	**Parent's Anonymous**: The proven effective Parents Anonymous® prevention program serves the entire family through Parents Anonymous® Groups and Children's Programs. Parents learn new parenting strategies and create long lasting positive changes in their families. This program includes weekly, free of charge Parents Anonymous® Groups which are co-led by parents and professional Group Facilitators trained in the Parents Anonymous® model.					
Columbia Heights Shaw Collaborative	**Family Services**: Provide comprehensive assessment, resource and referral, and case management and short term therapy when necessary to families experiencing stress or crisis.	All families residing in the target area.				
Community Family Life Services	**Community Family Life Services:** Gives people living in poverty and homelessness the tools they need to move towards permanent economic and social self-sufficiency. Not only do we offer short-term crisis assistance, but we also empower families and individuals to change their lives for the better. Our dedicated staff and volunteers provide a variety of services in the following areas: Housing Services; Supportive Services & Community Outreach; and Youth Development & Advocacy.	Homeless individuals and families.				$200,000.00
Community of Hope	**Community of Hope**'s transitional housing provides a family with a private apartment that can accommodate a large family. Most recipients are single women with children. Social services are also provided, as each new resident is assigned a case manager who meets with them weekly. A family's course may include substance abuse treatment, GED training, familiarization with available social services, and parenting classes.	Families transitioning out of homelessness	All		On-site	

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Developing Families Center: Healthy Babies Project, Inc.	**The Fatherhood Initiative** meets weekly to educate, empower, and support fathers at The Healthy Babies Project.	Fathers and expectant fathers - typically teen, low income, African American		20 fathers	On-site at Healthy Babies Project	$5000 anonymous donation
East River Family Strengthening Collaborative	**Family Services Division**: This division provides supportive and preventive services to families living in Ward 7 who are at risk of abuse and/or neglect. The objective is to prevent children from entering foster care. The activities used in working with families include, family team meetings, case management, parenting, information and referral, budget management, housing, visitation, family group conferencing. The Family Assessment Form is used to assess risk factors associated with a family.	Families with children living in Ward 7. Some eligibility requirements are attached to certain programs (housing and emergency assistance)				$210,000.00
Georgetown University Center for Child and Human Development	**Supporting Children and Families**: This program provides child-focused services to support and increase parenting and advocacy skills. This service is coordinated with the service providers contracted to provide basic services to families at the DC Village Emergency Shelter, and utilizes community services already available. Conduct mental health screening and referral for parents.Conduct developmental and mental health screening and referral for children. Conduct health assessments and referral. Provide health, mental health and nutritional counseling using the Bright Futures guidelines. Instruct family members in how to stimulate their children's development via age-appropriate activities that can be conducted at DC Village or accessed in the community.	Families living at the DC Village Emergency Shelter				

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Latin American Youth Center	**Latin American Youth Center's Freddie Mac** A social service program specifically designed to provide services to young adolescents and adults who are part of the Foster Care Program or who are in danger of becoming homeless or runaway. The programs goals include: Rebuild supportive relationships between youth and their biological families, and seek family reunification when possible. Reduce incidence of prostitution and drug use among homeless and runaway youth by providing shelter and referrals to safe housing alternatives, including family reunification. Reduce clients long-term dependency on social services; build clients self-sufficiency in areas including housing, language skills, etc. Empower clients to develop effective interpersonal skills needed to maintain housing and a job. Provide minors with homes headed by competent caregivers.	All programs described above target at risk youth in danger of becoming or who are homeless or under the care of the DC CFSA. Together, these programs serve a 0 to 21 age cohort.				
Mary's Center for Maternal and Child Care, Inc.	**Healthy Start Healthy Families** partners with families to ensure children are healthy, safe, and ready for school through home visitation, and linkages with community resources. Program Services: Healthy Start Healthy Families services include intensive home visitation, parent activities, and linkages with outside services. All families also receive a home visit from a nurse at least once prenatally and once post-partum, unless medical risk is identified at which time, additional nurse visits are indicated. A mental health provider is also available to provide short-term, in-home counseling and support. Healthy Start Healthy Families staff is crucial to ensure that families access health care, educational support, safe housing, and employment—any service necessary for the health, stability and progress of the parents and their children. Staff becomes caring advocates and facilitators—teaching families to negotiate systemic barriers and challenges, advocating with schools to support teen parents in continuing with their education, identifying alternative school programs that can better meet their needs and coordinating service providers to ensure continuity of care.	Healthy Start Healthy Families' target population are typically difficult to reach families who may face barriers in accessing services, such as language difficulties, transportation, fear of becoming involved in "the system," lack of permanent housing,	parents of children less than five years old.	Approximately 200 families	On-site and home visitation and play groups on site	
Maternal and Family Health Administration	**SIDS Prevention education,** focusing on dissemination of *Back to Sleep* brochures, is operated in conjunction with other infant mortality reduction interventions.					Title V

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Metro DC PFLAG	**Metro DC PFLAG**: Provides support, education and advocacy to keep families together and promote the equality and well-being of gay/lesbian/bisexual/transgender and questioning individuals. Provide parent support groups and work with youth in schools. By promoting parental tolerance and understanding, g/l/b/t/q youth should be safer in their homes.	Parents, families and friends of g/l/b/t/q individuals. No eligibility requirements.				
Mt Carmel Baptist Church	**Parenting Education Training** is the primary function of the Parenting Education Ministry which was organized in response to the continuous deterioration of the family structure. The ministry's objectives include: To instruct participants in ways that would improve their parenting skills; to promote personal nad spiritual growth in participants; to strengthen moral values in participnats; to coach participants in better family relationships; to improve the skills of early child care providers. All of these objectives address risk factors related to child abuse and neglect. Parents have been referred to our classes by DC, MD, VA court systems because of neglect or abuse.	No eligibility requirements other than being referred by an agency or being a self-referral and completing four classes.				
Northwest Church Family Network NCFN	**NCFN**: Offers residential, apartment-style living to homeless families. Offer parenting skills developmenet, parent annonyomous support groups, youth enrichment programs, substance abuse prevention groups, healthy living groups focusing on prevention and living with HIV/AIDS/ individual and family therapy sessions	Primary traget population are homeless families. Homeless families are encouraged to contact the Coalition for the Homeless or for those families having a member living with HIV/AIDS, they are encouraged to contact HOPWA for referrals to the program.				
Northwest Settlement House	**Parenting Programs:** NWSH requires parents to complete their training program by attending workshops that focus on positive praise and family communication. Facilitators are provided by Catholic Charities. Operation Frontline is another program that teaches parents about food preparation, nutrition, and food expense budgeting.	Members of the Shaw community			On-site	

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Parklands Community Center	**Family Strengthening and Suport Program**: Provides services, educational workshops and support for low-income parents, to reduce the stress factors that lead to substance abuse and neglect. By working directly with parents to identify workable solutions to addressing problems that could impede a parent from providing a child(s) with a health and nuturing home environment. Activities: In-home assessments, case management, parenting and personal development training, employment and housing assistance, family bonding activities and referrals. Methods: Engage a parent in making decisions on their own behalf regarding support needed - engage their whole family in family activities and provide incentive to encourage regular participation and to stay in contact with the Parent Advocate.	Low-income Asian Americans living in Washington, DC. Description 2:Low income residents living in Ward 8.				1.8 Million
Salvation Armys Turning Point Center	**Turning Point Center for Women and Children**: Seeks to break the cycle of chronic homelessness and joblessness for single mothers and their children. Families may stay up to two years in safe, furnished apartments while gaining the skills to become self sufficient. The mothers are involved from the beginning in decision-making about their futures and must be enrolled in school or be employed while in the program. Services including case management, crisis intervention, individual and family counseling, advocacy, and independent living skills classes prepare them for the road ahead.					
Sasha Bruce Youthwork Inc	**Teen Mothers Program**: A structured, caring and therapeutic environment in which homeless teen mothers between ages 13 and 21 and their babies can remain together and receive support, guidance and other needed assistance. Residents are referred by CFSA. Residents receive education and career guidance, assistance with housing and employment, training in parenting and life skills, and pre- and post-natal medical support.	Teen mothers between the ages of 13 and 21 and their babies. These women would, withouth the program, be homeless. Historically, nearly 100% are African American and most have previously resided in Wards 7 or 8. Must be referred by CFSA.				N/A, Church funded

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Teaching for Change	**Tellin Stories:** A program of Teaching for Change, believes that for schools to provide the quality education our children deserve, families, schools and communities must be involved as purposeful partners in the education process. At the heart of Tellin Stories efforts to engage families and staff is the power of story to connect people from diverse backgrounds, to pass on valuable information and experiences and to organize collective action. Tellin Stories works with parents to create and implement action plans that affect the academic achievement and environment of neighborhood schools through relationship building (creating a story quilt), weekly meetings, workshops, trainings, and grassroots organizing. The most gratifying aspect of our work is that together Tellin' Stories, parents, educators, community members, and partner organizations are redefining the vision of school communities by helping those who are traditionally excluded from the decision-making process become a central part of it.	Low income and working class families, typically from immigrant families, both newly arrived and other	18-75	20-30 people at the weekly meetings at each school, 5 schools total	Work in depth in 5 schools	$50,000 District Funding; $16,0294 Non Federal / Non District Funding;
The Center for Child Protection and Family Support Inc	**Balancing Employment and Parenting (BEAP)**: Funded by the Department of Health and Human Services Administration for Children and Families, the program focuses on prevention and intervention of child abuse and neglect among predominately African-American TANF mothers with children 0-6 years old who reside in high risk neighborhoods. Balancing Employment and Parenting involves linkage with community agencies such as Head Start and Department of Employment Services to strengthen parenting skills through training of families involved in Welfare-to-Work and TANF job training.	.	Serves mothers with children 0-6 year olds			
The Family Place	**The Family Place** is a drop-in center for parents and children, providing parent education, life skills, self-help training, support, and community involvement.	Hispanic and African-American pregnant women and families with children under age 3	0-3 years old	approx. 300 families	Drop-in centers	$596,000.00

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The Keys to Canaan/Benning Terrace Parenting Center	**The Keys to Canaan**: Purpose is to provide parenting with positive and effective parenting skills. Objective is to help parents become more nurturing and to strengthen families. Activities will include parenting workshops and individual counseling sessions. The methods used to address risk factors will be one-on-one counseling sessions to help identify the source of the problems and referrals to seek the appropriate help.	Benning Terrace Community. Our only requirement is that the individual or family resides in the Benning Terrace Housing Development.				
The Little Blue House	**The Commitment to Hope Program**is a multidisciplinary approach to solving problems of child abuse and neglect within a family where substance abuse is an issue. The program addresses the mother's substance abuse, including physical and psycho-social components of addiction. Residential and outpatient treatment is available for mothers. The mother's parenting abilities are assessed and evaluated, and she receives independent living skills.	Neglected or abused children of parents who are substance abusers			On-site	
Washington Hospital Center	**Life As a New Mom**: This is a support group for new mothers. Mothers meet to discuss parenting issues and seek expert guest speakers.	New mothers, predominantly African-American and single. Many of the mothers are dealing with depression.				
Family Literacy						
Carlos Rosario International Career Center	**Family Literacy**: In collaboration with Elsie Whitlow Stokes Community Freedom Charter School, Seaton Elementary DCPS and Marie Reed Community Learning Center parents are able to becomemore involved in their child's education and school. Through parent education, children's books distribution and parent/child literacy activities parents strive towards improving reading comprehension and vocabulary building skills. PACT events (Parent and Child Together) occur monthly at each site, providing families with an opportunity to read together. Whether it's parents reading to children or children reading to parents these activities are vital to our families' literacy skills. Through these experiences parents are better equipped to assist their children by actively participating in their education.					

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
CentroNia	**Family/Community Development Institute**: This program supports parents and community members to become lifelong learners, strong and supportive parents, and powerful education advocates. Options include Healthy Families DC, the Family Institute, and the Family Literacy Program. The Family Literacy Program works with SPARK.	Parents and community members; includes 25 teen parents; Wards 1, 2, and 4			On-Site	$6.3 million CentroNia overall
Edward C. Mazique Parent Child Center	**Literacy Initiatives:** The Home-based Stork Club is a program under which Mazique regularly distributes new books to pregnant women and children with infants. The Family of Readers/Building Home Libraries Project distributes free and used books to children and their family members, in order to promote family reading habits and the parent's role as an active participant in their children's education. The Mazique Parent Child Center also provides comprehensive child care services.				Group socialization experiences	
Child Support						
Girls and Boys Town of Washington DC	**Long Term Residential Traditional Group Homes**: Focuses on family style living. Each home, led by a married couple known as Family-Teachers, is home to six boys or girls ages 13-17. The Family-Teachers and Assistant Family-Teachers work to provide a loving, caring home and ensure the children's physical, spiritual, emotional and treatment needs are met. All youth care staff are trained and certified annually through an ongoing professional development and evaluation process. This certification ensures they are providing the best care possible to their "family."					
Far Southeast Family Strengthening Collaborative Inc	**Neighborhood Based Child Welfare**: Provides neighborhood-based services including case management, information and referrals, and speciality services to families residing in the Ward 8 community.	Families residing in the Ward 8 community.				$1.3 million
Metro DC PFLAG	**Metro DC PFLAG**: Provides support, education and advocacy to keep families together and promote the equality and well-being of gay/lesbian/bisexual/transgender and questioning individuals. Provide parent support groups and work with youth in schools. By promoting parental tolerance and understanding, g/l/b/t/q youth should be safer in their homes.	Parents, families and friends of g/l/b/t/q individuals. No eligibility requirements.				

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Family Stability						
Asian American Leadership Empowerment and Development (AALEAD)	**Family Stabilization Program** includes comprehensive case management and advocacy for parents and families, and guidance to parents on local systems and raising children in the U.S. AALEAD has a two-person Family Strengthening Program staff. The prevention portion of this program is with individual parents or groups of parents discussing child-abuse and child-neglect, and to help parents understand the system. Staff reports cases as needed.					
Bright Beginnings, Inc.	**Bright Beginnings, Inc.** is a developmental child care center for homeless preschoolers whose families are in crisis shelters or transitional housing. Also offered: on-site therapeutic services (speech, occupational, psychiatric), parent involvement, transition support for parents, and family enrichment.	Homeless preschoolers, Ward 6	6 weeks. - 5 yrs.	Approx. 100	On-site	
Bright Beginnings, Inc.	**Bright Beginnings Child Development Program** is a developmental child care center for homeless preschoolers whose families are in crisis shelters or transitional housing. Also offered: on-site therapeutic services (speech, occupational, psychiatric), parent involvement, transition support for parents, and family enrichment.	Children at 6 weeks to 5 years of age from homeless families in DC area.		Approx. 100	On-site (undisclosed location)	
Calvary Womens Services	**Calvary Womens Services** provides housing and support services to homeless women in Washington, DC. We operate three housing programs - Calvary Women's Shelter, Pathways and Sister Circle - that offer a range of housing services from low-barrier shelter to permanent housing. Calvary provides on-site mental health services, case management, addiction recovery groups, life skills classes, and supported employment to the women we serve. While we wouldn't necessarily refer to Calvary as a child abuse and neglect prevention program, we do seek to support women as they re-build their lives and prepare to re-connect in a positive way with their children and families.	Calvary's programs serve single, homeless women.				$550,000.00

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Capitol Hill Group Ministry	**Congregation Based Shelter** is a project that assists homeless families in becoming self sufficient utilizing a wholistic approach to family needs. The project addresses the risk factors through prevention, parenting classes and age appropriate expectations. The shelter provides overnight coverage for supervision of the families.	Families that are homeless and at risk to homelessness. Demographical data TANF recipeints, welfare to work and educational issues. Families are deemed eligible for shelter through the Virginia Williams Emergency Shelter program.				$616,142.00
Child and Family Services Agency	**Adoption and Guardianship Subsidy** provides financial assistance services to eligible relatives and adoptive parents so that they can maintain children in permanent homes.					$26,796,918.00
Coalition for the Homeless DC Village	**DCV** is an emergency family shelter. We provide case management, referrals services, and community linkages. Our main goal is to promote self-sufficiency and successfully place homeless families into permanent and transitional housing.	Homeless families in the District of Columbia. Sometimes socio-economics does not play a factor in families that we receive. Requirements include being a homeless 'family' or a pregnant mother in her third trimester are eligible for shelter				$90,000.00
Family and Child Services of Washington DC Inc	**Family Counseling / Mental Health**: Objective is to stabilize families and individuals through the use of individual, family and group counseling/therapy; parenting classes; and a domestic violence prevention program	Program addresses individual and families with social and emotional problem significant enough to interupt normal activities				$1,158.301.10

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For Love of Children	**Hope and A Home** rents apartments to families for up to three years at far below market rates. Family stability is encouraged by weekly meetings and goal setting, workshops on topics that parents feel are important to their success, family activities, and ongoing peer celebration and recognition.	Families with limited resources				
Georgetown University Center for Child and Human Development	**Supporting Children and Families**: This program provides child-focused services to support and increase parenting and advocacy skills. This service is coordinated with the service providers contracted to provide basic services to families at the DC Village Emergency Shelter, and utilizes community services already available. Conduct mental health screening and referral for parents.Conduct developmental and mental health screening and referral for children. Conduct health assessments and referral. Provide health, mental health and nutritional counseling using the Bright Futures guidelines. Instruct family members in how to stimulate their children's development via age-appropriate activities that can be conducted at DC Village or accessed in the community.	Families living at the DC Village Emergency Shelter				
Mary's Center for Maternal and Child Care, Inc.	The **Family Social Services Program** meets the social and emotional needs of families, many of whom are immigrants, helping them become self-sufficient, and encouraging active participation in their new communities while continuing to respect their heritage and traditions. Bilingual family support workers help clients to access housing and food programs, education, financial assistance, employment, mental health care and legal services. Often, clients are referred to the Family Social Services Program by physicians or mental health professionals and Family Support Workers act as a liaison between the client and the health professionals.		0-12 years old.			

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
North Capitol Collaborative Inc	**Neighborhood Based Community Service Organization**: NCCI's objectives are to provide a comprehensive Neighborhood Based Family Support and Child Welfare Service Delivery System through the service categories of Family Stabilization, which includes information and referral services, community case management, supportive case management for cases referred from CFSA to NCCI, youth aftercare case management for youth aging out of the foster care system. Further NCCI, will support this objective through the delivery of services in the category of Community Capacity Building, which designed to increase the knowledge of and enhance the capacity of internal and external community resources for the prevention of abuse and neglect. Community Building Services are achieved through the development of initiatives designed to support and enhance a family support network: parent education training, parent support group, youth, and parent-geared activities. Through the development of partnerships with area service providers, board development and trainings and increased staff development; community engagement strategies: hot spot reports, engagement activities with the local ANCs, police departments, roving leaders and other key partners within the community.	North Capitol Collaborative, Inc. services seven neighborhoods in the District of Columbia. On the south side, the neighborhoods are China Town and Mount Vernon, on the West side, Truxton Circle, Bloomingdale, and Ledroit Park, and on the East side, Edgewood				$6,600,000.00
Northwest Church Family Network NCFN	**NCFN**: Offers residential, apartment-style living to homeless families. We offer parenting skills developmenet, parent annonyomous support groups, youth enrichment programs, substance abuse prevention groups, healthy living groups focusing on prevention and living with HIV/AIDS/ individual and family therapy sessions	Our primary traget population are homeless families. Homeless families are encouraged to contact the Coalition for the Homeless or for those families having a member living with HIV/AIDS, they are encouraged to contact HOPWA for referrals to our program.				

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Salvation Armys Turning Point Center	**Turning Point Center for Women and Children:** Seeks to break the cycle of chronic homelessness and joblessness for single mothers and their children. Families may stay up to two years in safe, furnished apartments while gaining the skills to become self sufficient. The mothers are involved from the beginning in decision-making about their futures and must be enrolled in school or be employed while in the program. Services including case management, crisis intervention, individual and family counseling, advocacy, and independent living skills classes prepare them for the road ahead.					
The Center for Child Protection and Family Support Inc	**Families and Schools Together (FAST)** is funded by the Addition Prevention Recovery Administration, FAST seeks to enhance family functioning, prevent school failure among youth, reduce day-to-day stressors among parents and families and prevent the use of drugs and alcohol within the family. Fast replicates a national science-based substance abuse prevention model, based on selected research in family therapy, child psychiatry, community development and social support. The FAST structure allows both youth and families to have a voice and role in the prevention process.					
The Center for Child Protection and Family Support Inc	**Village Family Support Center (VFSC**) The Center offers home visits crisis intervention counseling, and individual/group counseling in Southeast Washington, through the Victim Service Center. The focus is on prevention and early intervention. The Center works with local schools, shelters, churches and other community groups.					
The Center for Child Protection and Family Support Inc	**Discovering Every Parents Positive Image (DEPPI)** is funded by the Children and Youth DC Investment Trust Corporation and other partnering agencies, is designed to provide a community-based site of early childhood education programs with family support services to promote stronger healthier and less at-risk families. Parents participate in weekly parent skill building training programs that promote safety and resiliency and minimize the risk of harm to infants, toddlers and pre-school children.					

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The Georgia Avenue Rock Creek East Family Support Collaborative	families including intensive case management, housing support, financial assistance, information and referral services. Family stabilization services involves the provision of interventions across the service continuum aimed at resolving immediate crisis, identifying and linking to needed resources, and/or providing the support and supervision necessary to achieve permanency goals and family wellbeing. The purpose is to provide neighborhood-based service intervention to families to prevent abuse and/or neglect of children. The objectives of this program are: To update and maintain a resource database or resource manual for use by Collaborative staff, community partners, and families in the target area To provide adequate and appropriate referrals based on the needs of families and children To prevent children from entering the child welfare system. To increase the stability and capacity of families to nurture and maintain their children within their homes and communities. To provide comprehensive case management and services to at-risk families. To support CFSA in their efforts to stabilize and reunify families with open cases in the child welfare	For the Family Stabilization Program: Families with minor children 18 and under living in Ward 4, Families referred by CFSA, Youth involved in the foster care system referred by CFSA. For the Capacity Building Program: Parents, Children and Youth				minimal
The Georgia Avenue Rock Creek East Family Support Collaborative	**Community Care Grant Program:** This program is a community-based program designed to assist homeless families in Washington, DC obtain safe, stable housing with time-limited supportive services that advance and support the families effort to become independent and self sufficient. The goal of this program is to provide families with an array of resources through the allocation of rent subsidies and support services that will ultimately result in housing stability and independence. Activities include: Intake/Engagement Case management Psychosocial Assessment Housing Search Mental Health Services Employment Assistance Financial Counseling	Families that are homeless, living in a shelter or at-risk of homelessness.				

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Transitional Housing Corp.	**Partner Arms I and II** is a faith-based non-profit program that provides housing and comprehensive support services to homeless and at-risk families so that they can make transformational changes in their lives and attain self-sufficiency. Parenting workshops are provided on a regular schedule in order to promote nurturing and the proper care of children in a healthy, safe and supportive environment. Best methods in the care of children are also promoted during case management sessions and enhanced via mental health and substance abuse supportive services.	Homeless and families who are at-risk of being homeless are the target population we serve. Due to the lack of affordable housing in the DC region, families with low to moderate incomes are also at risk of becoming homeless. Along with proof of home				$200,000.00
Valley Place Family Transitional Apartment Program	**Family Transitional Apartment Program:** The Coalition For The Homeless provides 18 fully equipped apartment units to provide Transitional Housing for 18 familes who have become homeless. Services include 24 hour residential housing, general social services which include: (food stamps, TANF, child care, etc.) case management, substance abuse counseling, assess medical/mental health needs and make appropriate referrals.					
Foster Care						
Child and Family Services	**Child and Family Services** provides therapeutic and traditional foster care, offering interim environments for children whose families are in crisis.	Children whose families are in crisis				
Child and Family Services Agency	**Out-Of-Home Care and Support - Family Resources** provides recruitment, training, licensing, monitoring, and support services to current and potential foster, kinship and adoptive parents.					Total Out-of-Home Care and Support budget: $104,605,024
Child and Family Services Agency	**Out-Of-Home Care and Support - Child Placement** provides living arrangement services to children.					Total Out-of-Home Care and Support budget: $104,605,024
Child and Family Services Agency	**Out-of-Home Care and Support - Licensing and Monitoring** provides licensing approval and ongoing monitoring services to operators of private agency foster homes, group homes, and independent living facilities.					Total Out-of-Home Care and Support budget: $104,605,025

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DRAFT Resource Map of Programs and Services

Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Children's Law Center	**Family Permanency Project:** The CLC helps children find safe, permanent homes by representing foster and kinship caregivers in adoption and other permanency procedures.			175		
Consortium for Child Welfare	**Foster Parenting:** The Consortium for Child Welfare's member agencies train and support foster parents to provide homes to D.C. children.				Member organizations	
For Love of Children	**The Family Intervention Program** provides foster care and family support for children removed from their homes due to abuse or neglect. FIP runs a Family Group Decision Making Conference, in which members of the child's family meet with a staff member to discuss legal options and formulate a long-range plan for the child.					
Helping Children Grow, Inc.	**Helping Children Grow, Inc.** operates community-based family care homes that provide stable family environments for child victims of abuse and neglect. The homes are not institutionalized and are located in secure residential neighborhoods, indistinguishable from other homes in their areas. The staff includes a consulting psychologist, parent aides, and full-time social workers.	Child victims of abuse and neglect			Homes in residential neighborhoods	
The National Center for Children and Families	**Greenleaf Treatment Foster Care** pairs children and adolescents with families. Services include in-home therapy and case management, pre-service and in-service foster parent training, respite care, foster parent support groups, in-home crisis intervention, 24-hour on-call staff support, permanency planning and advocacy, psychiatrist consultation, treatment, and medication management, educational advocacy and support, resource referrals, and recreational activities.	Vulnerable children and adolescents	Licensed for 6-20 year olds	90 youth and 87 families. Licensed for 45 adolescents aged 6 to 20.		
Respite Care						
Bright Beginnings, Inc.	**Family Stability**: Bright Beginnings alleviates a major source of anxiety for homeless parents by providing their children with a safe, nurturing, secure environment. Bright Beginnings' family service team works one-on-one with families to identify personal challenges, set goals to overcome obstacles and achieve self-sufficiency. Social workers provide parents with referrals to shelters, food banks, mental health services, child protective services, disability services, and educational job training programs.					
Teen Pregnancy						

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Developing Families Center: Healthy Babies Project, Inc.	**Teen Parent Empowerment Program:** This free program allows pregnant teens and teen parents to partake in programs to lift them out of the cycle of poverty. Programs include health education, counseling, support groups, GED tutoring, and parenting classes.	Mothers or pregnant teenagers, age 12-21		30-40	On-site at The Healthy Babies Project	
Faith-based Institutions						
Capitol Hill Pregnancy Center	**The Capitol Hill Pregnancy Center** provides support and assistance to anyone facing a pregnancy or experiencing post-abortion stress. Services include ongoing pregnancy support, prenatal and parenting classes, maternity and baby clothing and supplies, post abortion peer support and Bible studies, and medical, legal, adoption, and housing referrals. The center also runs an abstinence teen program.	Anyone facing a pregnancy or experiencing post-abortion stress			On-site	
One Church, One Child	**One Church, One Child** is an adoption recruitment initiative that encourages the religious community to support adoption. The initiative's goal is to place one adopted child at every African-American church.					
Transitional Housing Corp.	**Partner Arms I and II** is a faith-based non-profit program that provides housing and comprehensive support services to homeless and at-risk families so that they can make transformational changes in their lives and attain self-sufficiency. Parenting workshops are provided on a regular schedule in order to promote nurturing and the proper care of children in a healthy, safe and supportive environment. Best methods in the care of children are also promoted during case management sessions and enhanced via mental health and substance abuse supportive services.	Homeless and families who are at-risk of being homeless are the target population we serve. Due to the lack of affordable housing in the DC region, families with low to moderate incomes are also at risk of becoming homeless. Along with proof of home				$200,000.00

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Planning Groups and Collaborative Processes						
DC Children's Trust Fund	**Parent Empowerment**: A network of parent support groups and children's programs following the Parents Anonymous model. Purpose: To strengthen families. Open to all parents; some groups are specialized, i.e., fathers, teen parents, etc. Groups meet once per week for around 2 hours. Parents give and receive support. The model is one of shared leadership.	Parents - general population, fathers, parents of children with special needs, kinship providers, teen parents, new parents, parents who are homeless.				
Edgewood/Brookland Family Support Collaborative	support networks that promote healthy families, safe neighborhoods and thriving communities. Our mission is to strengthen families and build vibrant communities. Our goal is to reduce the incidents of child abuse and neglect by engaging residents and community stakeholders in the process of supporting children and families in our targeted neighborhoods. E/BFSC is one of seven neighborhood-based Collaboratives in the District of Columbia, which make up the city-wide Healthy Families, Thriving Communities Collaborative. E/BFSC has been in existence since 1996 when a partnership consisting of residents and neighborhood based organizations received a planning grant from the D.C. Child and Family Services Agency (CFSA). The planning grant facilitated the development of a community based collaborative effort to design and implement a neighborhood-based family support system. After a year of planning, E/BFSC opened its first Family Support Center in Brookland Manor in 1997 and began formally serving families. Currently, E/BFSC operates Family Support Centers in Brookland Manor, Carver/Langston and Trinidad/Ivy City. The Family Preservation and Support Program is made up of neighborhood-based services and	EBFSC provides community-based case management and supportive services to families with dependent children who reside in Ward 5 and in parts of Ward 6 in the District of Columbia. Additionally, EBFSC develops the capacity of partners and service provide				$250,000.00

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Family Education and Support						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Teaching for Change	**Tellin Stories:** A program of Teaching for Change, believes that for schools to provide the quality education our children deserve, families, schools and communities must be involved as purposeful partners in the education process. At the heart of Tellin Stories efforts to engage families and staff is the power of story to connect people from diverse backgrounds, to pass on valuable information and experiences and to organize collective action. Tellin Stories works with parents to create and implement action plans that affect the academic achievement and environment of neighborhood schools through relationship building (creating a story quilt), weekly meetings, workshops, trainings, and grassroots organizing. The most gratifying aspect of our work is that together Tellin' Stories, parents, educators, community members, and partner organizations are redefining the vision of school communities by helping those who are traditionally excluded from the decision-making process become a central part of it.	Low income and working class families, typically from immigrant families, both newly arrived and other	18-75	20-30 people at the weekly meetings at each school, 5 schools total	Work in depth in 5 schools	$50,000 District Funding; $16,0294 Non Federal / Non District Funding;
Turning the Page	**Families Learning Together** believes that families are D.C. public schools' most important community resource. Education research consistently shows a direct link between family involvement and high student achievement. For that reason, Turning the Page helps schools build connections with families and gives families the tools and resources to become more actively involved in their children's education: community nights, author visits, museum partnerships, social services, etc.					
Washington Parent Education Collaborative (WPEC)	**The Washington Parent Education Collaborative** is funded and sponsored by Catholic Charities, the OECD, and the Freddie Mac Foundations. Over 50 other organizations have become members since 1991.			Over 50 member organizations		

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Organization name	*Children growing up in homes and communities where essential needs are met to ensure positive growth and development through services such as social and emergency support, job training and other means to achieve self-sufficiency. Efforts that ensure the community is safe for and supportive of children and families*	*Description of the children and families the program seeks to affect, including eligibility criteria*	*Ages of children*	*# children eligible/served*	*Physical doors of entry (On-site and Home Visitation)*	*Total annual programmatic budget*
African Heritage Dancers & Drummers	The parent institution, the **African Heritage Dance Center**, offers free and nominal fee Dance, Music and Crafts workshops to children and youth as a Safe Space after school youth intervention program, and provides Cross-Cultural lectures and performing programs as a multi-cultural educational tool in creating a wider respect for the diversity of cultures existing in American society.				On-site	$50,000 Fees for Service Revenue; $40,000 Other Revenue
DC Developing Families Center	**The Nation's Capital Child and Family Development** operates DCDFC's Child Development Center, which serves infants and toddlers. It also provides comprehensive services to meet the intellectual, physical, social, and emotional concerns of children and families. Also provided is job training, GED classes, and a first-time home buyers program.	Families enrolled in HBP and the DC Birth Center, and families residing in Carver Terrace		Early childhood (6 wks - 5 yrs), school age (4-12 yrs), and family care (6 wks - 12 yrs)	15 early childhood centers, 9 school-age centers, 24 family child care providers	$30,000 from the Moriah Fund for its Education and Employment Training Program
Latin American Youth Center	**The Family Connections/Social Services Division** serves youths from a variety of ethnic and cultural backgrounds with the following services: advocacy, substance abuse prevention and treatment, case management, counseling, crisis intervention, housing, and tutoring assistance.					
Martha's Table, Inc.	**Family and Community Center** provides outreach and basic services to families and children in need. Services include a family-centered laundry, health education, clothing distribution, showers, and a day center for neighborhood adults.	Adults and children in need; Ward 1		1,200 per day	On-site	
So Others Might Eat	**Elderly Services:** SOME runs an Interfaith Caregivers Program wherein volunteers visit homebound seniors to do light housekeeping, errands, and companionship. Senior Summer Camp is a week-long retreat for seniors who cannot otherwise afford to vacation away from the city. Two Senior Centers provide hot meals, transportation, and recreation and social activities.	The elderly - particularly home-bound or low-income elderly	Elderly		Summer Camp, Senior Centers (Dwelling Place and Shalom)	Social Services - Elderly: $911,065. Camp: $44,266. Total: $10,222,810.
Financial/Emergency Assistance						

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Child and Family Services Agency	**Adoption and Guardianship Subsidy** provides financial assistance services to eligible relatives and adoptive parents so that they can maintain children in permanent homes.					$26,796,918.00
My Sister's Place	**My Sister's Place** is a shelter for battered women and their children. MSP provides safe, confidential transitional housing, as well as a children's program. The children's program allows child victims of abuse to receive counseling and support from trained volunteers and staff members.	Battered women and their children			On-site (undisclosed location)	
Office of Early Childhood Development	**The CCSD** provides child care financial assistance for eligible families with children 6 weeks through 12 years of age and for children with disabilities up to age 19. Services are provided (part-time and full-time care) by center based and family child care homes, by relatives and in-home providers.		6 wks - 12 yrs; disabled until age 19			
So Others Might Eat	**Immediate Needs** programs provide poor and homeless individuals with meals, warm clothing, showers, and medicine. Legal services are made available once a week through a partnership with the Washington Legal Clinic for the Homeless.	Poor and homeless people		294,630 meals, 14,287 showers and free clothing	On-site	Emergency Aid and Shelter: $2,807,532. Health services: $1,214,255. Social Services - Other: $4,540,422. Total budget: $10,222,810
The Family Place	**The Family Place** offers drop-in/hospitality services that include emergency food, clothing, diapers, and financial assistance.	Hispanic and African-American pregnant women and families with children under age 3	0-3 years old	approx. 300 families	Drop-in centers	$596,000.00
Washington Scholarship Fund	**The Opportunity Scholarship** is extended to families below 185% of the poverty level, with children currently attending school. This scholarship covers the cost of attending a private school.	Children in families below 185% poverty	K-12			
Economic Development						
United Planning Organization	**Sisters in Service**: To provide service to the Washington, D.C. community through activities designed to identify the skills, talents, and capabilities of the residents of the District and to use these resources to develop distressed neighborhoods.	Ward 8, youth aged 14 to 24	14 to 24	In SY 01-02, there were 192,748 encounters and 256 facilitated referrals from Jan-June '02.		

Washington, DC Early Child Development

DRAFT Resource Map of Programs and Services

Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Housing						
Community of Hope	**Community of Hope**'s transitional housing provides a family with a private apartment that can accommodate a large family. Most recipients are single women with children. Social services are also provided, as each new resident is assigned a case manager who meets with them weekly. A family's course may include substance abuse treatment, GED training, familiarization with available social services, and parenting classes.	Families transitioning out of homelessness	All		On-site	
Department of Human Services	**Affordable Housing/Residential Service**provides stable housing and support services to eligible individuals and families.					$31,762,900 Initiative Based Funding
For Love of Children	**Hope and A Home** rents apartments to families for up to three years at far below market rates. The program provides workshops on creating and maintaining a safe home and assistance locating permanent housing.	Families with limited resources				
Latin American Youth Center	**YouthBuild** trains neighborhood youth and young adults in construction and leadership skills while providing life skills enhancement and support for each youth's educational goals. It also seeks to increase the stock of affordable housing for homeless and low-income residents.					
So Others Might Eat	**Affordable Housing The Single Room Occupancy**model offers single adults a renewable one-year lease at 30 percent of the person's income. A building currently under construction will provide housing for families.	Homeless low-income single adults	Adults	294,630 meals, 14,287 showers and free clothing	On-site	Emergency Aid and Shelter: $2,807,532. Social Services - Other: $4,540,422. Total budget: $10,222,810
So Others Might Eat	**Transitional Housing:**This program provides a safe and structured environment between dependence and independence. It helps residents pursue addictions recovery programs, find and maintain a job, and find long-term housing. Pre-recovery and post-recovery housing is available.	Pre- and post-recovery adults and their families	Adults		Post-recovery: Leland Place and Harvest House. Families: Thea Bowman Housing Program.	Emergency Aid and Shelter: $2,807,532. Social Services - Other: $4,540,422. Total budget: $10,222,810

Washington, DC Early Child Development
DRAFT Resource Map of Programs and Services

Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
So Others Might Eat	**Transitional Housing**is provided for abused and neglected elderly, where they find temporary housing, nutritious meals, companionship, and assistance obtaining Social Security benefits and permanent housing.	Abused and neglected elderly	Elderly		Dwelling Place Shelter for Abused Elderly	Emergency Aid and Shelter: $2,807,532. Social Services - Elderly: $911,065. Total budget: $10,222,810
Public Safety						
Break the Cycle	**Break the Cycle** is a domestic violence law center that promotes the health and protects the rights of youth. Our comprehensive programs provide positive intervention in the lives of youth as they are forming their first relationships. Engage We encourage youth to take action and mobilize to raise awareness in their communities about domestic violence and its impact on their peers. We are promoting youth as the next generation of leaders in the domestic violence prevention movement. Educate Break the Cycles preventive education program teaches teens about domestic violence, healthy relationships and the legal options and responsibilities of young victims. The interactive curriculum connects students to practical tools and confidential resources for information and advice. We also work to increase awareness about teen dating violence in the community at-large through public awareness campaigns, tabling and our website. Empower Break the Cycle helps young victims, ages 12 to 24, achieve safe, violence-free lives through legal advice, referrals and counsel. Our public policy efforts work to ensure that young people are protected by domestic violence laws and that funding exists to support programs to help youth.	Young people between the ages of 12-24 who are experiencing dating or domestic violence and are in need of free legal services.				
Center for Child Protection and Family Support, The	**Child Abuse and Neglect Training Initiative (CANTI)** is funded by the DOH and Office of Early Child Development. The program provides expertise training and resources to daycare providers in the District in the area of child abuse and neglect. The Center partners with the Latin American Youth Center and the Asian American LEAD using a cultural competency model to increase providers knowledge and skills on early identification and appropriate intervention in cases of child maltreatment.			Training and resources to 400 day care providers.		

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DRAFT Resource Map of Programs and Services

Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Center for Child Protection and Family Support, The	**Far Southeast Youth Violence Prevention and Coalition** has a focus on decreasing incidents of violence among the young people of Anacostia, decreasing delinquent behavior and improving academic performance. The coalition provides networking, resource building and information sharing.					
Employment and Job Training						
DC Developing Families Center	**The DC Developing Families Center** provides a variety of healthcare and childcare services, as well as job training and continuing education to low-income communities.	Low-income women and their families				
Department of Human Services	**Employment Readiness and Placement - Employment Readiness and Job Services** provides education, employment, and support services to individuals.					$2,414,129 Initiative Based Funding
Latin American Youth Center	**The Youth Opportunities Initiative** in collaboration with the DC Department of Employment Services, prepares and places out-of-school youth in private sector jobs.	Out-of-school youths				
Latin American Youth Center	**YouthBuild** trains neighborhood youth and young adults in construction and leadership skills while providing life skills enhancement and support for each youth's educational goals. It also seeks to increase the stock of affordable housing for homeless and low-income residents.					
So Others Might Eat	**Job Training:** the Center for Employment Training intensively trains extremely low-income homeless adults in the following areas: Computer and Office Skills, Building Maintenance and Repair, and Certified Nursing Assistant. Students are also taught general workplace skills such as punctuality and grammar.	Poor and homeless adults	Adults		On-site	CET: $694,641. Total: $10,222,810
Entrepreneurship						
Latin American Youth Center	**Social Enterprises** at the LAYC include two Ben & Jerry's Partnershops, the Art & Media House, which encourages youth to express themselves through arts-related enterprise, and IMPACTO, through which strategies and programs are shared with other organizations committed to the engagement and integration of immigrant youth and their families.	Youths				
Work Readiness						
Latin American Youth Center	**The Youth Opportunities Initiative** in collaboration with the DC Department of Employment Services, prepares and places out-of-school youth in private sector jobs.	Out-of-school youths				

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Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Latin American Youth Center	**YouthBuild** trains neighborhood youth and young adults in construction and leadership skills while providing life skills enhancement and support for each youth's educational goals. It also seeks to increase the stock of affordable housing for homeless and low-income residents.					
Maternal and Family Health Administration	**The Healthy and Ready to Work project** coordinates services for up to 60 special needs youth who are aging out of the educational and social services programs and are referred by DC Public Schools. The Interagency Transition Council Steering Committee serves to identify existing resources and services gaps, and is working to institutionalize referral networks.					
Workforce Development						
Adult Education						
Children's National Medical Center	**The International Center to Heal Our Children (ICHOC)** was designed to provide information, training, and outreach to communities nationally and internationally coping with traumatic events. Our vision is to help foster, promote, and maintain the emotional health of children who have been psychologically traumatized by acts of violence, disasters, and terrorism. The primary focus of the ICHOC is to train professionals and the public to better understand child and adolescent stress responses and to learn strategies to help build resiliency in children so that they can better cope and heal from these traumatic events.	Work on infants and toddlers with disasters of all types. Bus drivers of day care and schools. Foster care services, social workers. The ICHOC programs and resoruces are intended to be used by the multidisciplinary range of providers who come into direct	Infants and toddlers			Receives District Funding and Non Federal / Non District Funding
Reentry and Incarceration						

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Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The National Center for Children and Families	**The Family Ties Program**delivers services for children ho are separated from a parent because of incarceration. Services include child advocacy, community referrals, mentoring and tutoring, child and family recreational activities, support groups, family and individual therapy, psychological and social assessments, job readiness services, organized trips to correctional facilities, youth leadership initiatives, Rites of Passage (Girls/Boys), parenting education and support, re-entry services, case management, and summer camp.	Children in Wards 7 and 8 whose parents are incarcerated	6-12 years old	128 children and 58 families		
Self-Esteem and Positive Development						
Life Pieces to Masterpieces	**Life Pieces to Masterpieces** provides African American males in low-income and public housing the opportunity to discover their ability to change challenges into possibilities.	African-American males in low-income or public housing, east of the Anacostia River; Wards 7 and 8	3-21 years old	550 in 2002		

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Community Development						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Mental Health						
So Others Might Eat	**Behavioral Health Services:** professional clinicians provide individual and grou counseling to homeless and extremely low-income individuals. Treatment is offered for mental illness, substance abuse, and general mental health. After assessment, referrals may be given to other programs such as Addictions Recovery or Transitional Housing. Isaiah House is a daily program for mentally ill homeless adults.	Homeless and extremely low-income individuals				Health Services: $1,214,255. Total: $10,222,810.
Counseling						
So Others Might Eat	**Behavioral Health Services: Continuing Care** provides recipients six months of counseling and support during the transition back into society. The program requires that participants maintain sobriety and follow traditional NA or AA steps.	Adults transitioning out of substance abuse treatment				Health Services: $1,214,255. Total: $10,222,810.
Inter-generational Relations						
Transportation						
Maternal and Family Health Association	**MFHA** provides transportation for medical visits for pregnant women and infants who have no other method of transport. The door-to-door van is essential to those whose enrollment in DC Healthy Families has not been completed.					Title V

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DRAFT Resource Map of Programs and Services

System Access and Quality Assurance

Organization Name	*Programs and Descriptions*	*Population Served*	*Ages Served*	*Capacity*	*Access Points*	*Funding*
Organization name	*Institutions, services and programs that impact the lives of children and families through system improvement, institutional alignments, and by supporting those who care for and work with children and families directly.*	*Description of the children and families the program seeks to affect, including eligibility criteria*	*Ages of children*	*# children eligible/served*	*Stakeholder partners and physical doors of entry*	*Total annual programmatic budget*
Child Care Works	**Child Care Works** offers grants and loans to expand the supply of family and center based child care.					Receives Funding From: Aced, Freddie Mac, Ford, Community Foundation, Riggs Bank, Industrial Bank of Washington, CitiBank, Mariah Fund, Bank of America Foundation, Packard, Mailman and Meyer Foundation
Office of Early Child Development	The **DC Early Intervention Program** is part of the Department of Human Services Office of Early Childhood and Development and serves as a single point of entry for the Districts infant/toddler program. The program seeks to identify and serve infants and toddlers with developmental delays. Delays may occur in one or more of the following areas: physical development, cognitive development, language and speech development, social/emotional development, and adaptive/self-help skills. For eligibility, a child must be 50% or more delayed in one of the areas. DCEIP also provides service coordination and case management services.	All the Districts families with children 0-2 year olds who may have a development delay. 69.5% are Medicaid eligible and TANF eligible. Child Find is available to children who meet the eligibility criteria for Parts B and C services.	0-2 year olds	1,438 developmental screenings; 600 children served; 450 active cases; 457 children placed for therapeutic services	Child Find: National Children's Center, Georgetown Univ. Child Dev. Ctr., Children's National Medical Center, Howard Univ. Hosp., Out Came the Sun, Washington Hospital Center. Training: Zero to Three. Administrative Support: ES, Inc.	$2.1 million from OECD office; Title V

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Uplift Community Foundation, The	**The Uplift Community Foundation** is committed to supporting programs that ensure that minority communities achieve a higher standard of living through education, economic development, and cultural awareness. UCF supports its mission by stimulating the establishment of endowments to serve the community now and in the future by realizing the intent of donors and carrying out their charitable intentions. Through UCF's "Impact Initiatives" it creates substantive programs and events, implements such programs to benefit minorities and women, and awards grants to other nonprofit organizations.	No Data Entered		The coalition serves over 34,000 individuals through over a hundred programs and groups.		Receives Federal Funding and Non District / Non Federal Funding
Capacity-Building						
21st Century School Fund	**The 21st Century School Fund**s mission is to build the public will and capacity to improve urban public school facilities. Program strategies fall into three broad categories: 1.) Innovation: addressing complex educational challenges through practical application of ideas, processes, and methods, including the use of technology, community partnerships, and effective implementation; 2.) Community Engagement in Government Reform: leveraging constituencies to develop, advocate for, and monitor policies, procedures, and practices in support of their agenda regarding community involvement in planning, schools as community centers, solid management, and proper funding for schools; and 3.) Research and Communication (raising awareness and communicating best practices for healthy, safe school environments).				40 clinical sites completed paper surveys, 14 had on-site surveys.	$7,833,333 total; $2.5 million from US Department of Health and Human Services, Health Resources and Services Administration (through the Healthy Communities Access Program) for three years. City of DC granted $21 million over three years.

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Consumer Health Foundation	**The Consumer Health Foundation**provides grants to community-focused organizations that improve the health of DC residents. Over $6.5 million in grants have been made to 52 nonprofit groups since 1994. CHF's four goals are to make grants for projects that address the Foundation's priorities and values, to improve the capacity of grantees by facilitating training and technical assistance, to support critical partnerships and build key alliances, and to implement a communications plan to inform the community.	DC-area nonprofit organizations that improve access to health care.				
D.C. Children and Youth Investment Trust Corporation	**Lifelong Learning Initiative:**The CYITC is designated by the State Education Office to implement the Lifelong Learning Initiative, distributing funds to community-based organizations that deliver adult literacy services.					
D.C. Children's Trust Fund	**The D.C. Children's Trust Fund**stimulates innovative programs directed toward the prevention of child abuse and neglect. One of its major functions is to leverage funds available for child abuse prevention in D.C. It can receive and distribute funds on behalf of other organizations, and all non-federal monies received by the Trust are eligible to be matched through the Community-Based Family Resource and Support Program.					
DC Children's Trust Fund	**Grantmaking**: Title II Lead Agency to prevent child abuse and neglec in the District of Columbia. Annually inventories prevention activities/programs to identify gaps. Awards grants to address gaps in prevention activities. Current focus is parent support.	Community-based organizations, schools, and faith-based organizations			13 sites with Lifelong Learning Coaches	State Education Office

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
District of Columbia Primary Care Association (DCPCA)	**Medical Homes DC** is a project of The DC Primary Care Association and a public-private partnership supported by the Mayor and the City Council. It expands and improves clinics in order to improve care, hoping to add 200,000 square feet to existing facilities. An estimated $110 million will accomplish the task in 7-10 years. Medical homes will apply to be certified by MHDC, which funds improvement in business management, clinical quality, and facilities. Partners include the following: DC Primary Care Association; Brookings Institution Greater Washington Research Program; Department of Health; Office of the City Administrator, Executive Office of the Mayor; Capital Link, Inc.; RAND Corporation; D.C. Bar Pro Bono Program; Children's National Medical Center; Health Working Group; Washington Regional Association of Grantmakers; DC Hospital Association; Howard university College of Medicine and Howard University Hospital; Corwell & Moring, L.L.P.; Hunter Law L.L.C.P.; National Capital revitalization Corporation; 21st Century School Fund; Management Solutions Consulting Group; Jair Lynch Construction; Robert Gelzer, MD, MPH	210,000 vulnerable residents identified; an estimated 300,000 residents struggle to find a doctor	0-12 years old		DC Public Schools, DC Healthy Schools Coalition	
Maternal and Family Health Administration	The **Annual Maternal and Child Health Conference** is presented and attended by more than 700 District parents, clients, front-end service workers, program administrators and advocates. The conference serves to inform a broad audience of important family health issues and to engage the public in finding solutions to problems.					The cost is the cost to pay to the group facilitators: payment depends on the number of memebers enrolled in the group.
Office of Early Child Development's Program Development Division	**Head Start State Collaboration Project** is implemented by the OECD's Program Development division. All Head Start programs have a legislative mandate for a minimum of its service population to include children with disabilities (health, physical, mental).					
Supporting Providers and Parents						

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Department of Health, MFHA, Division of Children with Special Health Care Needs	**Genetics Services:** This program promotes accessibility to services and information on genetic disorders for families. It also collects and relays information on genetic disorders and the findings of newborn screenings to care providers.	Children with genetic disorders and their families				
Latin American Youth Center	**Latin American Youth Centers Foster Care**provides bilingual foster children and adolescents with bilingual case management and room and board services. In addition, the program provides training and licensing services to bilingual families within the Hispanic community in order to ensure that the need for culturally competent foster families is met.	All programs described above target at risk youth in danger of becoming or who are homeless or under the care of the DC CFSA. Together, these programs serve a 0 to 21 age cohort.				The program budget is not separated out from the overall agency budget.
Public Education						
D.C. Children's Trust Fund	**The D.C. Children's Trust Fund**stimulates innovative programs directed toward the prevention of child abuse and neglect. It seeks to develop public education materials promoting primary prevention, develop messages supporting strong families and healthy children, and collecting and disseminating data regarding children and families in the city to inform policy making and system reform.					
Developing Programmatic Linkages						
D.C. Children's Trust Fund	**The D.C. Children's Trust Fund**stimulates innovative programs directed toward the prevention of child abuse and neglect. It conducts outreach to organizations in D.C. that provide resources to support primary prevention, serves as a resource on primary prevention models, programs, strategies, and materials, and conducts outreach to policy-makers advocating for primary prevention's inclusion in human services.					

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Strategic Planning and Coordination						
DC Children's Trust Fund	**Grantmaking**: Title II Lead Agency to prevent child abuse and neglec in the District of Columbia. Annually inventories prevention activities/programs to identify gaps. Awards grants to address gaps in prevention activities. Current focus is parent support.	Community-based organizations, schools, and faith-based organizations				The cost is the cost to pay to the group facilitators: payment depends on the number of memebers enrolled in the group.
Department of Health	**DC Can Control Asthma Now Program (DC CAN)** seeks to improve health outcomes and reduce the burden of asthma through planning, data collection, education, and access to appropriate care				Collaborative of at least 60 stakeholders	$200,000 FY03
SPARK-DC	**SPARK-DC** is a study with the goal of aligning systems that apply to the early care and education of children in order to increase the consistency of policies and practices. In three Wards, this study pairs child development program with an elementary school so that implementation and transition strategies can be followed over time. The initiative's evaluation is managed by Child Trends. Partners: Calvary Bilingual Multicultural Learning Center and Harriet Tubman-Elementary School; Kenilworth-Parkside Recreation Center and Kenilworth-Elementary School; Frederick Douglass II Center and Turner Elementary School.	Elementary school children in Wards 1, 7, and 8	Age 2.5 or 3 to age 5. Five year long study, three cohorts.	420 enrolled per year; est. 1000 at end of study	Elementary schools and partner institutions; SPARK-DC leadership team, NBCDI, OECD, DCPS, DOH MFHA, Parks and Recreation	National Black Child Development Institute (NBCDI)
The DC Home Visiting Council	**The DC Home Visiting Council** is a collaboration of government agencies and community based organizations that provide home visitation. The DC HVC identified best practice standards for training, cultural competency, and universal screening. DC HVC facilitates implementation by providing technical assistance, coordination, training, funding, and other resources to various agencies.					
Resource and Referral						

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System Access and Quality Assurance

Organization Name	*Programs and Descriptions*	*Population Served*	*Ages Served*	*Capacity*	*Access Points*	*Funding*
Children's Law Center	**Guardian Ad Litem Program:** CLC attorneys help abused and neglected children find safe, permanent homes and ensure that they receive appropriate services by acting as the children's advocate, or guardian ad litem.	Children in the child welfare system		400 children and families in CLC overall		
Children's Law Center	**Three to Third Project:** The CLC works with special needs children between age three and third grade, ensuring that they receive appropriate education.	Special needs children	3 years - 3rd grade	400 children and families in CLC overall		
Children's Law Center	**Health Access Project:** CLC collaborates with Children's National Medical Center to overcome non-medical barriers to health for poor children.	Poor children		400 children and families in CLC overall	Children's National Medical Center	
Children's Law Center	**Protecting Child Witnesses to Domestic Violence:** Through appointment by the DC Family Court, CLC represents children in custody cases involving domestic violence.	Children in custody cases		400 children and families in CLC overall		
East Capitol Center for Change	**Consumer Health Access Team (CHAT):** This project provides information to uninsured families regarding medical care that they are eligible to receive. Services are performed by members of the community.	Uninsured or low-income families	All		Ward 1: Mary's Center. Ward 5: Efforts. Wards 7&8: East Capitol Center for Change	
Maternal and Family Health Administration	**MFHA** uses Title V funds to support managed care health services for immigrant children (including undocumented immigrants) who do not meet Medicaid or CHIPS eligibility criteria due to their immigration status. The program assists these children in enrolling in Medicaid managed care. The Title V Block Grant funds the support of the Information and referral through the 24 hour multi-language and TTY/TTD accessible 1-800-MOM-baby HEALTHLINE, which in addition to providing information to consumers and providers, arranges for home visits for at-risk pregnant women and infants.					1-800-MOM-BABY: $359,970 FY03

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Maternal and Family Health Administration	**The Healthy and Ready to Work project** coordinates services for up to 60 special needs youth who are aging out of the educational and social services programs and are referred by DC Public Schools. The Interagency Transition Council Steering Committee serves to identify existing resources and services gaps, and is working to institutionalize referral networks.					
Washington Child Development Council	**Child Care Information, Resource and Referral Service:** This computerized database is provided free of charge over the phone. It assists people seeking placement for children in child care centers, family child care homes, or before and after school programs.	Parents, parent groups, organizations			Telephone service	
Research						
Child Trends	**Child Trends** is a nonprofit, nonpartisan research organization dedicated to improving the lives of children by conducting research and providing science-based information to improve the decisions, programs, and policies that affect children and their families.				7 birthing hospitals, Hospital for Sick Children, Title V screening programs, vital records.	
DC Fiscal Policy Institute	**The DC Fiscal Policy Institute** conducts research and public education on budget and tax issues in DC, with an emphasis on issues affecting low- and moderate-income residents. Areas of work include analyzing the impact of tax and other revenue policies on the District; working to ensure that programs for low- and moderate-income residents are well designed, effective, and funded; and researching income and poverty trends, as well as serious problems such as the shortage of affordable housing.	Focus on low- and middle-income families				Total Policy, Planning, and Research budget: $4,520,029
Department of Health	**The DC Birth Defects Surveillance and Prevention Program** promotes research to identify causes of birth defects and to design education and prevention programs. Also collects and disseminates data on birth defects through the DC Birth Defect Registry	Children born with birth defects in the DC area	Screening age 0-1, or 0-6 for fetal alcohol syndrome			

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Department of Health	**Policy, Planning, and Research - State Center for Health Statistics** provides health statistics and vital records to the Department of Health and to the public					Receives Federal and Foundation Funding
Lt. Joseph P. Kennedy Foundation	**Research and Demonstration** programs seek to change the way systems and staff provide support as well as new opportunities for people facing complex issues such as developmental disorders. Projects fall under the following categories: Early Childhood Development, Inclusion in Education, Inclusion in the Workforce, Health & Safety of People with Disabilities, and Preparation of the Next Generation of Providers of Disability Services.					
Stop the Silence Stop Child Sexual Abuse Inc	**National Childrens Bench Book (NCBB) Project** The Bench Book is a critical information tool for judges and other professionals to use as they address child sexual abuse maltreatment cases. When finalized in 2007, 1,500 books will be distributed to courts throughout the U.S. Internationally recognized experts, including physicians, social workers, child abuse experts, attorneys, and professors are developing the Bench Book on a how to best protect children when they come before the courts. The NCBB Project will also rely on the volunteer and pro bono efforts of top U.S. law firms, along with experts in trauma and experienced public service attorneys. Their presentations include scientific evidence about the facts that children can be victimized over and over by improper handling of their cases and the excessive interviewing and exposure to the family member who has abused them. The finalization of the NCBB Project will conclude with targeted training and outreach to discuss use of the information.	Judges primarily, but other court-related and child-related professionals				$75,000 from the Moriah Fund in 2003

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
The SEED Foundation	**Research Program:** The SEED Foundation sponsors and participates in both primary and secondary research studies regarding the development of college preparatory boarding schools for inner-city children. Projects have included Primary Market Research, the SEED Boarding Model Longitudinal Study, San Francisco Bay Area Feasibility Study, the Wisconsin Feasibility Study, and Comparative Study of Public Boarding Schools-"Residential Charger Schools: The Road Behind, the Path Ahead."					
Advocacy						
Alliance for Fairness in Reforms to Medicaid (AFFIRM)	**Managed Care Quality and Access Project:** This project works to improve the access to and quality of health care received by families enrolled in Medicaid, as well as to support ongoing advocacy for children and their parents enrolled in Medicaid. The program also supports an intensive education program about DC's health care system, called *TOUCH: Teaching, Outreach and Understanding While Communicating Health.*	Families on Medicaid	All			Consumer Health Foundation: $35,000
Center for Mental Health	**The Center for Mental Health** partners with the Rebecca Project for human rights to develop a broad umbrella of consumer support and peer advocacy for people in recovery from long-term mental illness and from addiction.					Consumer Health Foundation: $35,000
Consortium for Child Welfare	**Public Policy:** The Consortium for Child Welfare's Public Policy Committee advocates for a family-centered approach to child welfare. CCW conducts an annual conference on public policy to discuss future trends in child welfare.					
D.C. Parent-Teacher Association	**The D.C. PTA**'s mission is to advocate for services and policies that benefit children, to educate parents to be advocates for their children, and to engage the community members in support of public education.					

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
DC Action for Children	**DC ACT** is an independent non-profit multi-issue advocacy organization for children, youth, and their families in DC. Their four broad strategies consist of informing citizens, public officials, and service providers; promoting government accountability; mobilizing a constituency for children; and empowering families and neighborhoods to advocate for children.	All DC children	All		Constituency of over 4000 individuals (public officials, service providers, funders, advocates)	$30,000 from Moriah Fund in 2003
DC Appleseed Center for Law and Justice	**The DC Appleseed Center for Law and Justice** addresses serious local issues, publishing recommendations and advocating for appropriate solutions. Current initiatives include DC voting rights, access to quality health care for low and moderate income DC residents, Anacostia Watershed restoration, and DCPS Special Education issues. Issues under review include the District's response t the HIV/AIDS epidemic, structural deficit in the DC budget, and lead in the drinking water.					
Horton's Kids	**Horton's Kids** provides comprehensive services to the underserved children of Anacostia's Wellington Park housing project, including advocacy for the children and their families with the city government, the schools, and in other settings.	Children in Anacostia's Wellington Park housing project in Ward 8				
Northwest Settlement House	**NWSH** advocates for low-income residents of Washington, DC by preparing community awareness events, testifying at City Council hearings, and developing concrete budget requests through their partners (Shaw Education for Action, Project LEAD - IMA - IDA, and the Fair Budget Coalition.)	Low-income residents of Washington, DC			Shaw Education for Action, Project LEAD - IMA - IDA, and the Fair Budget Coalition	
Quality Trust for Individuals with Disabilities	**The Quality Trust** provides advocacy and legal services for DC residents with developmental disabilities. Legal services ensure access to legal representation.	DC residents with developmental disabilities				

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System Access and Quality Assurance

Organization Name	*Programs and Descriptions*	*Population Served*	*Ages Served*	*Capacity*	*Access Points*	*Funding*
SPARK-DC	**SPARK-DC** advocates for system change to improve child development processes in DC. It is a study with the goal of aligning systems that apply to the early care and education of children in order to increase the consistency of policies and practices. In three Wards, this study pairs a child development program with an elementary school so that implementation and transition strategies can be followed over time. The initiative's evaluation is managed by Child Trends. Partners: Calvary Bilingual Multicultural Learning Center and Harriet Tubman-Elementary School; Kenilworth-Parkside Recreation Center and Kenilworth-Elementary School; Frederick Douglass II Center and Turner Elementary School.	Elementary school children in Wards 1, 7, and 8	Age 2.5 or 3 to age 5. Five year long study, three cohorts.	420 enrolled per year; est. 1000 at end of study	Elementary schools and partner institutions; SPARK-DC leadership team, NBCDI, OECD, DCPS, DOH MFHA, Parks and Recreation	National Black Child Development Institute (NBCDI)
Stop the Silence Stop Child Sexual Abuse Inc	**Media Advocacy and Education:** The goal of the current focus is to increase public awareness and understanding of CSA toward individual and community action. The specific objectives on which we are focusing are to: (1) Garner substantial local airtime and thereby increase exposure to primary messages, resulting in increased awareness and problem recognition; (2) Raise community members' awareness, knowledge, and understanding about CSA, resulting in an increase in their competency and effectiveness to ensure victims' right The programming is focusing on the following audiences in the Washington, D.C. area and beyond: 1.The local public, to increase awareness and knowledge, and pave the way for relevant action(s), e.g., reporting suspected abuse; 2.Community-based organizations in Washington, D.C. to help them better understand the issue and increas their ability to reach out to their constituents about CSA 3.Local stakeholders, to ensure available support for the developing programming. 4.Policymakers, to provide overarching support. Media advocacy-Stop the Silence uses media to catalyze public awareness and social change. Campaigns run each year, in the spring (before the Race) and fall. The campaigns have reached millions	CSA crosses socio-economic boundaries. As such, the programming focuses on the following audiences in the Washington, D.C. area to have maximum impact on communities, families and individuals: 1.Local stakeholders, to ensure available support for the de				

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Teaching for Change	**Tellin Stories:** A program of Teaching for Change, believes that for schools to provide the quality education our children deserve, families, schools and communities must be involved as purposeful partners in the education process. At the heart of Tellin Stories efforts to engage families and staff is the power of story to connect people from diverse backgrounds, to pass on valuable information and experiences and to organize collective action. Tellin Stories works with parents to create and implement action plans that affect the academic achievement and environment of neighborhood schools through relationship building (creating a story quilt), weekly meetings, workshops, trainings, and grassroots organizing. The most gratifying aspect of our work is that together Tellin' Stories, parents, educators, community members, and partner organizations are redefining the vision of school communities by helping those who are traditionally excluded from the decision-making process become a central part of it.	Low income and working class families, typically from immigrant families, both newly arrived and other	18-75	20-30 people at the weekly meetings at each school, 5 schools total	Work in depth in 5 schools	$50,000 District Funding; $16,0294 Non Federal / Non District Funding;
The Interfaith Child Advocacy Network of Metro Washington	**The Interfaith Child Advocacy Network of Metro Washington** is an interfaith coalition of faith communities that promote and assist wit government, private sector and faith based initiatives on behalf of children at the local, state, and federal levels.					
The SEED Foundation	**Advocacy Program:** The SEED Foundation has cultivated bi-partisan support for legislation providing public funds for public boarding schools.					
Volunteers for Abused & Neglected Children	**Volunteers for Abused & Neglected Children** recruits, trains, assigns and manages volunteers to advocate for abused and neglected children in court. Volunteers also provide information and recommendations to the judge in the best interests of children.	Abused and neglected children in the court system		4,500 children are served by the Family Court of D.C. Superior Court.		
Washington Child Development Council	**Washington Child Development Council** works to guide public policy and highlight the importance of establishing and maintaining quality child care development programs.					

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Professional Development						
CentroNia	**The Professional Development Academy** helps staff, parents, and other community members through its Child development Associate (CDA) Training Program, a professional certification in early childhood education that can be used nationwide. With Mary's Center, the PDA supports participants in the licensing process to operate day care out of the home. The staff is available to graduates, and ongoing workshops are held.	Staff, parents, and community members		12 family child care licenses	23 clubs, a camp in DC, Maryland, and Virginia each.	$6.3 million CentroNia overall
Child and Family Services Agency	**Child Welfare - Training** provides educational services to CFSA staff (and related service providers and external stakeholders - DCPS, MPD, DMH, etc.)					Total Child Welfare budget: $39,399,088
D.C. Children and Youth Investment Trust Corporation	**"Advancing Youth Development" Supervisors' Course:** This 15-hour training course is offered by the CYITC to supervisors and frontline youth workers. It teaches best practices in the supervision of youth development programs.			300 youth workers total since 1999		Meyer Foundation, Moriah Fund, Fannie Mae Foundation, Freddie Mac Foundation
In2Books	**Professional Development Program:** In2Books provides courses to help primary school teachers learn to encourage reading and literacy.		Grades 2-5			
Maternal and Family Health Administration	**The Newborn Screening Program** conducts early detection and treatment of irreversible disorders that contribute to severe childhood morbidities and developmental delays. The program also provides training to hospital-based providers. The program is currently developing a birth defects registry.					

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Maternal and Family Health Administration	**MFHA** provides training to the Child Care Health Consultant Corps. It also is working to establish medical homes for children with special needs who receive health care at selected community sites in Wards 5,6,7 and 8. Training and continuing medical education units are provided to providers and advocates to expand their skills in the provision of medical homes for patients. Additionally, the Administration has implemented an aggressive Group B Streptococcus health education campaign targeting OB/GYN Providers.					
OECD's Program Development Division	**OECD's Program Development Division** designs and implements child care program expansion and improvement efforts, and coordinates professional development initiatives for early care and education providers. It also enrolls new providers in the Child Care Subsidy program and monitors compliance with contractual agreements.					
Teaching For Change	**Early Childhood Equity Initiative:** This program equips early childhood leaders with the tools necessary to create and maintain culturally responsive learning environments for young children, emphasizing early literacy development. Services include networking, bi-monthly training sessions, workshops and "book talks," and training in providing anti-bias education to students.					
Washington Child Development Council	**The Licensing Buddy** program provides assistance for individuals interested in obtaining certification to be an in-home child care provider.	Potential in-home child care providers				
Washington Child Development Council	**Childcare Works** matches potential and existing child care providers with the training and funding that they need. Loans are available to licensed providers. WCDC also provides funding and assistance to child care centers interested in pursuing accreditation.	Potential and current in-home child care providers				OECD, The Community Foundation for the National Capital Region, and local banks
Evaluation and Monitoring						

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System Access and Quality Assurance						
Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Child and Family Services Agency	**Child Welfare - Quality Assurance and Administrative Review** provides assessment, monitoring, and recommendation services to CFSA staff and key stakeholders.					Total Child Welfare budget: $39,399,088
Department of Human Services	**Child Development - Child Development Provider Services** furnishes financial monitoring and educational services to child development providers					Total Child Development budget: $75,932,897
Maternal and Family Health Administration	**The Maternal and Family Health Administration** has developed standards of care in collaboration with the Home Visiting Council.					
Quality Trust for Individuals with Disabilities	**The Quality Trust** monitors the protections, services, and supports provided to all members of the District of Columbia's developmental disabilities service delivery system.	All DC residents with developmental disabilities				
Outcomes						
D.C. Children and Youth Investment Trust Corporation	**The Outcomes Project:** The CYITC contracted Child Trends to study the effectiveness of grants to youth programs. Much of the data used WEBSTARS, a web-based tool for program management and grant proposals. Child Trends published a pilot study, which is available online.					
System Linkages						
Safe Shores - The D.C. Children's Advocacy Center	**The D.C. Children's Advocacy Center** works with a multidisciplinary team of law enforcement, legal, social service, and medial agencies, to address cases of child abuse and neglect. Partners include the United States Attorney's Office for the District of Columbia (Domestic Violence and Sex Offense Unit and the Victim/Witness Unit), the Office of the Attorney General (Abuse and Neglect Section and Juvenile Section), the Metropolitan Police Department (Youth and Preventive Services Division and Special Victims Unit), the Child and Family Services Agency (Intake Unit), and Children's National Medical Center (the Freddie Mac Child and Adolescent Protection Center).	Victims of child abuse	3-18 years old		Five members of the Multidisciplinary Team	
Communications						

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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
Information and Knowledge Management						
Department of Health	**Policy, Planning, and Research - State Center for Health Statistics** provides health statistics and vital records to the Department of Health and to the public					Total Policy, Planning, and Research budget: $4,520,029
Planning Groups and Collaborative Processes						
Family and Maternal Health Administration	**The D.C. Children With Special Health Care Needs Advisory Board** meets six times a year to advise the CSHCN Division of the FMHA. Meetings include community leaders, members of the advisee organization, and occasional guests.					$2.1 million from OECD office
Healthy Families Thriving Communities Collaboratives	**The Georgia Avenue/Rock Creek East Family Support Collaborative** links urban families with regional assets and opportunities, builds on existing strengths, and expands involvement in local programs. The Collaborative provides case management service to 140 at-risk families, as well as information and referral services, support groups for fathers and other caregivers, community grants, and partner development.	Local residents		140 in case management		
Office of Early Child Development	**The D.C. Early Intervention Program** participates in the following planning groups: **The Interagency Coordination Council,** CSHN Advisory Committee, Developmental Disabilities Council, State Policy Council on Family Support, Infant Mortality Review Committee, Fetal Alcohol Syndrome Steering Committee, DC HEARS, and the Early Head Start Committee.					$25,000 from the Meyer Foundation for the Client Information Database
South Washington Collaborative	**The South Washington / West of the River Family Strengthening Collaborative (South Washington Collaborative)** develops and/or coordinates resources and services in our community (e.g. residents, churches, schools, businesses, non-profit agencies and civic groups) to build the capacity of our residents and organizations, to reduce the conditions leading to child abuse and neglect by supporting and promoting the social, emotional, physical, spiritual and economic growth and stability of our children, youth, and families.	Residents who live in Ward 6 and are parenting children under the age of 18.				