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Spending Smarter

A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness

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The National Center for Children in Poverty identifies and promotes strategies that prevent child poverty in the United States and that improve the lives of low-income children and families.

Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness

by Kay Johnson and Jane Knitzer

This document is part of a policy series intended to improve social, emotional, and learning outcomes for young children. Building on NCCP's work over the past several years (see Promoting the Emotional Well-Being of Children and Families series, at www.nccp.org), *Spending Smarter* describes effective programs, highlights policy opportunities, and offers fiscal strategies to promote the emotional health of young children and their families. The analyses in this series will help state officials, community leaders, and advocates take action to ensure the healthy development of children and their families. *Spending Smarter* focuses on strategies to maximize existing funding streams by building on federal programs. The companion document, *Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families—A Community Guide*, describes targeted interventions that can help parents and other early care providers, such as home visitors and teachers, be more effective in promoting healthy relationships and reducing challenging behavior in infants, toddlers, and preschoolers.

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Executive Summary

"The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs ... establish explicit and effective linkages among agencies that currently are charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult [health] and mental health services."

—*Neurons to Neighborhoods*. Recommendation 10, p. 12

Spending Smarter is designed to help state legislators, agency officials, families, and other advocates think strategically and take steps to meet the challenge of utilizing existing funding streams to promote the social and emotional health and school readiness of young children. The framework and content of *Spending Smarter* is designed to help state and local leaders maximize the impact of federal funding and feel confident that they are using existing resources in the most effective way. More detailed information is available in a summary checklist and a technical appendix on the web site of the National Center for Children in Poverty (www.nccp.org).

The Challenge

Research tells us that social and emotional skills and competencies are the foundation for success in school. Yet reports from all over the country suggest that many young children lack these skills, while a large number struggle with even more distressing behaviors.

Research on early brain development makes a powerful case for investing in strategies to promote healthy early relationships, intervene early when there are signs of problems, and provide intensive treatment for troubled young children and families to improve school-linked outcomes. This is particularly true for young children whose development is compromised by poverty and other risk factors. We also know the costs of not intervening. Children who do not succeed in the first three elementary school grades are often headed for a much longer-term and costly trajectory of failure.

Most importantly, knowledge is growing about effective, evidence-based interventions to help these young children, their families, and others who interact with them promote, prevent and treat signs of early childhood mental health problems so they will not interfere with school learning. But paying for the services remains a major challenge.

What Policymakers Should Know About Social and Emotional Health and School Readiness

Put most simply, social and emotional health and school readiness means that children have the age-appropriate ability to:

- Manage and regulate emotions (such as how a preschooler responds when another child takes his toy; whether a baby can comfort herself).
- Relate to and trust adults and eventually peers.
- Experience themselves as competent learners (for example, are they eager to engage in learning, or are they too anxious or sad to try new things?).

Because most young children develop age-appropriate social and emotional skills through everyday interactions with parents, caregivers, siblings, and others, it is sometimes difficult for families, policymakers, legislators, and administrators, and even the general public to believe that there are some children who, absent intervention, will not outgrow their problems. But just as there are deliberate ways to promote early literacy, so there are ways to promote healthy early social and emotional development. While they cannot solve every problem, early childhood mental health interventions, especially those that are grounded in strengthening positive relationships, can often make a critical difference in promoting resilience and early school success.

How Should Policymakers Invest to Promote Social and Emotional Health and School Readiness?

In general, clinical and developmental knowledge indicates that the best way to help young children thrive socially and emotionally is to ensure that those who are closest to them have the needed knowledge and emotional support to be good guides. The primary aim is to change the child's environment and to intervene directly with the child only when the child's problem cannot be addressed by changing the way the caregivers respond or how the environment is structured. Based on scientific evidence, intervention research, and real-world experience, capacity building should focus on three broad types of interventions.

1) **Promotion and prevention strategies targeted to all children, but especially low-income children.** Many of these strategies focus on improving the skills of parents, other caregivers, and front-line providers. Screening, in a variety of settings, with follow-up advice and support for caregivers, is core to promotion and prevention.

   Promotion and prevention strategies include:

   - Screening all pregnant women for depression in public health clinics and community health centers.
   - Routinely screening all young children for developmental risk factors in the context of primary health care.
   - Training all community providers working with low-income families in how to help parents "read" the cues of their babies.
   - Assuring social-emotional screening and anticipatory guidance in pediatric practices and/or supporting child development specialists in pediatric practices.
   - Implementing a social skills curriculum for preschoolers in prekindergarten programs.

2) **Early intervention strategies for groups of young children who face especially high social risks.** Young children at special risk include those with disabilities and special health care needs, those in foster care, those whose parents face serious mental health issues, particularly depression, and those whose parents are incarcerated or abuse drugs.

   Early intervention strategies include:

   - Routinely screening all young children in foster care for social and emotional problems.
   - Training child welfare workers, court personnel, home visitors, family-support team members, and others in the principles of early childhood development and their implications in family service systems.
   - Making a mental health consultant available to center-based and family child care to help staff improve how they respond to young children showing early signs of problems.
   - Implementing strategies in early childhood settings to help children, staff, and families respond when young children have witnessed domestic violence or have depressed parents.

3) **Child and family-focused treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their parents (or other primary caregivers) and siblings.** These kinds of interventions include services that can help families stay together and ensure the safety and healthy development of young children. For young children, treatments should be relationship-based, involving the parents and other caregivers.

   More intensive interventions include:

   - Addressing parental trauma and embedding therapy for parents facing special risks, such as depression, in home visiting and early childhood programs.
   - Supporting behavioral aides in early childhood programs to promote inclusive child care.
   - Ensuring that foster parents have access to training and supports to help them better meet the needs of young children who have been removed from their homes.
   - Providing wraparound planning and family-driven case management for young children with serious emotional and behavioral disorders.

Making the Most of Individual Federal Programs to Promote Social and Emotional Health and School Readiness

There is no one funding stream targeted to young children facing social and emotional threats to school readiness. Thus, figuring out how to mix and match the multiple funding streams, eligibility requirements, and administrative requirements to ensure access to developmentally appropriate, family-focused, preventive, early intervention, and treatment services is very challenging. Predictable barriers include:

- **Funding restrictions.** Although major funding streams, such as Medicaid, pay for health and related services to children, it is much more difficult to fund interventions to help parents and other caregivers.
- **Eligibility criteria.** Many of the demographic, familial, and environmental risk factors that predict later problems are not included in the eligibility criteria for mental health and related services unless the child has a diagnosed disorder or delay.
- **Limited financing for parent-child, two-generation interventions.** Reimbursement for services to address the adult conditions that affect parenting, such as depression, and paying for parent-child relationship-based interventions is very difficult.
- **Inadequate systems for tracking children who are deemed at risk.** Screening for social and emotional problems in young children is haphazard, and follow-up monitoring to see if there are any status changes is quite limited.
- **Limited investments in training (and retraining) the workforce.** Mechanisms to disseminate and increase information about evidence-based and effective practices are limited, and workforce development is needed.

Federal funding streams and programs to help these vulnerable children can be divided into three categories:

- **Child health and mental health programs.** Anchor programs that provide potentially major sources of funding for an array of services related to the social, emotional, and behavioral health of young children include Medicaid, the State Children's Health Insurance Program (SCHIP), Title V of the Maternal and Child Health Services (MCH) Block Grant, and to a lesser extent, the Comprehensive Services for Children cooperative agreements or the federal Community Mental Health Services Program for Children and Families.
- **Early care and learning programs** include the Child Care and Development Fund (CCDF), Head Start, Early Head Start, and other early education program, as well as the Infant-Toddler Early Intervention and Preschool Special Education programs.
- **Programs serving young children and families at greater risk** that can be used as entry points and/or funding streams, include: the Child Abuse Prevention and Treatment Act (CAPTA), Title IV-B and Safe and Stable Families, Foster Care—Title IV-E, and Temporary Assistance for Needy Families (TANF) as well as several smaller grant programs. Several smaller programs also offer opportunities to direct resources toward these most vulnerable children and families, including: the Foundations for Learning Act, Social Services Block Grant (SSBG), Community-based Family Resource and Support grants, Violence Against Women Act, and Substance Abuse Prevention and Treatment Block Grant (SPATBG)

Spending Smarter highlights how these programs might be used to:

- Provide screening and diagnostic assessment.
- Monitor young children who have identified risk factors but are ineligible for individual services.
- Improve access to preventive, early intervention, and treatment services for young children, their families, and their caregivers.

- Address inconsistencies or confusion related to eligibility, and clarify the extent to which at-risk children can be served.
- Enhance workforce capacity through training and other means.
- Build infrastructure to support an array of services and supports.

Moving Forward: Opportunities to Act Now

The development of state and community infrastructure for fiscal and service strategies to promote social, emotional, and behavioral health in young children as part of a school readiness agenda requires detailed knowledge of how individual programs and funding streams work. It also requires thoughtful planning to build a common vision, identify priorities, take action to address barriers, and, to the extent possible, promote research-informed practices. Communities and states, however, can begin with the following action steps.

1) Convene a broad array of stakeholders, including families, public officials, and advocates to conduct a cross-system programmatic and fiscal analysis of currently funded social and emotional services to identify overlap, gaps, and action priorities.
2) Support financing strategies with interagency plans and written agreements to clarify and sustain cross-system efforts and potentially identify new matching funds.
3) Adopt a statewide definition of factors that place young children at high risk for social, emotional, and behavioral delays and conditions, and mobilize resources on behalf of these at-risk children across programs.
4) Blend dollars to cross-train a variety of professionals regarding early childhood emotional development.
5) Use block grants or smaller grant programs to provide flexible funding that can fill gaps left by Medicaid, Part C Early Intervention, and other core funding streams. Certain federal and private philanthropic funds also can be used to launch an initiative, support a pilot project, or convene a planning group.
6) Clarify eligibility and payment mechanisms between Medicaid's EPSDT child health component, the IDEA Part C Early Intervention program, child welfare, mental health, and other programs especially for children with dual or multiple eligibility status.
7) Adopt policy and billing mechanisms that encourage providers to perform developmental screening with age-appropriate tools and to offer follow-up referrals and treatment, in both medical office-based and nonoffice-based settings.
8) Target subpopulations of high-risk children and families for more intensive identification, outreach, and services. Start with one group of vulnerable children, such as young children experiencing abuse and neglect, or with depressed mothers.
9) Finance two-generation strategies and parent-child therapeutic interventions that can give two-for-one results.
10) Monitor children at risk but not yet eligible for entitlement programs and link them to existing services, for example through the establishment of a high-risk young child tracking program.

The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers

Below are a set of questions for state officials, families, advocates, and practitioners that can help drive a strategic approach to strengthening social and emotional school readiness and building early childhood mental health capacity. No state has implemented all of these recommendations, but together they provide a framework for prioritizing state and local action.

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

1. Does your state have a cross-agency strategic planning group to build strategic early childhood mental health capacity? Does the planning group:
   - Include families? Providers?
   - Link to a larger early childhood/school readiness planning process?
   - Include a dedicated fiscal planning group?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

2. Does the state cross-agency strategic agenda include explicit efforts to build overall system capacity? Does your state:
   - Map how each system currently supports prevention, early intervention, and treatment services?
   - Map gaps in existing community-based programs or early childhood mental health initiatives across the state?
   - Create incentives for community-based, cross-agency training initiatives?
   - Implement targeted collaborations across IDEA Part C (Individuals with Disabilities Education Act), child welfare, and early childhood programs?
   - Build common definitions across programs for young children at risk of early school failure and/or developing social and emotional disorders?
   - Ensure family/two-generation treatment for the most vulnerable (e.g., promoting collaboration across child and adult mental health, substance abuse, and domestic violence programs)?
   - Pay for treatment for adults in the context of home visiting programs and comprehensive early childhood programs?
   - Use smaller grant programs strategically to promote system-building capacity (e.g., Foundations for Learning; Safe and Drug Free Schools; Early Learning Opportunities; and Good Start, Grow Smart)?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

3. Is your state maximizing the impact of Medicaid/SCHIP? Does your state:
   - Require/permit EPSDT age-appropriate screening and diagnostic tools for infants, toddlers, and preschoolers that are sensitive to social, emotional, and behavioral issues?
   - Pay for covered services delivered in a range of community-based settings?
   - Include separate definitions and billing codes for developmental assessment/screening and diagnostic evaluations?
   - Use state matching funds strategically with Medicaid to support behavioral and mental health consultation in child care and home visiting programs?
   - Provide reimbursement for parent-child therapy?
   - Cover necessary services for social and emotional needs under the SCHIP benefits package?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

4. Is your state maximizing the impact of Title V Maternal and Child Health Services Block Grant? Does your state:
   - Use Title V's flexible funding strategically to cover services and supports for families and other caregivers that cannot be provided through Medicaid (e.g., cross-training)?
   - Explicitly include children who are at increased risk for developmental, behavioral, or emotional challenges according to the state definition of Children with Special Health Care Needs (CSHCN)?
   - Maximize the potential of the State Early Childhood Comprehensive Systems (ECCS) planning grants, including a focus on the most vulnerable?
   - Use the flexibility under Title V to develop and/or finance programs for maternal depression or other two-generation treatment strategies?

The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers (continued)

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

5. Is your state maximizing the impact of the Child Care and Development Fund (CCDF) to promote social and emotional health and school readiness? Does your state:
   - Define explicit strategies to promote social and emotional health and school readiness competencies in children and improve the skills of caregivers in the state's CCDF plan?
   - Use CCDF funds to support training for the early childhood community on social, emotional, and school readiness issues?
   - Ensure that the highest-risk young children are in high-quality child care settings?
   - Use CCDF funds to support early childhood mental health consultation through the quality set-aside? Use other funds?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

6. Is your state maximizing the potential of special education programs on behalf of infants and toddlers at risk of developmental delays and on behalf of preschoolers with identified disabilities? Does your state:
   - Ensure appropriate social and emotional assessments in IDEA Part C Child Find screening activities, as well as in comprehensive, developmental, multidisciplinary evaluations?
   - Use the option to extend IDEA Part C eligibility to at-risk infants and toddlers, with emphasis on social, emotional, and environmental risk factors?
   - Identify infants and toddlers exposed to substance abuse, domestic violence, and maternal depression as a high-risk group? Extend eligibility for Part C services?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

7. Is your state maximizing the impact of the new CAPTA amendments? Does your state:
   - Require collaboration across public health agencies, child protection systems, and community-based programs to provide child abuse and neglect prevention as well as treatment services?
   - Have a mechanism to ensure that screenings of young children at risk who have experienced abuse or neglect and/or witnessed domestic violence lead to interperiodic reviews, assessments, and/or referrals for early intervention?
   - Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

8. Does your state maximize the impact of programs serving the most vulnerable families with young children? Does your state:
   - Use Title IV-B funding to create two-generation child mental health and behavioral interventions for families with young children in or at risk for foster care placement?
   - Use TANF grant dollars for family counseling, service coordination, substance abuse treatment, family support, and training activities?
   - Transfer TANF funds to the CCDF or the SSBG to jump-start behavioral and mental health early childhood consultation strategies?
   - Strategically use funds from family violence/domestic violence, substance abuse, prevention, treatment, and community-based family resource and support to promote treatment and two-generation strategies targeted to families with young children?

Introduction

In 1994, the Educate America Act set forth an ambitious national goal: "Every child shall enter school ready to learn."[1] Since then, a remarkable body of research has emerged, painting a rich portrait of the factors that promote or inhibit early learning success. This research makes it clear that caring parental relationships and other early life experiences equip most young children, including low-income children, with the appropriate tools to support their learning and enable them to succeed in school. It also makes clear that not only are babies born "wired to feel and to learn,"[2] but most children are "eager to learn."[3] All young children respond to high expectations and to environments that promote their curiosity and provide appropriate learning challenges.

At the same time, the research sounds a cautionary note. The early childhood years are a time of great opportunity, but they are also a time of vulnerability.[4] When a child's earliest experiences do not provide the kinds of warm and stimulating relationships that are the foundation of early success in school, the odds of early school failure become greater.[5] Poor social and emotional skills predict early school failure. This, in turn, predicts ongoing school problems, and, for some, later school failure leading ultimately to involvement in high-cost child welfare, mental health, and juvenile justice systems.[6]

The group of young children who are at risk of early school failure is sizable—somewhere between one-fourth and one-third of all young children.[7] Disproportionately, these are low-income children. Particularly vulnerable are those whose early experiences do not provide them with warm, nurturing environments, whose language development lags, and whose social and emotional development is problematic.

Some young children at risk are resilient and are able to thrive despite challenges. (Resilience in children is the capacity to cope with adversity in a positive way.) But many do not fare so well. Child care workers describe too many young children as "mad, bad, and sad," and even the most skilled and seasoned workers tell of encounters with young children they do not know how to help. The number one request from teachers of young children is for help in dealing with children with challenging behaviors, some of which are far more serious than many teachers have ever encountered.[8] Young children are being expelled from state preschool settings at three times the rate of older students.[9] Parents are being asked to remove even babies from child care settings.[10]

The knowledge base about how to design and implement strategies that can help infants, toddlers, and preschoolers develop age-appropriate social, emotional, and behavioral competencies is growing.[11] But building the fiscal and service delivery infrastructure to support the development of needed preventive, early intervention, and remediation strategies has proven to be very challenging. There is no one policy approach and no single, or even clearly targeted, funding stream. Instead, piecing together a coherent funding and service delivery infrastructure requires creative, strategic, and proactive leadership at both the state and community levels.

Spending Smarter is designed to help legislators, agency officials (e.g., heath, child care, mental health, early education, and child welfare professionals), families, and other advocates take steps to maximize the impact of existing funding streams and feel confident that they are using available resources in the most effective way. The first section, "Framing the Challenge," is a primer for policymakers about the social and emotional challenges facing young children, how these challenges prevent early school success, and what services and supports can make a difference. The second section, "Making the Most of Individual Federal Programs," provides an analysis of how individual funding streams and programs can be used to build components of a coherent system of supports and services. The third section, "Moving Forward," highlights strategies for advocates and policymakers to consider for immediate adoption in their own states or communities as well as questions to help guide strategic fiscal planning processes.

The strategies described in *Spending Smarter* cannot do the job alone. To build the kind of health, mental health, and quality early care and learning systems so crucial to America's future, additional investments will also be necessary. However, without a deliberate focus on the social and emotional well-being of young children, even schools and communities that are ready will not be enough for many children and their families.

Framing the Challenge: What Policymakers Should Know About Social and Emotional Health and School Readiness

What Does Social and Emotional Health and School Readiness Mean?

Put most simply, social and emotional health and school readiness is about the age-appropriate ability of children to:

- Manage and regulate emotions (e.g., how a preschooler responds when another child takes his toy; whether a baby can comfort herself)
- Relate to and trust adults and eventually peers
- Experience themselves as competent learners (e.g., are they eager to engage in learning, or are they too anxious or sad to try new things?)

Research tells us that these abilities are the foundation of effective learning and life skills (see Box 1). When the earliest nurturing and stimulation provided by parents (including foster parents and grandparents) and by others (e.g., child care providers and teachers) does not help young children develop these expected competencies, the stage is set for cascading problems in mental health and other areas of development and achievement. Social, emotional, and behavioral problems in young children can take many forms, from a child who will not listen to a teacher, to one who disrupts the class, to one who is always sad and will not engage with peers, to one with a diagnosable mental health disorder.

Box 1: Social, Emotional, and Behavioral Skills That Promote School Readiness

Young children are more likely to succeed in the transition to school if they can:

- Accurately identify emotions in themselves and others (Children who cannot do this persistently misinterpret social situations and routinely perceive the motivations of others as hostile.)
- Relate to teachers and peers in positive ways (Children who lack what are often called "prosocial skills" are likely to have few friends and negative relationships with teachers.)
- Manage feelings of anger, frustration, and distress when faced with emotionally charged situations (e.g., when another child takes a favorite toy)
- Enjoy academic learning and approach it enthusiastically
- Work attentively, independently, and cooperatively in a structured classroom environment

Young children are less likely to succeed in the transition to school if they:

- Engage in frequent fighting, hitting, shouting, or other aggressive behaviors
- Are unable to control impulsive behavior
- Are unable to pay attention to tasks or follow directions
- Engage in oppositional, noncompliant, or even defiant behavior
- Are unable to cooperate with others
- Constantly seek attention from peers or teachers
- Ignore peers or teachers

Source: Raver, C. C. & Knitzer, J. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

Just as there are deliberate strategies to promote early literacy, so there are strategies to promote healthy early social and emotional development.

Because most young children develop age-appropriate social and emotional skills through everyday interactions with parents, caregivers, siblings, and others, it is sometimes difficult for families, policymakers, legislators, administrators, and even the general public to believe that there are some children who, absent intervention, will not outgrow their problems. It is also difficult for them to comprehend that there are ways to promote social and emotional competencies in young children that, in turn, can help them succeed in school. Just as there are deliberate strategies to promote early literacy, so there are strategies to promote healthy early social and emotional development. While they cannot solve every problem, early childhood mental health interventions, especially those that are grounded in strengthening positive relationships, can often make a critical difference in promoting resilience and school success.

Why Should Policymakers Invest in Social and Emotional School Readiness?

There are five major reasons that policymakers should invest in young children's social and emotional school readiness and mental health:

1) The earliest years are a time of opportunity, with public investments showing a large payoff.[12]
2) There is a powerful body of scientific knowledge showing the consequences of failure to address early signs of risk factors. Children who do not succeed in the first three elementary school grades are often headed for a much longer-term and costly trajectory of failure.[13]
3) The knowledge of how to design, implement, and evaluate effective interventions is growing.
4) Research tells us that social, emotional, and cognitive learning are intertwined for young children. Improving the capacity of young children to regulate their emotions seems to be a critical pathway to improve cognitive and early academic learning. Research also tells us that teachers may not accurately see the academic capacity of children with problem behaviors.[14]
5) Mental health disorders are being identified in younger and younger children. Even babies can show signs of depression. The impact of trauma, particularly related to exposure to violence and abuse, is as devastating for babies and young children as it is for older children and adults. Moreover, for some disorders, such as early onset conduct disorder, the earliest years represent a window of opportunity for intervention that may shut down.

Box 2: What Early Learning Research Tells Us

Most young children are "eager to learn"[1] and have the cognitive and social and emotional skills to succeed.

- How the brain develops in the earliest years actually lays the foundation for later learning and the capacity to manage emotions.[2]
- The earliest relationships set the stage for healthy brain development and early learning.
- Almost all children are born "wired to learn."
- Social, emotional, and cognitive learning are all interconnected in young children (perhaps even more than in older children).[3]

Although there are many children in low-income families who excel in school, there is a persistent achievement gap related to family income.[4]

- The lower the income, the lower the children's academic achievement.
- The lower the income, the lower the children's social skills, and the greater the reports of children's emotional and behavioral problems.

Intentional strategies can make a difference.

- Improved parenting of infants and toddlers has been linked to improved cognitive, behavioral, and language skills in 3-year-olds.[5]
- Parents who have learned how to better manage young children's behavior report positive changes at home and at school.[6]
- Classroom-based strategies to help young children master social and emotional skills have been linked to improved reading ability.[7]

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[1] National Research Council, Committee on Early Childhood Pedagogy, Commission on Behavioral and Social Sciences; Bowman, B. T.; Donavan, M. S.; & Burns, M. S. (Eds.). (2001). *Eager to learn: Educating our preschoolers.* Washington, DC: National Academy Press.

[2] Institute of Medicine; Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). From *Neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

[3] Knitzer, J. & Raver, C. C. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

[4] Gershoff, E. T. (2003). *Low income and the development of America's kindergartners* (Living at the Edge Research Brief 4). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

[5] See findings from the Early Head Start Research and Evaluation Project at <www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/index.html>.

[6] Reid, M. J.; Webster-Stratton, C.; & Baydar, N. (2004). Halting the development of conduct problems in Head Start children: The effects of parenting training. *Journal of Clinical Child and Adolescent Psychology, 33*(2), pp. 279-291.

[7] Bodrova, E. & Leong, D. J. (2001). *Tools of the mind: A case study of implementing the Vygotskian approach in American early childhood and primary classrooms* (UNESCO Innodata Monographs: Educational Innovations in Action No. 7). Geneva, Switzerland: UNESCO, International Bureau of Education <www.ibe.unesco.org/International/Publications/INNODATAMonograph/inno07.pdf>.

How Large Is the Problem?

Although there are no national epidemiologic data, findings from small community-based samples and some larger national datasets tell a similar story. Overall, about 10 percent of young children entering kindergarten are rated by teachers as showing some degree of behavioral problems.[15] In samples of low-income young children, reported rates of behavioral problems are often two or three times higher. A recent national study found that young children are expelled from preschool settings at three times the rate of children in grades K through 12.[16] New data on young children with diagnosable disorders reveal that about 17 percent show some kind of significant mental health disorder, with rates varying by problem. About 10 percent of them have acting out, aggressive disorders.[17]

What Are Major Risk Factors for Poor Social and Emotional Development?

Four clusters of risk factors have been repeatedly identified in research:

1) **Poverty and low-income status.** Over 40 percent of all young children are in families with incomes at or below 200 percent of the poverty level; about 17 percent of them live at or below poverty, and half of those live in extreme poverty.[18] Poverty is the greatest risk factor for poor developmental outcomes, whether social, emotional, heath related, or academic. Although many low-income parents are nurturing and effective, sometimes the hardship and stress of unremitting poverty take their toll.

2) **Poor quality early care and learning.** The quality of early care and learning experiences affects the potential for early success in school. Young children spend large amounts of time in informal or formal child care and early learning settings.[19] Unfortunately, the quality of much of that care is poor, especially for low-income children.[20] The mental health of child care providers also plays a role. Providers who experience more job stress or higher levels of depression are also more likely to expel young children from their programs.[21] But regardless of caregiver mental health, those who work with young children in early care and learning settings are calling for help. A national survey carried out by the National Association for the Education of Young Children reported that help with behavioral problems was the number one request.[22]

3) **Parental risk factors.** Decades of research point to the power of nurturing relationships to foster resilience and counterbalance negative experiences. The converse is also true. The greatest threat to healthy emotional development is inadequate parenting—parenting marked by inappropriate expectations, indifference, inconsistency, or harshness.[23] Low educational levels, poor parental health, untreated parental trauma, and negative parenting role models all contribute to problematic parenting. Risk factors that receive far less attention than they should include substance abuse, domestic violence, and, especially, parental depression.[24]

4) **Child-specific risk factors.** There is also a group of young children who have serious, diagnosable emotional and behavioral problems. Sometimes these are young children in families facing multiple stresses and parental risk factors, but sometimes they are not. An analysis of a sample of young children served by mental health agencies found that, as with older children, about half of young children currently receiving mental health services are in families facing multiple demographic and psychosocial risk factors, while half are not.[25] Children with chronic health problems or with other disabilities are also at higher risk for emotional and behavioral problems. Supporting interventions for these most vulnerable young children and their families in an effort to improve school readiness is a crucial challenge. Such interventions need to be viewed through a family lens, addressing the parents, the parent-child relationship, and, if necessary, any developmental delays experienced by the child. Paying for such a combination of services, however, is particularly difficult.

What Kinds of Interventions Should Policymakers Support?

Based on scientific evidence, intervention research, and real-world experience, capacity building should focus on three broad types of interventions. (For specific examples, see Box 3.)

1) **Promotion and prevention strategies targeted to all children, but especially low-income children.** Such strategies can help families and caregivers foster social skills, emotional health, and positive behaviors as part of a school readiness agenda. These strategies include anticipatory guidance by pediatricians or others, social and emotional skill-building curricula in preschool programs, and mobilizing local community leaders, mentors, and coaches.

2) **Early intervention strategies for groups of young children who face special risks.** Young children at special risk include those whose parents are incarcerated or abuse drugs, those in foster care, those with disabilities, and those whose parents face serious mental health issues, particularly depression. Screening and assessment tools that focus on age-appropriate social and emotional functioning, as well as provide full-scale diagnostic evaluations, can also be important in identifying young children in need of early intervention or treatment.

3) **Treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their parents (or other primary caregivers) and siblings.** These kinds of interventions include access to case management, mental health, and other treatment services that can help families stay together and ensure the safety and healthy development of young children.

In general, clinical and developmental knowledge indicates that regardless of the type of intervention, the best way to help young children thrive socially and emotionally is to ensure that those who are closest to them have the needed knowledge and emotional support to be good guides. The primary aim is to change the environment that supports the child, and to intervene directly only when the child is the problem, not the symptom of the problem.

What's in a Name?

Many different terms are used to describe early childhood mental health, social and emotional health, and school readiness interventions. For example:

- In the health and pediatric world, such interventions are often called *developmental services*, especially if efforts are made to have them paid for by "bundling" discrete Medicaid-eligible services.
- The early childhood and school worlds use nonmental health language, and speak primarily of *social and emotional competencies* to prevent early school failure.
- In the mental health world, the terms *infant* or *early childhood mental health* are used, although these terms can initially be stigmatizing and off-putting to families and others, evoking images of young children on a psychiatrist's couch.

BOX 3: Early Childhood Mental Health in Action*

Examples of Prevention Strategies

- Screen all pregnant women for depression in public health clinics and community health centers.
- Routinely screen all young children for developmental risk factors in the context of primary health care.
- Talk to parents about their depression and safety in pediatric practices.
- Train all community providers working with low-income families in how to help parents "read" the cues of their babies.
- Support a child development specialist in pediatric practices.
- Implement a social skills curricula for preschoolers in prekindergarten programs.

Examples of Early Intervention Strategies

- Make mental health consultants available to all center-based and family child care programs to help staff improve how they respond to young children perceived as having challenging behaviors.
- Provide training to early childhood staff (home visitors, child care providers) in social and emotional development
- Provide family support groups to improve parenting practices and reduce the isolation of parents with known risk factors for poor parenting in early childhood settings.
- Routinely screen all young children in foster care for social and emotional problems.
- Train child welfare workers and court personnel in the principles of early childhood development and the implications for child welfare processes.
- Establish protocols for effective cross-agency referrals to early intervention, special education, and other community services.
- Offer parental support and training to incarcerated parents.

More Intensive Interventions

- Embed cognitive behavioral therapy for depressed parents in home visiting programs.
- Support intensive relationship-based therapies for infants, toddlers, and parents exposed to trauma.
- Support behavioral aides in early childhood programs to promote inclusive child care.
- Ensure that foster parents have access to training and supports to help them better meet the needs of young children who have been removed from their homes and placed with multiple caregivers.
- Provide wraparound planning and family-driven case management for young children with serious emotional and behavioral disorders.

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* For other resources see: The National Center for Children in Poverty <www.nccp.org>; The Center on the Social and Emotional Foundations for Early Learning <csefel.uiuc.edu>; The Center for Evidence-Based Practices <www.evidencebasedpractices.org>; Georgetown University Center for Child and Human Development's National Technical Assistance Center for Children's Mental Health <gucchd.georgetown.edu//cassp.html>; Child and Family Policy Center's State Early Childhood Policy Technical Assistance Network <www.cfpciowa.org>; and the Portland Research and Training Center on Family Support and Children's Mental Health <www.rtc.pdx.edu>.

Each of these terms may be useful in particular contexts. For example, if the Maternal and Child Health Bureau undertakes an initiative to reach out to pediatricians to encourage them to use age-appropriate screening tools, the terms *social and emotional health* and *child development services* may work best. If the public mental health agency embarks on a partnership with the early childhood community, it may be appropriate to speak of *promoting early childhood mental health*, particularly in relation to accessing funds. If Medicaid pays for wraparound services for a young child to support the parent and prevent placement in a residential treatment setting, they are funded as *mental health services*. The bottom line is that whichever

term is used—*social and emotional competencies, infant mental health*—is far less important than the goal: to promote healthy relationships among and age-appropriate social and emotional behaviors in all young children, even those whose early experiences place them at the greatest risk.

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With this as a framework, we turn now to the core challenge that this document addresses: how to fund a system of integrated strategies to promote the social and emotional health and school readiness of young children.

Making the Most of Individual Federal Programs to Promote Social and Emotional Health and School Readiness

Sarita is 4½ years old. She is very bright and very active, and is constantly asking interesting questions. The staff in her new child care program find her very challenging and at least once a day give her a time-out. She is becoming increasingly depressed and silent. She used to participate in discussions about books; now she does not. Her grandmother, who is raising her, does not know what is wrong. When she talks with the teachers, they say she needs to be disciplined; otherwise, they will have to expel her.

Jeremy is 18 months old but seems much younger. Often he is angry. He cries a lot and clings to almost anyone. Although the Early Head Start staff have tried to get him to be more responsive, their efforts have not worked, and they do not know what else to do. His mother, who has two other young children, seems listless and not interested in Jeremy.

Aliza is a 3½-year-old child whose single mother is trying to work full-time. Aliza has been asked to leave two child care settings because of her behavior. She constantly runs out of the room, hits other children, grabs toys and doesn't seem to enjoy the activities. Her mother has just received a call from the third child care program informing her that other parents are alarmed and the staff feels they cannot be helpful any longer. Aliza's mother is distraught; she has already lost one job because of child care problems.

—Adapted from Knitzer, J. (2001). *Building Services and Systems to Support the Healthy Emotional Development of Young Children: An Action Guide for Policymakers.*[26]

These children illustrate the kinds of social and emotional challenges likely to get in the way of successful early learning. They also illustrate why funding interventions to help these children is so complex. Absent intervention, each child may be at risk of early school failure. But each is likely to need a different type of intervention. For Sarita, help needs to be targeted to her caregivers and perhaps to support her exhausted grandmother. For Jeremy to thrive, it appears his mother will need help with her depression, preferably in the context of the Early Head Start program. For Aliza, who is showing signs of a more significant disorder, and her family, careful assessment and treatment are needed.

Because there is no one funding stream targeted to young children facing social and emotional threats to school readiness, figuring out how to mix and match the multiple funding streams, eligibility requirements, and administrative requirements to ensure access to developmentally appropriate, family-focused, preventive, early intervention, and treatment services is very challenging. Predictable barriers include:

- **Funding restrictions.** Although major funding streams, such as Medicaid, pay for direct services to children, and some involvement with parents, it is much more difficult to fund interventions directed to others who work with children (e.g., for consultations with child care providers or teachers). Therefore, one major policy challenge for promoting social

and emotional health in the context of school readiness is developing state-level planning and financing approaches to pay for services that improve nonfamily caregiver skills and interactions.

- **Eligibility that excludes at-risk children.** There is a mismatch between knowledge about the kinds of risk factors that increase the odds for poor social and emotional development in young children and existing eligibility rules for early intervention and treatment of young children, their families, and their other caregivers. The demographic, familial, and environmental risk factors that put young children in harm's way for poor social and emotional development are not typically included in the eligibility criteria for mental health and related services; only having a diagnosis is. There are no major "categorical" federal programs providing resources for young children and their families who are at risk of early school failure because of familial or environmental risk factors.
- **Limited financing for parent-child, two-generation interventions.** For higher-risk young children, addressing the mental health and related needs of their primary caregivers is often essential for change to happen. Yet, in some states, it is still difficult to pay for parent-child or family therapy. In other states, it is almost impossible to get adults the help they need to address the barriers, such as depression, that they face and that reduce their parenting capacity. Yet the adult treatment systems and the early childhood systems have limited experience in collaborating together.
- **Inadequate systems for tracking children who are deemed at risk.** Screening for social and emotional problems, even through Medicaid, is haphazard, and follow-up monitoring to see if there are any status changes is quite limited. Screening and/or evaluation in Part C (Infants and Toddlers with Disabilities) Early Intervention programs of the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 may identify an infant or toddler at risk but may not allow that child to receive services under state eligibility criteria. Models exist for how states may use high-risk tracking, referrals, and alternative service strategies to intervene before children's risks turn into more serious and costly problems, but these models are not widespread.
- **Limited investments in training (and retraining) the workforce.** Mechanisms to disseminate and increase information about evidence-based and effective practices are limited, and workforce development is needed. Virtually every initiative focused on early childhood mental health or social and emotional school readiness reports that too few professionals have the combination of required skills: deep knowledge of early child development and the science of prevention and promotion, clinical knowledge about family dynamics and psychopathology, and the ability to consult with adults. Moreover, too much money is spent on fragmented and disconnected workshops rather than on coherent training strategies consistent with the principles of adult learning. There is also a need to invest in preservice, academic training to build the workforce.

Based on this analysis, the remainder of this section highlights the federal programs that might be used to:

- Provide screening and diagnostic assessment.
- Monitor young children who have identified risk factors but are ineligible for individual services.

- Improve access to preventive, early intervention, and treatment services for young children, their families, and their caregivers.
- Address inconsistencies or confusion related to eligibility, and clarify the extent to which at-risk children can be served.
- Enhance workforce capacity through training and other means.
- Improve infrastructure to support an array of services and supports.

Although *Spending Smarter* focuses on federal programs, state, and even local funding streams can be directed to address these same goals, and public-private funding partnerships can be organized to fill the gaps.

Note: Shaded boxes in this report provide strategies for specific federal programs.

Child Health and Mental Health Programs

Child health and mental health programs are "anchor" programs, providing potentially major sources of funding for an array of services related to the social, emotional, and behavioral health of young children. Child health programs fund screening, diagnostic assessment, early intervention, and treatment for individual children. Medicaid, as the largest source of public financing for child health and mental health, is the most important program in this cluster. The State Children's Health Insurance Program (SCHIP) offers parallel services to Medicaid in some states but has more limited coverage in others. Title V Maternal and Child Health (MCH) Block Grant funds are flexible, permitting states to finance an array of services (including direct services), enabling such services as case management, population-based screening, and infrastructure improvements (e.g., professional training). Funding streams that support children's mental health, either through the Comprehensive Services for Children cooperative agreements or the federal Community Mental Health Services Program for Children and Families, are also being used to support early childhood mental health in a growing number of places.

The Medicaid Program

Medicaid is a federal-state entitlement program for medical assistance to low-income children and pregnant women, as well as to persons over age 65 and to those with disabilities who meet income and resource requirements. (At the state's discretion, certain persons regardless of their income who are considered medically needy based on their high medical costs may also be eligible for Medicaid assistance.)[27] Most states now purchase services through contracts with managed care plans, and many states separate behavioral/mental health financing from physical health services.

Medicaid and Young Children

Medicaid is particularly important for young children. Congress and the states have made special efforts to ensure the coverage of young children through Medicaid, requiring eligibi-

BOX 4: Correcting Misperceptions About Medicaid Rules

Under Medicaid rules:

- States can be flexible about the location of screening or treatment, as long as the child, the provider, and the services qualify under Medicaid rules. *There is no federal requirement for office- or clinic-based services.*
- States are allowed to distinguish between (and pay separately for) a routine developmental screening conducted as part of an EPSDT screen and a more detailed developmental exam or diagnostic assessment (evaluation). Either of these might focus on social and emotional development and mental health; evaluation would be more in-depth and specific.
- Current federal Medicaid rules do not define child development services or provide incentives for bundling them (see Box 7). However, states can issue and have issued guidelines for providers and set payments to promote child development, including healthy social and emotional development.
- Parents, pediatricians, and/or teachers can recommend an interperiodic screen to track emerging problems.
- Although every state has an obligation under EPSDT to cover medically necessary and appropriate services for children with social, emotional, and behavioral risk factors, medical necessity is defined differently in different states.*

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* For more information, go to the Centers for Medicare and Medicaid: <www.cms.gov>. Also see Rosenbaum, S. & Sonosky, C. (2000). *Federal EPSDT coverage policy.* Washington, DC: Prepared by the George Washington University Center for Health Services Research and Policy under contract to the U.S. Health Care Finance Administration, U.S. Department of Health and Human Services <www.gwumc.edu/sphhs/healthpolicy/chsrp/medicaid_publications.html>; Rosenbaum, S.; Proser, M.; Schneider, A.; & Sonosky, C. (2002). *Room to grow: Promoting child development through Medicaid and CHIP.* New York, NY: Commonwealth Fund; Perkins, J. (2002). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early intervention services.* Los Angeles, CA: National Health Law Program; and Perkins, J. & Olson, K. (1999). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early development services.* New York, NY: Prepared by the National Health Law Program for the Commonwealth Fund <www.cmwf.org/publications/>.

lity for children younger than age 6 in families with income up to 133 percent of the federal poverty level (FPL). Many states use the option to cover infants and pregnant women up to 185 percent FPL.[28] All states have the option to extend Medicaid coverage for children and pregnant women to a higher percentage of the poverty level (e.g., 200 percent or 300 percent FPL). Some states also extend Medicaid coverage to low-income parents, but typically the eligibility levels are very low.[29] (Lack of parental coverage is a significant barrier when children are covered but parents facing health, mental health, or substance abuse challenges are not.)

Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides a comprehensive child health benefit that requires states to fund well-child health care, diagnostic services, and medically necessary treatment services to all Medicaid-eligible children from birth through age 21. Under federal EPSDT law (Section 1905 of the Social Security Act), states must cover any Medicaid-covered (i.e., allowed under the federal Medicaid statute) service that would reasonably be considered medically necessary to prevent, correct, or ameliorate children's physical and mental conditions. This requirement is at the heart of EPSDT's preventive purpose and potential. (In contrast, most employer-based health plans address only "diagnosis or treatment of disease, illness, or injury.") Services to prevent, correct, or ameliorate physical and mental conditions are covered for children, whether or not they are part of the state Medicaid plan for adults.[30] Thus, services such as children's intensive mental health therapy, home visits, rehabilitation, or dental care are covered by Medicaid because they are part of the EPSDT benefit.

In theory, Medicaid/EPSDT is the most important potential source of funding for prevention of, early intervention for, and treatment of the social and emotional challenges facing young children. Many services targeted to individual children can be covered through Medicaid,[31] but sometimes explicit state policy guidance is necessary.

Making Screening Work for Young Children. EPSDT requires periodic (based on a state-established schedule) and, as necessary, interperiodic (as needed outside the established schedule) screening. But for screening to be effective, screening tools must be age-appropriate and include developmental, emotional, and behavioral measures.[32] (Federal EPSDT regulations call for screening, diagnosis, and treatment of mental health and development but do not specify the mechanisms or tools to be used.) Additionally, reimbursement mechanisms must be in place. Most states have not yet identified such age-appropriate screening tools or established simple reimbursement mechanisms for providers who conduct these screenings and assessments.

Financing Services to Prevent Problems. Another problematic area is the difficulty of using Medicaid to finance services to promote healthy development before problems start. There is widespread agreement about the importance of what health professionals and many others are calling early childhood development services to promote healthy child development (physical, emotional, and cognitive) in infants, toddlers, and preschoolers.[33] (See Box 5.) However, financing such services through Medicaid is not simple. One problem is that current federal guidance does not specifically define child development services.[34] Thus, despite potential overlaps between Medicaid's EPSDT benefits and commonly defined early childhood development services, the final determination as to whether federal Medicaid matching funds are allowable for a particular service is made by the federal Centers for Medicare and Medicaid Services (CMS). A second problem is that Medicaid was designed to finance health care, while child development services often are provided by education or social service agencies, which generally do not qualify as Medicaid providers on their own. A third problem is that a number of other public programs (e.g., for early intervention, mental health, or children with special health needs) are involved in the delivery of child development services, making it difficult to sort out which program rules apply and who should pay. However, states are taking steps to deal with the confusion. For example, Illinois and Iowa are looking at levels of early childhood developmental screening and assessment to streamline the process for Medicaid providers and families. Other states (e.g., Connecticut and Florida) are considering new billing codes for a defined set of services related to social and emotional development. (See Box 6.)

Delivering Services Where Young Children and Families Are. Another misperception about Medicaid that can have a chilling effect on its role in preventing physical and mental conditions is the widespread belief that services must be delivered in office settings. In fact, while the provider must be qualified to deliver the medical assistance covered, *nothing in federal law* requires that the service be delivered in a clinic or physician's office.[35] Reimbursing for early childhood health and mental health services in settings where the children, families, and caregivers are (e.g., in Early Head Start, child care, and home visiting programs; domestic violence shelters; and community health clinics) is an important way to "spend smarter." Some states (e.g., Illinois and North Carolina) have guidelines that define the role of nurse home visitors or clinical social workers who deliver services to families with young children outside medical care settings.

BOX 5: How to Use Medicaid to Promote Social and Emotional Health and School Readiness

Provide effective screening and diagnostic assessment.

- Promote use of EPSDT screening tools that are appropriate for identifying social and emotional concerns among young children.
- Differentiate developmental screening done as a component of an EPSDT screen from a developmental diagnostic assessment (evaluation).
- Ensure that the EPSDT screens that every child should have within 60 days of enrollment are age-appropriate and can detect social, emotional, and behavioral problems.
- Strengthen links between EPSDT screens and follow-up referrals for services.
- Improve the mechanisms to ensure that every young child entering foster care has an appropriate screening, followed, as needed, by an appropriate assessment that pays special attention to attachment and other issues and includes a family assessment.

Offer more outreach and monitoring for high-risk children.

- Use the required EPSDT family-informing process to provide information to families about the benefits of early screening and intervention to promote social and emotional health and school readiness.
- Use interperiodic screening for ongoing assessment of children who are at risk of social and emotional delays and disabilities but who do not yet have a mental health diagnosis.

Improve access to appropriate services.

- Use EPSDT to provide financing for a broad array of child development and mental health services for young children, including early childhood mental health consultation for individual children and parent-child therapy.
- Develop a definition of child development services that can be used by Medicaid providers and includes managed care contracts.
- Use billing codes that are appropriate for children from birth to age 5 to clarify state coverage of:
  - Parent-child, relationship-based therapies
  - Early childhood mental health consultation by a Medicaid-qualified provider in child care settings, home visiting programs, and pediatric offices
  - Various components of child development services, such as parent-child assessment or comprehensive social and emotional evaluation
  - Treatment services to ameliorate social, emotional, and behavioral problems (delivered in offices, clinics, or nonoffice-based settings by qualified providers)
- Provide Medicaid financing for early childhood mental health consultation provided in child care settings by a Medicaid-qualified provider to individual children enrolled in Medicaid. (Note: While a potentially covered service, this would require states to develop benefit definitions, provider qualifications, and billing codes, such as who is a qualified provider, what agency gives prior authorization, and what are the billing codes for consultations.)

Develop clear eligibility definitions.

- Clarify financing (i.e., who pays for what) when children have dual eligibility in Medicaid and Part C.
- Clarify which young children are eligible for services under Medicaid behavioral health managed care "carve-outs" and which young children should continue to receive social and emotional services and supports from their primary care provider (medical home).

Enhance professional training and capacity.

- While Medicaid funds are not generally available to train professionals, state Medicaid agencies are responsible for determining which providers may participate and bill for specified services. To maximize the provider pool available to provide services such as comprehensive assessments and interventions, states should include licensed psychologists, social workers, and other health providers who serve young children as qualified Medicaid providers.

Improve infrastructure.

- Use state interagency planning, rulemaking, and managed care contracts to clarify and coordinate Medicaid financing. These are the tools for carrying out the recommendations above.
- Coordinate mental and physical health financing mechanisms. Medicaid pays for mental health services for children and adolescents, but often these services are administered through a separate agency.

Box 6: ABCD II: Building State Medicaid Capacity to Deliver Care That Supports Healthy Mental Development in Children

The Assuring Better Child Health and Development (ABCD) Program is funded by the Commonwealth Fund, administered by the National Academy for State Health Policy (NASHP), and designed to assist states in improving the delivery of early childhood development services for low-income children and their families.[1]

The ABCD Program is now in its second phase.[2] The first ABCD Consortium (2000–2003) provided grants to four states (North Carolina, Utah, Vermont, Washington) to develop or expand service delivery and financing strategies aimed at enhancing healthy child development for low-income children and their families. The experiences of the ABCD I Consortium made clear that it is entirely feasible for states to put programs in place to enhance child development and that Medicaid is a viable home for such programs.

The ABCD II Initiative, launched in 2003, is designed to strengthen primary health care services and systems that support the healthy mental development of young children from birth to age 3. The program focuses on the preventive care of children, and the approach is to assist states in building the capacity of Medicaid programs to deliver care that supports children's healthy mental development. California, Iowa, Minnesota, and Utah have projects funded by the Commonwealth Fund, and Illinois has a locally funded project. These five states form the ABCD II Consortium, a laboratory for program development and innovation that shares its findings with all 50 states. A brief description of the projects underway in these five states follows:

- **California's BEST-PCP.** Behavioral, Developmental, Emotional Screening and Treatment by Primary Care Providers (BEST-PCP), administered by the California Department of Health Services, is a two-tiered project that seeks to clarify various agency responsibilities for mental health and developmental services for young children, identify policy and finance changes needed, and implement quality improvement projects in primary care practices in two counties. During the first year, California's ABCD II project convened stakeholder groups, developed a matrix framework for identifying roles and responsibilities of agencies, identified pilot sites, recommended screening tools for use in the pilot sites, and reviewed privacy laws that may inhibit collaboration. In 2005, the ABCD II project in California aims to begin pilot site implementation, identify areas for policy and process change, and develop the quality improvement model.
- Significant collaborative efforts have emerged to promote children's healthy physical, social, and emotional development in Illinois, including the ABCD II project known as **Illinois Healthy Beginnings**. The goals of the project are to pilot a range of strategies that will improve children's primary care, reach more mothers with needed mental health services, and make changes in Medicaid policy. The pilot is administered by the Illinois Department of Public Aid (the parent organization of the Medicaid agency). During the first year, the Illinois project formed an advisory committee, conducted a needs assessment, identified four pilot sites, launched a training effort, modified Medicaid reimbursement policy for perinatal depression screening and consultation services, and clarified billing policy related to children's developmental screening. During 2005, Illinois Healthy Beginnings ABCD II project has aimed to implement the service strategy in pilot sites, review the impact of Medicaid policy changes, expand resources for maternal depression, engage managed care plans, and increase parental awareness.
- **Iowa's Care for Kids Healthy Mental Development project** was designed to build on existing efforts. Over the last 10 years, Iowa has engaged in a number of initiatives to improve the health and well-being of children. The state's Care for Kids ABCD II project is intended to build the capacity of primary care providers to deliver developmental assessment for all Medicaid-eligible children from birth to age 3. The project is administered through the Iowa Department of Human Services (parent to the Medicaid agency). During its first year, the state's ABCD II project: established an advisory structure, endorsed a screening tool for well-child visits, defined levels of care and established minimum standards for services associated with those levels, and defined a process to ensure that all children are referred to appropriate services. In 2005, state leaders aim to assess capacity, select and implement two pilot sites, improve interagency linkages, assess gaps in care coordination, identify Medicaid barriers, and educate providers.
- The **Great Start Minnesota** project, administered by the Minnesota Department of Human Services (parent organization to the Medicaid agency), is building on several previous and ongoing initiatives. The goal is to address the emotional and behavioral needs of young children under age 3 by giving primary care practitioners the ability to detect children's mental health problems early. Through Great Start Minnesota, the state Medicaid program aims to introduce mental health screening of parents, expand early childhood mental health screenings through the co-location of behavioral health specialists in primary pediatric practices, establish a separate billing

Box 6: ABCD II: Building State Medicaid Capacity to Deliver Care That Supports Healthy Mental Development in Children *(continued)*

mechanism, establish a new Medicaid benefit for at-risk children who do not meet current diagnostic criteria, link existing diagnostic criteria to Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3), and train primary pediatric practitioners. During the first year, Minnesota leaders convened an Interagency Planning Group and a stakeholder advisory group, identified the Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) as the screening tool of preference, received approval from the Centers for Medicare and Medicaid Services (CMS) to use the DC:0–3 for the state's new Medicaid Rehabilitation Option benefit, prepared and distributed a review of maternal depression screening tools, and began significant collaboration with Head Start.

- The Utah Department of Health, Division of Health Care Financing, initiated a multipronged project—**Enhancing Utah's Capacity to Support Children's Healthy Mental Development**—to increase the number of children enrolled in Medicaid who receive developmental screenings, including a focus on mental health concerns, as part of regular well-child visits, as well as appropriate treatment when indicated. This work builds on efforts already underway. In its first year, the Utah ABCD II project formed an advisory council, recommended developmental and social emotional screening tools, sponsored a learning collaborative on social and emotional development for infants, conducted a system capacity study, and supported development of a Utah Medical Home web portal. During 2005, Utah has aimed to enhance the system capacity report to track trends, place practicum students in community provider settings, identify a menu of social and emotional screening tools for toddlers (ages 1 through 3) and host a learning collaborative on this issue, and update the CHEC (EPSDT) provider manual regarding a recommended screening schedule and screening tools.

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[1] Johnson, K. & Kaye, N. (2003). *Using Medicaid to support children's healthy mental development*. Portland, ME: National Academy for State Health Policy.

[2] For more information, see The Commonwealth Fund child development initiatives <www.cmwf.org>.

Covering Parent-Child Therapy. States have opportunities to clarify Medicaid rules to cover parent-child therapy for the youngest children. No federal law prohibits state Medicaid programs from financing so-called "family therapy" for a child at risk for or diagnosed with a mental or behavioral health condition. Coverage of parent-child treatment in the case of children younger than age 6 makes sense in clinical terms. Experience in Florida, particularly in the Infant Mental Health Pilot Project, suggests that Medicaid financing for parent-child therapy in the case of very young children is both clinically appropriate and fiscally feasible.[36]

Promoting Early Childhood Development Through Medicaid Managed Care. Medicaid managed care offers clear opportunities to promote early childhood development. Medicaid managed care contracts typically include prevention and early intervention through EPSDT, as well as treatment. States can clarify which services are covered under managed care and/or behavioral health contracts and give particular attention to services such as developmental screening, diagnostic assessment, and monitoring health and developmental risk factors. In 2004, Connecticut, Ohio, and Wisconsin convened interagency workshops to focus on opportunities to better use Medicaid managed care for young children with social and emotional risk factors and conditions. Researchers at George Washington University have prepared purchasing specifications to assist states in efforts to finance child development and mental health services through Medicaid managed care. (See Title V discussion below.)[37]

State Children's Health Insurance Program (SCHIP)

SCHIP is a federal-state program to enable states to expand health coverage to uninsured, low-income children (and their parents). Unlike Medicaid, it is not an entitlement, but it does help states provide health insurance coverage to uninsured children whose family income is up to 200 percent of the federal poverty line (FPL) (and with federal approval well above that level). State SCHIP plans either expand eligibility for children under Medicaid or create a separate children's health insurance program managed by the state and typically operated by private insurance companies. Currently 39 states[38] have created separate, non-Medicaid SCHIP plans, sometimes in combination with Medicaid SCHIP plans. In either case, only uninsured children (and their families, with a federal waiver) may qualify for SCHIP.

If SCHIP is part of Medicaid, the benefits must be comparable, including EPSDT. Thus, for children with social and emotional challenges, the Medicaid strategies highlighted above would also help children covered by Medicaid-SCHIP expansions. For example, Medicaid-SCHIP plans should offer appropriate screening and diagnostic tools and interperiodic screens to check on mental health risk factors among young children.

If the state uses a separate SCHIP plan, benefits may be more limited, and family cost sharing may be required. In the case of separate SCHIP programs, states could promote social, emotional, and behavioral readiness by offering coverage for a small set of key services. In particular, states should use a broad definition of medical necessity and cover child development services. Covering children and their parents also is a valuable strategy to finance services essential for family health and mental health. Because SCHIP is not an entitlement to children, states may reduce eligibility and/or create waiting lists when the budget is low, or the state benefit plan may or may not cover necessary services.

States could also ensure mental health parity in SCHIP coverage, even if they do not require mental health parity for all privately insured adults. Such policies are important when SCHIP plans are private insurance, rather than Medicaid, and do not have Medicaid's EPSDT benefit package. For example, Arkansas adopted such a provision for children in 2001, requiring "coverage for the diagnosis and mental health treatment of mental illnesses and mental health treatment of those [children] with developmental disorders under the same terms and conditions as provided for covered benefits offered under the [SCHIP] program."[39]

Title V Maternal and Child Health (MCH) Block Grant

Title V is a program of grants to help state public health agencies maintain and strengthen their leadership in planning, promoting, coordinating, and evaluating service systems for pregnant women, mothers, infants, and children who do not have access to adequate health care and to coordinate or provide health services to children with special health care needs (CSHCN) and their families.

As defined in the legislation, state Title V MCH Block Grant programs aim to:

- Reduce infant mortality.

- Reduce the incidence of handicapping conditions among children.
- Increase the number of children appropriately immunized against disease.
- Increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services.
- Provide and ensure access to perinatal care for pregnant women, preventive child health services, and comprehensive care for CSHCN and disabled children eligible for Supplemental Security Income (SSI).
- Facilitate the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for CSHCN.

In the context of Title V, young children with social and emotional risk factors may be considered among those with special health needs. CSHCN are defined as: "children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."[40] Because Title V funds are limited, however, each state defines which categories of special-needs children will be eligible for the programs and services for CSHCN. (See Box 7.) Typically, these categories include children with chronic illnesses, genetic conditions, and physical disabilities, but not children with social and emotional disabilities. Therefore, it is important that each state's definition of children with special health care needs explicitly include children who have or are at risk for chronic developmental, behavioral, or emotional conditions.

Every state Title V agency has both a Maternal and Child Health (MCH) unit and a CSHCN unit that receive core funding and special grant initiatives funding. The Title V MCH Block Grant funds are allocated to the states based on a matching formula that requires a $3 state match for every $4 in federal funds. At least 30 percent of each state's allocation must be spent on activities for CSHCN, and an additional 30 percent must be dedicated to primary health care for children. A portion of overall funding is set aside at the federal level for Special Projects of Regional and National Significance (SPRANS). Other funds are set aside for special initiatives.

Title V funding can be used for direct services, enabling case management, population-based screening, and infrastructure improvements, such as professional training. It can be used stra-

BOX 7: Components of Early Childhood Development Services That Can Be Integrated into Title V and Medicaid

- Developmental surveillance, screening, and assessment
- Developmentally based health promotion and education
- Developmentally based interventions
- Care coordination

Source: Grason, H.; Hess, C.; Van Landeghem, K.; Silver, G.; Brown, B.; & Schor, E. (2004). *Integrating measures of early childhood health and development into state Title V Maternal and Child Health Services Block Grant plans.* Baltimore, MD: The Women's and Children's Health Policy Center, Johns Hopkins Bloomberg School of Public Health; Washington, DC: Child Trends; New York, NY: The Commonwealth Fund. This brief is based on the skills-building session, "Enhancing State Measurement for Early Childhood Preventive Health and Developmental Services, supported by The Commonwealth Fund and presented at the Association of Maternal and Child Health Programs 2004 Annual Meeting. The session web cast and visuals are available at: <128.248.232.90/archives/mchb/amchp2004/>.

tegically to balance the Medicaid medical model with a public health model that can address risk factors through both population-based services (e.g., screening for maternal depression, and early childhood mental health consultants) and direct services (e.g., parent-child relationship-building services). It is also possible to use enabling services to support outreach to families and family engagement strategies (e.g., care coordination using peer-parent advisers).

Title V and Young Children

In fiscal year 2002–2004, Title V funded 3-year State Early Childhood Comprehensive Systems (ECCS) planning grants to help develop more comprehensive approaches to early childhood service delivery.[41] States were charged to build partnerships with other stakeholders, to improve early childhood outcomes, and to develop an early childhood strategic plan. Five priority areas are: 1) access to "medical homes" (i.e., pediatric care providers who coordinate comprehensive health services); 2) services and supports to promote the positive social and emotional development and mental health of young children; 3) early care and education services; 4) parenting education services; and 5) family support services.[42] The ECCS planning grants offer one opportunity to move the agenda for integrated early childhood systems, providing resources for interagency planning, leadership development, fiscal analysis, and other infrastructure supports. (See Box 8.) The implementation grants in future years will create additional opportunities for state-level action. Some states (e.g., Indiana) have used SPRANS and other special project funding to integrate and coordinate services for children with social and emotional risk factors. Most state Title V agencies also have an initiative to establish CSHCN medical homes. This is an opportunity to identify providers with the capacity to screen and coordinate services for young children with social and emotional risk factors.

Title V agencies can also influence the quality and availability of services. Flexible Title V funds can be used to provide cross-training for a range of professionals serving young children. Title V agencies might promote use of *Bright Futures in Practice: Mental Health*,[43] which includes guidelines for screening and referrals for early childhood mental health in pediatric practices and well-baby clinics, as well as encourage collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, and social workers). States have the flexibility to carry out these activities with their usual block grant allocation; no special initiative grants are required. The organization of Title V services into direct services, population-based services, concrete enabling services (e.g., transportation), and infrastructure services represents another possible lens through which to analyze not just Title V but other streams as well.

Other Health and Mental Health Programs

Community and Migrant Health Center Programs

Health centers are a major health care provider for low-income children and families,[44] caring for 1.3 million children under age 6 per year nationwide.[45] They care for families before and after the birth of a child, providing opportunities to screen, assess, and monitor social and emotional risk factors and conditions both in the young child and in the parent. Some-

BOX 8: Using Title V to Promote Social and Emotional Health and School Readiness

Provide effective screening and diagnostic assessment.

- Provide screening for adult risk factors that impair parenting in pediatric settings as well as community health and mental health centers.

Offer more outreach and monitoring for high-risk children.

- Integrate services (or expand integrated services) for infants and toddlers through the Part C Early Intervention program and the Program for Children with Special Need to pay for combined training, pooled funding streams, and consolidated service contracts).

Improve access to appropriate services.

- Develop a definition of child development services that can be used by Medicaid providers and is included in managed care contracts.
- Finance services not covered under Medicaid and/or SCHIP such as:
  - Early childhood mental health program/staff consultation.
  - Various components of child development services, such as parent-child assessment.
  - Screening and treatment programs for maternal depression.
- Support evidenced-based treatment for parents to improve child development outcomes in early childhood settings (e.g., initiatives to reduce depression in Early Head Start parents, Cognitive Behavioral Therapy in Home-Visiting).

Develop clear eligibility definitions.

- Include children who are at risk of or who have chronic developmental, behavioral or emotional conditions in the state definition of Children with Special Health Care Needs.

Enhance professional training and capacity.

- Support the cross-training of community providers to build capacity to promote social and emotional health and competencies, to respond to challenging behavior and to facilitate referrals for high-risk families.
- When advancing the concept of a "medical home" for children—a pediatric care provider who coordinates comprehensive health service—identify providers with the capacity to screen and coordinate services for young children with social-emotional risks.
- Promote use of the early childhood mental health guidelines in setting where young children access health care (e.g. well-baby clinics, pediatric offices). *Bright Futures in Practice: Mental Health** includes guidelines for screening and referrals for early childhood mental health in pediatric practices, and offers suggestions for primary care pediatric practice and for collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, social workers).

Improve infrastructure.

- Use Title V resources to support cross-agency team planning, fiscal analysis and the development of state plan to promote social and emotional school readiness in the context of broader school readiness strategies.
- Apply for Special Projects of Regional and National Significance (SPRANS) and other special project funding. For example, use the current ECCS project as a basis for planning and development of an early childhood system that includes services for more vulnerable families and children at-risk.

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* Jellinek, M. (2002). *Bright Futures in pactice: Mental health—Vol. I. Practice guide.* Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University <www.brightfutures.org/mentalhealth/>.

times, they can serve parents and children in the same visit, although some payer rules (e.g., Medicaid) may not allow this. Also, they offer families enabling services, such as translation, transportation, and case management, which may make it easier for families to use the health services. Thus, while health centers do not represent a funding stream, they do represent an important entry point within the service delivery system to identify and offer health and related services to low-income young children and families. They should be included in cross-training efforts and be part of any strategic effort to integrate and coordinate services to promote social and emotional health and school readiness.

Community Mental Health Programs for Children and Adults

Although the recently released President's New Freedom Commission on Mental Health Report explicitly calls for the development of early childhood mental health services,[46] federal funding streams do not provide any targeted support for early childhood mental health. Other than Medicaid, the major mental health funding stream explicitly targeted to children is the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, which provides multi-year grants to communities to develop systems of care for children with, and sometimes at risk for, serious emotional and behavioral disorders. There is no explicit incentive to address the mental health needs of young children, families, and caregivers. However, states have successfully sought approval to use the funds for early childhood mental health initiatives. For example, in Vermont, a 6-year, $5.7-million federal Child Mental Health Services grant stimulated state and local activities aimed at prevention and funded the Children's UPstream Services (CUPS) project. Colorado is engaged in a similar effort. As new money is available for systems development, other states might target system-building efforts for young children, families, providers, teachers, and other caregivers. This program provides important opportunities to focus on the small group of young children who are seriously emotionally disturbed and on their families, building on the lessons from working with older children and their families.

The Community Mental Health Services Block Grant Program assists states in providing comprehensive community mental health services to children and adults and in implementing a comprehensive, community-based mental health system. Overall, the program provides only about $400 million, so it is a limited part of mental health funding streams. Funding goes to the states on a formula basis. The program is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). States could choose to set aside some funding to provide incentives to local communities to address early childhood mental health issues more strategically, especially in concert with other school readiness initiatives.

Early Childhood Care, Education, and Special Education Funding Streams and Programs

Funding streams and programs that focus on early childhood care and learning include the Child Care and Development Fund, Head Start, Early Head Start, and other early education programs, as well as the Infant-Toddler Early Intervention and Preschool Special Education programs. Resources from some of these programs can be used for activities to promote social and emotional competencies in young children, particularly prevention and early interven-

BOX 9: Using the Child Care and Development Fund (CCDF) to Promote Social and Emotional Health and School Readiness

Provide effective screening and diagnostic assessment.

- Ensure that all providers know about Medicaid EPSDT screens and can inform parents.

Offer more outreach and monitoring for high-risk children.

- Build links to providers to facilitate on-site screening.

Improve access to appropriate services.

- Use quality initiative funds to help providers promote social and emotional health and school readiness.
- Support early childhood mental health consultant programs for the early childhood community to reduce child care staff turnover and work with young children at risk of child care expulsion.
- Support the capacity of resource and referral (R&R) agencies to help parents with young children at higher risk to find appropriate child care.
- Support efforts to reach out to family child care providers as well as other providers (e.g., friends and neighbors) to help promote social and emotional health and school readiness in the context of broader school readiness outreach efforts.

Enhance professional training and capacity.

- Support the cross-training of community providers to build capacity, promote social and emotional health and competencies, respond to challenging behavior, and facilitate referrals for high-risk families.
- Provide child care providers special training in working with higher-risk young children and families (e.g., those affected by substance abuse or domestic violence).
- Provide training in the inclusion of young children with serious emotional and behavioral disorders.

Improve infrastructure.

- Build linkages between child care and Title V efforts to enhance the early childhood system of care.
- Create a work group, plan, or other mechanism to study the availability of early childhood mental health consultation to child care centers and family child care homes.

tion strategies, such as classroom-based social and behavioral interventions for individual children and teacher-training strategies. These programs are also important entry points for the delivery of services financed through Medicaid or mental health funding streams. In addition, states are increasingly investing in programs for preschoolers, with schools or child care settings serving as delivery sites.

The Child Care and Development Fund (CCDF)

Child Care and Development Fund (CCDF) dollars go to states on a formula basis to be used for child care subsidies to low-income working families, as well as for activities to improve the quality and availability of child care. States, territories and tribal governments must spend 70 percent of their CCDF monies to provide child care services for families on or transitioning off the Temporary Assistance to Needy Families (TANF) program or at risk of welfare dependency. Consistent with a block grant approach, states have the flexibility to create child care programs and policies that best suit the needs of their populations, that help working parents make informed choices about child care, and that implement each state's health, safety, licensing, and registration standards. Four percent of program funds are set aside for implementing strategies to improve the quality of child care.

States can use CCDF allocations to increase access to services that promote the social, emotional, and behavioral health and school readiness of young children. For example, states have used the 4 percent quality set-aside, state-appropriated, and/or TANF funds to finance early childhood mental health consultation in child care settings. By blending federal, state, and local child care quality funds, states might finance training for child care professionals in the area of social and emotional development, as well as support early childhood mental health consultation.

Head Start and Early Head Start

Head Start and Early Head Start serve young children in comprehensive, developmentally appropriate programs. Head Start programs enroll preschool-age children (i.e., children 3 or 4 years old), while Early Head Start programs serve children from birth through age 2. Approximately 700,000 children participate in Head Start, while 62,500 participate in Early Head Start. Both Head Start and Early Head Start programs are designed to:

- Promote school readiness by enhancing the social and cognitive development of low-income children.
- Provide comprehensive health (including mental health), educational, nutritional, social, and other services.
- Involve parents in their children's learning.
- Help parents make progress toward achieving their educational, literacy, and employment goals.

Head Start and Early Head Start emphasize the importance of parental involvement in the operation and administration of their local programs.

Project grant funds for local Head Start/Early Head Start programs, including a portion of training and technical assistance funds, are awarded by regional offices directly to the grantees. Head Start grantees are required to provide (match) 20 percent of the total cost of the program, although this requirement may be waived. Many states use their own dollars to provide state-funded Head Start programs, and a few support Early Head Start. Both Head Start and Early Head Start must meet performance standards that include requirements for on-site mental health services and collaboration with parents. However, because of limits in Head Start budgets, programs often struggle to meet even the minimal performance requirements.

Helping Head Start programs access other funding streams to support activities that strengthen staff capacity to promote positive social and emotional outcomes and to respond more effectively to families could be part of a state strategy to serve higher-risk young children and families. Although Early Head Start improves outcomes for most of the enrolled babies, toddlers, and parents, research shows that it is not as effective for mothers with high levels of depression[47] or for parents and young children with four or more demographic risk factors. As a result, Early Head Start programs are trying to embed more intensive mental health supports into the program. Similarly, national initiatives such as Free To Grow[48] are helping Head Start redesign programs to better serve families with different levels of needs. State attention to supporting, evaluating, and expanding these efforts could have a long-term payoff.

Special Education Programs

Under the Individuals with Disabilities Education Improvement Act (IDEA), Congress authorized two major special education programs for young children with disabilities, one focused on children from birth to age 3 and the other on children ages 3 through 5. Every state participates in both programs. Because of differences in the structure of the two programs, the program for infants and toddlers is especially important.

IDEA Part C: Early Intervention Program for Infants and Toddlers with Disabilities

Part C of IDEA gives limited funds to assist states in developing and implementing statewide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants and toddlers with disabilities and their families. The law also requires that there be an individualized family services plan (IFSP), while many other federal programs require only child-focused plans. States choosing to participate in the program must serve infants and toddlers with developmental delays or disabilities, or with a high probability of developmental delays or disabilities, who meet the state's criteria. States also may serve children at risk for developing delays or disabilities (e.g., children with combinations of demographic, familial, or environmental risk factors).[49]

Problems and Opportunities. While Part C could be a major tool in helping infants and toddlers at risk for poor social and emotional outcomes, at present there are at least three core barriers that states might address: 1) Too few states actually include at-risk infants and toddlers; 2) too few states have developed tracking programs for those at risk; and 3) there has been no focus on infants and toddlers with serious emotional delays and disabilities, even though the law requires it.

In 2004, only eight states included definitions of at-risk infants and toddlers in their Part C eligibility criteria,[50]and only a few states (e.g., California, New Hampshire, New Mexico, and North Carolina) explicitly mentioned family or environmental risk factors in those definitions.[51] Although some states (e.g., Arkansas, Michigan Montana, Ohio, and Washington) use various other programs to offer services and supports to families with children at risk, such approaches do not ensure access to assessment and potential treatment. For states that do not extend eligibility to at-risk infants and toddlers, federal law permits the use of IDEA funds to identify, evaluate, refer, and conduct periodic follow-up to determine changes in eligibility status. Thus, even if states do not serve at-risk children or expand eligibility, they could establish a monitoring system (similar to high-risk infant tracking, which is often used for babies leaving neonatal intensive care) for those children showing elevated risk factors in screening or evaluation. Several states report that they might strengthen the emphasis on social and emotional risk factors in these tracking systems (e.g., Connecticut, Idaho, Maryland, Minnesota, Puerto Rico, Utah, and Virginia). Augmented monitoring systems also might be linked with programs such as EPSDT, foster care, or Early Head Start.

Most state Part C eligibility definitions do not mention social-emotional, psychosocial, or behavioral conditions in their list of qualifying developmental delays. If they do, the system to identify such children is weak, and few early interventionists are trained in relationship-based servi-

BOX 10: Using Part C of IDEA to Promote Social and Emotional Health and School Readiness

Provide effective screening and diagnostic assessment.

- Ensure that all providers know about Medicaid EPSDT screens and can inform parents.
- Require that local agencies conduct an assessment of all children from birth to age 3 entering the foster care system to determine whether or not they are eligible for early intervention services. This is similar to linkages with child abuse and neglect programs. (See description below.)
- Monitor program performance to ensure that appropriate social and emotional assessments are included as part of Child Find screening activities as well as a comprehensive developmental, multidisciplinary evaluation for each potentially eligible infant and toddler identified through screening.

Offer more outreach and monitoring for high-risk children.

- For at-risk children not yet eligible for Part C, monitor their developmental status through identification, evaluation, referral, and ongoing, periodic follow-up.

Improve access to appropriate services.

- Require that the Individualized Family Service Plan (IFSP) contain a statement and services plan regarding appropriate child care for young children with delays and disabilities, including those who do have identified social and emotional challenges.
- Include psychologists in the set of qualified providers (federal law mentions "psychological services" as a required category of services).

Develop clear eligibility definitions.

- Use the option to extend eligibility to infants and toddlers who are at risk if they do not receive early intervention, with emphasis on social and emotional conditions and multiple social/environmental risk factors. For example, states might include all children who have parents with substance abuse problems, have experienced or witnessed family violence, and/or have a mother with diagnosed depression.
- Include "atypical development based on clinical judgment" as one of the eligibility categories.

Enhance professional training and capacity.

- Use training dollars as part of a strategy to cross-train professionals in early childhood development and risks.

Improve infrastructure.

- Build linkages between Part C and Title V efforts to enhance the early childhood system of care.
- Create an interagency work group, plan, or other mechanisms (e.g., through the required state Part C Interagency Coordinating Committee) to study the availability of screening, early intervention, and treatment for social, emotional, and behavioral problems under Part C.
- Track social and emotional indicators (now required).*

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* New IDEA requirements for infants and toddlers with disabilities and their families mandate that indicators for these risk factors, one of which deals with children and their social-emotional skills, are to be incorporated in new state 6-year plans and reported on annually to the U.S. Department of Education. Similar requirements apply to preschool-aged children. For more information, see Part C Annual Performance Reports at <www.ed.gov/policy/speced/guid/idea/capr/index.html>.

ces. The Part C legislation mentions social and emotional development as one of five domains to be assessed, but neither the required Child Find screening nor comprehensive evaluations to determine eligibility generally do enough to identify and measure social and emotional delays.

However, there have been recent important developments. First, states are now required to refer children with substantiated abuse for Part C screening as a result of recent amendments to the Child Abuse Prevention and Treatment Act. (See description below.) Each Part C program has or will need to set up mechanisms for evaluating the children referred and for financing appropriate services for those determined eligible.[52] It is important for states to use this opportunity to evaluate and treat infants and toddlers with serious attachment and other relationship disorders.

BOX 11: Foundations for Learning Grant Program

The Foundations for Learning Grant Program, enacted in 2002, is the only federally legislated program that is directly focused on improving school readiness and preventing school failure among children at social and emotional risk. It is explicitly structured to help children whose social and emotional development is compromised by demographic, familial, or community risk factors. The funds can be used on behalf of children under age 7, who are at social and emotional risk for school failure, as indicated by the presence of two or more of the following factors: 1) abuse, maltreatment, or neglect; 2) exposure to violence; 3) homelessness; 4) removal from child care, Head Start, or preschool for behavioral reasons or at risk of being removed; 5) exposure to parental depression or other mental illness; 6) family income below 200 percent of the federal poverty level (FPL); 7) exposure to parental substance abuse; 8) early behavioral and peer relationship problems; 9) low birth weight; or 10) cognitive deficit or developmental disability.

Second, new federal guidelines have been released that include a new indicator that will require states to focus more attention on social and emotional issues. States must now indicate the number of infants and toddlers enrolled in Part C who demonstrate:

- Improved positive social-emotional skills, including social relationships.
- Acquisition and use of knowledge and skills, including early language and communications skills.
- Use of appropriate behaviors to meet their needs.[53]

There are a number of other ways states could strengthen the Part C program to be more responsive to infants and toddlers with social and emotional disabilities and developmental delays, as well as to those at risk for delays and disabilities. States could monitor program performance to ensure that appropriate social and emotional assessments are included as part of Child Find screening activities, as well as in the comprehensive developmental, multidisciplinary evaluation of each infant and toddler identified through screening as potentially eligible. States might also deem young children exposed to domestic violence, substance abuse, or maternal depression as eligible for services, rather than categorize them merely as at risk.[54] (A recent effort to do so was proposed at the national level.)

IDEA Part B (Section 619): Special Education Preschool Grants

The IDEA Preschool Grants program provides states with formula grants for special education and related services for children with disabilities aged 3 through 5. Unlike the Part C program, the Part B preschool program uses definitions comparable with those for older children, including children with behavioral disorders or serious emotional disturbance. It can be used to promote inclusion of these children in early care and learning settings[55] and may provide some training funds. However, as this program is currently structured, there is no possibility of reaching out to and serving at-risk children. This means that there is no continuity for at-risk children served under Part C when they become preschool aged, although, as noted below, states do have the option.

States can decide to merge Part C and Part B preschool programs to provide a continuum of services and early interventions for all children from birth to age 5. The 2004 reauthorization of IDEA gives states the option (i.e., gives parents the choice) to allow a child to stay in the

Part C program until kindergarten instead of moving to the Part B, Section 619, Preschool Special Education Program at age 3.[56] Such continuation programs would apply only to children and their families who had previously participated in Part C and there must be services in place to promote school readiness until the children enter (or are eligible under state law to enter) kindergarten. Under this approach, state dollars, which already comprise more than one-third of most Part C programs, can be used to facilitate continued coverage of at-risk children.

Other Programs Focusing on Early Learning and School Success

A number of small grant programs also have the potential to promote social and emotional health and school readiness. Three are highlighted below, but others also exist and could be used as part of a planning process. While these smaller grant programs do not provide funds for sustained services, they could be used as catalysts to build partnerships between the schools and early childhood and mental health agencies in high-need communities, as well as to design preventive interventions in the context of prekindergarten, kindergarten, the primary grades, and preschool special education. Of particular potential importance are the Foundations for Learning Grant Programs. Although woefully underfunded, this is the only federal grant project specifically designed to support social and emotional interventions for children experiencing multiple risk factors before their problems escalate.

States could adopt the Foundations for Learning framework (see Box 11) to develop state definitions and fund programs serving similar populations of young children at risk for early school failure by virtue of exposure to multiple risk factors. It is likely there will also be efforts to increase the federal dollars for this program since it is the only one of its kind.

Another potential platform is Even Start, which combines adult literacy (adult basic education or instruction for English language learners), parenting education, early childhood education, and interactive parent and child literacy activities into a unified family literacy program. The focus is on families with children from birth through age 7. The goals are to help parents improve their literacy or basic educational skills, become full partners in educating their children, and assist their children in reaching their full potential as learners. States receive formula grants from the federal Department of Education and, in turn, make competitive subgrants to partnerships comprised of local education agencies (LEAs) and other organizations, giving priority to areas with large numbers of families most in need. Even Start offers a special opportunity to address social and emotional issues through family literacy strategies.

The Early Learning Opportunities Act (ELOA) was passed by Congress to award grants to local councils (directly or through the states) for increasing, supporting, expanding, and better coordinating early learning opportunities. ELOA grants could be used to increase the availability of services that support early childhood development, remove barriers that limit access to early learning programs, increase professional development activities and compensation, and "facilitate the development of community-based systems of collaborative service delivery models characterized by resource sharing, linkages between appropriate supports, and local planning for services." The federal Child Care Bureau of the Administration on Children, Youth and Families, which administers the Child Care and Development Fund (CCDF) and ELOA, has accepted initial applications in 2005 and anticipates awards for 30 to 55 projects.

Other grant programs include the Safe and Drug-Free Schools program, which provides approximately 20 federal grants to LEAs each year to assist in implementation of "an integrated, comprehensive, communitywide plan designed to create safe and drug-free schools and promote prosocial skills and healthy childhood development." LEAs establish interagency agreements and work in partnership with local law enforcement, juvenile justice, and mental health agencies, and include an explicit focus on prevention and early intervention for young children.[57] States and communities can also ensure that efforts to promote early reading and literacy through Early Reading First and Good Start, Grow Smart, the President's initiative to promote early school success, include attention to social and emotional skill development.[58]

Programs Serving Young Children and Families at Greater Risk

Young children who witness domestic violence, are parented by a severely depressed parent, are abused or neglected, or are in foster care are young children whose social and emotional health is severely threatened. Some of these children are resilient and will make it, but many are on a trajectory of failure that is likely to cost the public systems dearly. To promote social and emotional health and school readiness in every child, it is critical that states include special attention to groups of young children in especially compromised circumstances. Several key programs can be used as entry points and/or funding streams.

Child Abuse Prevention and Treatment Act (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA) is a formula-funded, state grant program that provides flexible funding to improve child protective service systems. States may use CAPTA funds to improve the investigative process, management of cases, information and tracking systems, staff and provider training, prevention and treatment, and research. The program also funds the National Center for Child Abuse and Neglect. Acting on advocacy by a variety of organizations concerned with the development and emotional well-being of children, Congress amended CAPTA to require that children under age 3 in substantiated cases of abuse or neglect be referred to early intervention services funded under IDEA Part C. The Community-Based Child Abuse Prevention Program (CBCAP), authorized in 2003 by Title II of the CAPTA, also provides funding to States to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. Clearly, this language fits with the principles and purposes of ECCS projects. While the amounts of funding through CAPTA is not large, these provisions create a window of opportunity and leverage for ECCS planners.

The amendments of the Keeping Children and Families Safe Act of 2003 call for states to support and enhance "collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports." Other new provisions call for

improving training, retention and supervision of caseworkers, protection of infants affected by prenatal substance abuse, and an array of administrative improvements.

In most states, responding to the intent of new CAPTA rules will require a substantial change in practice for staff in local child welfare, TANF, Medicaid, and Part C programs. CAPTA now requires each state to submit a plan for early intervention referrals among children from birth to age 3 with confirmed cases of child abuse and neglect. Some states are using this requirement as an opportunity to restructure the linkages between child welfare, the Part C Early Intervention program, and Medicaid (e.g., Rhode Island and Connecticut). Strategies include contracts with child mental health professionals to complete the social and emotional assessment of children referred to IDEA Part C early intervention programs under CAPTA rules, similar to the approach states have often used for children with physical disabilities. States also might use CAPTA research and demonstration funds to pilot test innovative approaches, particularly in combination with Medicaid, to help address the trauma these young children have already experienced and to try to ensure that they get back on a positive trajectory for social and emotional development. Research on adults who have been abused as children shows that for many of them, the trauma has long-lasting, negative consequences.

Title IV-B and Promoting Safe and Stable Families

Title IV-B of the Social Security Act has two parts: 1) the standard Title IV-B program, which can be used to finance services for both families in care and families at risk, and 2) the Promoting Safe and Stable Families program (formerly Family Preservation and Support), which is designed to prevent separation of children and their families. Part 1 of Title IV-B provides grants to states for child welfare services, including preventive intervention, placements and permanent homes through foster care or adoption, and reunification services to encourage a return home for children who have been removed from their families for reasons of safety. The primary goals of the Promoting Safe and Stable Families program are to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents or by facilitating adoption or another permanent living arrangement. The funds may be used by states to provide family support, family preservation, time-limited family reunification services, and services to promote and support adoptions.

Most Title IV-B funding is designated for services that prevent child welfare placement. To be eligible for funds, states (and Native American tribes) are required to ensure certain protections for all children in foster care. In addition, state courts receive grants to improve foster care and adoption proceedings. Administrative expenditures are limited to 10 percent of state grants.

Title IV-B and Young Children

Title IV-B funds can be used to improve the social, emotional, and behavioral health and school readiness of young children, particularly in combination with Medicaid or early intervention programs. States could provide EPSDT screening for children served under the Title IV-B program according to a schedule for periodic screening, along with additional necessary interperiodic screening, diagnosis, and follow-up treatment. Such an intensive screening ini-

tiative might be linked to a statewide, early childhood, high-risk tracking effort. (See discussion above of IDEA, Part C.) Title IV-B funds also permit states to establish two-generation intervention models designed to provide parent-child mental health and behavioral interventions for families with young children.

Title IV-E Foster Care

Title IV-E Foster Care is an open-ended entitlement program that provides funds to states to assist with the costs of foster care and adoption assistance for eligible children; administrative costs to manage the program; and training for staff, foster parents, and private agency staff. Funds may not be used for costs of services provided to a child, the child's family, or the child's foster family if those services include counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions.

As a group, young children in foster care are among the most vulnerable. They have already experienced at least one separation from their family, and many experience multiple moves. Although Title IV-E does not provide service funds, the children in foster care should be the focus of careful planning to ensure that they receive appropriate screening and intervention services to reverse early emotional damage and/or promote healthy relationships with their current caregivers through both EPSDT and Part C Early Intervention programs. For example, states might require that all children from birth to age 3 entering the foster care system be evaluated through the Part C program to determine whether they have delays or risk factors that meet state eligibility rules for early intervention services.[59] This requirement would parallel efforts for children exposed to abuse and neglect. (See description above of CAPTA.) Repeated EPSDT screening could then be provided, along with treatment, as necessary. (The Appendix lists additional opportunities.) States also could implement evidence-based approaches to support foster parents caring for young children who have already experienced trauma and loss.[60]

Temporary Assistance for Needy Families (TANF)

Adopted under the welfare reform legislation—Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996—Temporary Assistance for Needy Families (TANF) replaced the Aid to Families with Dependent Children (AFDC) entitlement program. The new program provides formula-based grants to states, giving them broad flexibility to use the grant funds in any manner that promotes self-sufficiency. Many states have used TANF dollars to support child care activities, either through TANF or by transferring funds (up to 30 percent per year) to either the Child Care and Development Fund (CCDF) or the Social Services Block Grant (SSBG).

Jurisdictions have used TANF dollars to address the social and emotional needs of young children and to improve the quality of child care as a work support for parents transitioning off TANF. For example, in San Francisco, county-level flexibility has permitted the use of child care quality funds from the TANF program as the base funding for an early childhood mental health consultation program that has reached hundreds of child care providers and thousands of families. States also might use TANF grant dollars for two-generation strategies, such as: 1) family counseling, service coordination, and family support activities (e.g., creation of family resource centers

and funding of home visiting programs); 2) intensive home visiting for families with young children at risk (e.g., Ohio), or 3) substance abuse treatment for parents, as part of their efforts to reduce dependency and prepare for work. (The Appendix lists additional opportunities.)

Social Services Block Grant (SSBG)

The Social Services Block Grant (SSBG) gives states flexibility in furnishing social services. SSGB funds may be used to provide services directed toward one of five goals. The program goal of "preventing neglect, abuse or exploitation of children" links directly to promoting school readiness for vulnerable children. The annual SSBG allotments to states are determined by a formula based on population. A state may transfer up to 10 percent of its allotment for any fiscal year to preventive health and health services, alcohol and drug abuse, mental health services, maternal and child health services, and low-income home energy assistance block grants. Transfer to other agencies can ensure that the impact of these monies is maximized.

SSBG funds are flexible and can be used in combination with other programs to improve the social, emotional, and behavioral health and school readiness of young children, particularly for professional training, family services and supports, tracking at-risk children, or other related activities. (The Appendix lists additional opportunities.)

Community-Based Family Resource and Support Grants

This program is designed to assist states in implementing and enhancing a statewide system of community-based, family-centered, family resource programs through innovative funding mechanisms and broad collaboration with educational, vocational, rehabilitation, health, mental health, employment and training, and child welfare and other social services. The primary goals of these family resource programs are to strengthen family supports and prevent child abuse and neglect. Whether family resource programs or centers are funded through these federal grants or other combinations of state and federal dollars, they can be a potent source of support for families. Attention to social and emotional issues could be embedded into the strategies.

Violence Against Women Act (VAWA)

The Violence Against Women Act (VAWA) was reauthorized in 2000 to provide grants to states for training police, prosecutors, and courts and for enhancing law enforcement activities (e.g., STOP Grants—Services and Training for Officers and Prosecutors); for shelter services for battered women and their children; for civil legal services to give women help with protection orders, family court matters, housing, immigration, and administrative matters; for battered immigrant women to receive protections and receive lawful permanent residence without leaving the country; for grants for research and data collection on violence; and for training law enforcement personnel and developing policies to address the needs of older or disabled victims of domestic and sexual violence.[61]

VAWA has been authorized for $3.3 billion; however, congressional appropriations have yet to reach this "allowed" amount. Additionally, VAWA is set to expire in 2005. Advocates are fighting to reauthorize the bill.

Substance Abuse Prevention and Treatment Block Grant (SPATBG)

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG), which provides formula-based funds to the states, includes an emphasis on the provision of treatment for special groups, specifically injecting drug users, pregnant substance-using women, and women with dependent children. Priority goes to populations that are at risk for developing a pattern of substance abuse. SAPTBG was also designed to educate and counsel persons with substance abuse issues, provide activities to reduce the risk of substance abuse, and increase the availability of treatment services designed for pregnant women and women with dependent children, either by establishing new programs or by expanding the capacity of existing programs.

Moving Forward: Opportunities to Act Now

"The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs ... establish explicit and effective linkages among agencies that currently are charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult [health] and mental health services."

—*Neurons to Neighborhoods*. Recommendation 10, p. 12

The development of state and community infrastructure for fiscal and service strategies to promote social, emotional, and behavioral health in young children as part of a school readiness agenda requires detailed knowledge of how individual programs and funding streams work. It also requires thoughtful planning to build a common vision, identify priorities, take action to address barriers, and, to the extent possible, promote research-informed practices. (**See Appendix 1 for questions policymakers and advocates should ask**.) Drawing on all the many suggestions provided in the previous section, 10 foci are highlighted below for immediate action.

1) **Convene a work group to review currently funded social and emotional services and systems to support young children, their families, and their caregivers, and to identify priority funding strategies for early childhood mental health prevention, early intervention, and treatment.**

   In the context of larger efforts to strengthen early childhood systems to better achieve school readiness goals, some states are trying to increase the capacity to provide intentional prevention, early intervention, and treatment to families, other caregivers, and, when needed, young children. For example, a number of states have used strategic planning efforts to create a vision and build a common purpose across multiple agencies, stakeholders, and funding streams (e.g., Colorado, Connecticut, Florida, Iowa, Maryland, and Vermont) around social and emotional health and school readiness.

   One key to success, as reported by state officials and advocates, is to engage a broad array of stakeholders, including families, public officials, and advocates. It is important to include in this group the early childhood community (child care, Head Start, education); health, mental health, early intervention, and special education professionals; and agencies serving higher-risk young children and families (e.g., child welfare, domestic violence). It is also helpful to have representatives from Medicaid and the state budget office involved from the beginning. Most states already have partnerships to build on. For example, almost all states have State Early Childhood Comprehensive Systems (ECCS) grants, and over half the states have joint planning efforts between the CCDF and IDEA agencies. Other states use the recently enacted requirements to refer children with substantiated child abuse or neglect to Part C of IDEA as an opportunity to build

BOX 12: Maximizing Entitlement Funds

Better serve children.

- Focus on enrolling more currently eligible children.
- Specify clear definitions of benefits.
- Adopt optional eligibility categories for at-risk children (e.g., IDEA Part C).
- Create special initiatives to better serve entitled children (e.g., Medicaid and IDEA Part C services for children in the child welfare system).
- Adopt targeted case management approaches (e.g., Medicaid).

Use leverage to augment existing funds.

- Use state and local funds to leverage federal matching funds.
- Apply for and use federal waiver authority.
- Blend and braid funds to offer parallel services to children not eligible under federal criteria.

Operate more efficiently.

- Reduce administrative costs through central billing, shared staff, joint training, and other mechanisms.
- Better use entitlement funds available for administrative costs.
- Streamline enrollment and services for children eligible for two or more programs.

stronger linkages between child welfare and early intervention programs. The Child and Family Policy Center has proposed model legislation to structure an office and advisory board to promote child development and health.[62]

In these cross-system planning efforts, some states have used a "system-mapping" approach to identify gaps within and between systems. Using the programs identified in this document, states can begin to identify gaps and opportunities to "spend smarter," and then use this analysis to develop state-specific priorities and action strategies. It is important to conduct analyses both within individual programs as well as across programs to identify current opportunities and barriers. (Some states, such as Connecticut, have actually been able to map existing financing and services.) The next step is to begin to restructure programs and financing in ways that promote social and emotional health and school readiness for more children. In some ways, given the many cuts in core federal programs, this is a difficult time to engage in such planning. However, looked at in another way, it is an important time to ensure that the resources that are available are used most wisely. Moreover, even though federal funding is being cut, some states continue to realize the wisdom of continuing to invest in young children and prevention. State circumstances vary considerably.

2) **Support priority financing strategies with interagency plans and written agreements.**

State and local governments have many, often untapped opportunities to maximize flexibility and streamline administration. The Finance Project[63] has compiled strategies for success in creating more flexibility in financing. It suggests pooling (or blending) funds across agency or program lines, decategorizing funds by removing eligibility requirements and allocation rules, and coordinating (or braiding) categorical funds to

better support an array of services within a single program. The State Early Childhood Policy Technical Assistance Network has compiled a useful bibliography of resources on financing school readiness.[64] States and communities have also relied on the strategic use of state funds to match federal dollars. (For case studies of how this plays out in actual communities and states, see *Making Dollars Follow Sense*.[65])

Once opportunities for flexible financing or administrative changes have been identified, interagency agreements are valuable implementation tools. Interagency memoranda of understanding (MOU) and similar agreements clarify the terms for sharing fiscal or personnel resources, specify roles and responsibilities, and institutionalize changes. Practically, such agreements also serve as documentation of how the state intends to carry out integration of federal programs.

3) **Adopt a statewide definition of factors that place young children at high risk for social, emotional, and behavioral delays and conditions, and mobilize resources to engage in prevention and early intervention on behalf of these at-risk children.**

Once states have reviewed definitions for young children at risk for social and emotional problems across programs, the next step is to explore a common definition that can streamline administrative burdens and promote simplified access. The Foundations for Learning Grant Program sets out one possible framework that can be used on behalf of children under age 7 who are at social and emotional risk for school failure. Young children are eligible if two or more of the following factors are present: 1) abuse, maltreatment, or neglect; 2) exposure to violence; 3) homelessness; 4) removal from child care, Head Start, or preschool for behavioral reasons or at risk for being so removed; 5) exposure to parental depression or other mental illness; 6) family income below 200 percent of the federal poverty level; 7) exposure to parental substance abuse; 8) early behavioral and peer relationship problems; 9) low birth weight; or 10) cognitive deficit or developmental disability.

The Title V–funded 3-year State Early Childhood Comprehensive Systems planning grants have been used by some states as the umbrella for work groups that are turning their attention to state definitions (e.g., Colorado, Connecticut, and Illinois). The reevaluation of state definitions is necessary for drawing up a state early childhood strategic plan and for supporting the development of integrated community-based platforms for promoting optimal child development. States that secure implementation grants will be well positioned to adopt statewide definitions and frameworks for an early childhood system.

4) **Blend dollars to cross-train a variety of professionals regarding early childhood emotional development.**

Flexible funding for training is available in many programs and often can be used on an interagency basis. For example, at least 34 states conducted joint training between CCDF and IDEA Part C programs in 2003.[66] Some states have made specific efforts to provide training related to early childhood social and emotional development. Indiana created a common, core training curriculum for early childhood mental health and financed training with flexible funding from a Title V MCH Block Grant. In Vermont

and Michigan, core principles and a training approach aimed at system development infused these principles into a variety of settings. Other states, such as Connecticut, Illinois, Iowa, Ohio, and Colorado, are in the planning stages of training projects.

5) **Use block grants or smaller grant programs to provide flexible funding that can fill gaps left by Medicaid and other core funding streams.**

The Title V MCH Block Grant, Social Services Block Grant, TANF, and Substance Abuse Prevention and Treatment Block Grant are examples of programs that provide flexible funding. Such funds can support colocation of social work or child development staff in pediatric offices and clinics, early childhood mental health program consultation, and/or programs for maternal depression or substance abuse. State funds can also be used for similar purposes.

One core task is to engage in fiscal strategizing to support early childhood mental health consultation, building on the models and approaches emerging around the country. Innovative state and local programs reach children and their caregivers at child care centers, family day care homes, Head Start centers, family resource centers, shelters, and other settings. Different federal funding streams are being used, including mental health, child care, TANF, Medicaid, Title V MCH Block Grant, and Social Services Block Grant, as well as state general funds, county tax dollars, and private foundation support.

6) **Clarify eligibility and payment mechanisms between Medicaid's EPSDT child health component, the IDEA Part C Early Intervention program, child welfare, mental health, and other programs (i.e., clarify financing for children with dual or multiple eligibility status).**

While no state can afford to extend eligibility to all at-risk children, use of targeted and clear definitions can help include more children in need of interventions to achieve school readiness. States should also clarify eligibility rules and financing (e.g., who pays for what) when children have dual or multiple eligibility in Medicaid and Part C, or Medicaid and foster care. For example, some Medicaid agencies now require the signature of a primary care provider on each child's Individualized Family Service Plan under the IDEA Part C Early Intervention program, which then activates prior approval for Medicaid-covered services (e.g., Louisiana).

The most important step in maximizing available funding is to ensure that each child eligible for a federal entitlement program is enrolled for needed services. National estimates indicate that more than 2 million children are eligible for but not enrolled in Medicaid. As states plan for ways to refer young children with confirmed abuse and neglect to Part C Early Intervention, most are finding that infants and toddlers are eligible for but not previously enrolled in programs for children from birth to age 3 with developmental delays and disabilities. Most states also have identified young children from poor families who need child care subsidies and may need augmented or specialized child care services. Targeting existing funds to meet the needs of children eligible for federal entitlements maximizes the total amount of funds available to serve those children.[67]

7) **Adopt policy and billing mechanisms that encourage providers to perform developmental screening with age-appropriate tools and follow-up referrals and treatment in nonoffice-based settings.**

Surveys indicate that care for the social, emotional, and behavioral development of young children lags behind that of other preventive and developmental services recommended by the American Academy of Pediatrics.[68] Studies have reported screening-related problems not just in Medicaid, but through the Part C program for infants and toddlers, as well as through the Title V Children with Special Health Care Needs programs. (CSHCN is comprised of young children and families especially in need of social and emotional supports.) Screening for social and emotional issues represents what the President's New Freedom Commission report calls "social and emotional check-ups." For states to spend smarter, screening must use appropriate tools, be appropriately reimbursed, and, where indicated, lead to follow-up steps.

One starting point is for states to promote uniform and appropriate screening for children entering foster care based on protocols developed by professionals, as well as approved for financing by Medicaid, Part C, and other resources. Mandatory referrals for Part C screening or EPSDT exams could be better implemented. States also might give "prior authorization" for Medicaid financing of developmental assessments for young children entering foster care. States could also promote the use of the same tools across programs as well as ensure that there are follow-up evaluations, referrals, and, above all, access to timely and appropriate early services.

A most important strategy is to adopt clear billing codes. Without clear billing codes and payment rates, providers are less likely to deliver early development services essential to screening, diagnosis, and treatment of social and emotional needs. Some states have found that billing codes tailored to young children's conditions—using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–3)[69]—helps to reduce unnecessary spending, minimize fraud, and maximize early intervention.

8) **Target subpopulations of high-risk children and families for more intensive identification, outreach, and services. Start with one group of vulnerable children.**

Research is clear that some groups of young children are, in the aggregate, at higher risk for poor social and emotional health and poor early school outcomes. Entry points through Part C and CAPTA have already been described. However, working across multiple systems, states could provide incentives for community planning for all high-risk young children, as, for example, has been done in Pima County, Arizona.[70]

9) **Finance two-generation strategies and parent-child interventions that can give two-for-one results.**

The financing for two-generation strategies is reportedly one of the biggest challenges in developing services and supports to improve social and emotional health and

school readiness. Flexible funding sources, such as Title V, SSBG, and SAPTBG, offer opportunities to finance services otherwise uncovered. In addition, some smaller programs are targeted at specific risk factors—domestic violence, child abuse, or substance abuse. Similarly, developing partnerships among agencies that do not usually partner (e.g., mental health, early childhood, and domestic violence, substance abuse, and mental health agencies serving adults) to fund cross-generational service initiatives could provide an important jump start to increasing state capacity to serve the more vulnerable.

States also might:

- Require a parent-child, relationship-based, family support approach in all programs for young children.
- Identify existing financing that can be used for parent-related services (e.g., treatment for maternal depression, substance abuse).
- Create special programs (with blended or new funding) for parent-child dyads who have experienced extreme social/family distress (e.g., party or witness to violence, incarceration, abuse).

10) **Monitor children at risk but not yet eligible for entitlement programs and link them to existing services. This might lead to establishment of a high-risk young child tracking program to monitor all at-risk children from birth to age 5, following an adverse report or screen.**

A high-risk young child tracking program might imitate the design of a state's high-risk newborn tracking program. Such a project might include a follow-up database linked to case management, reminders, and ongoing assessments. It might be funded through a combination of administrative dollars from IDEA, Title IV-B, Title IV-E, and Medicaid. Models for structuring a follow-up database might be found in the state's Part C, birth defects, lead screening, and/or newborn screening programs.

Several existing mechanisms could be used by states to finance efforts for monitoring the status of young children at risk. For example:

- Part C regulations permit those states not serving at-risk children (all except nine states) to use IDEA money to identify, evaluate, refer, and conduct periodic follow-up to determine changes in children's status.
- For the youngest children identified through the child welfare system, monitoring could become a routine activity financed jointly by IDEA, Title IV-B, and Title IV-E.
- For children whose EPSDT periodic screening exams indicate a high risk for social, emotional, or developmental delays, state Medicaid agencies should finance more frequent interperiodic screening to assess their progress and indicate if a need for treatment arises.
- Families of young children referred to IDEA Part C programs who do not yet have a delay sufficient to qualify for eligibility could be offered reassessment at appropriate intervals.

Conclusion

Most states are facing fiscal challenges across a broad range of programs, and federal support for core programs that are the lifeline for low-income children and families is shrinking. At the same time, in every state, considerable resources targeted to young children in need do exist. Strategic fiscal planning to maximize the impact of these resources as well as to target funds for intentional interventions before serious problems escalate is key, especially for young children. Preventing early school failure in young children at risk for poor social and emotional development is too important for their future and the future of this country to leave to chance.

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28. See Centers for Medicare and Medicaid Services for specific state eligibility levels <www.cms.gov>.

29. Under federal law, states have flexibility to cover pregnant women and women with children at income levels up to or beyond poverty. Using Medicaid waiver programs and options under the SCHIP program, states also may extend coverage to low-income parents with children. These options are applied in various ways across the country. Notable examples are Illinois, Minnesota, Washington State, and Wisconsin See National Center for Children in Poverty state databases at <www.nccp.org>.

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35. See Section 1905 of the Social Security Act.

36. See The Center for Prevention & Early Intervention Policy at the University of Southern Florida: www.cpeip.fsu.edu/ and also Lynch, T. & Harrington, J. (2003). *Cost benefit analysis of the Florida Infant & Young Child Mental Health Pilot Project*. Tallahassee, FL: Center for Economic Forecasting and Analysis (CEFA).

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38. As of October 2004, more than 20 states were using both Medicaid and non-Medicaid SCHIP plans, sometimes referred to as combination programs. Only 18 states have only separate SCHIP plans, that is, these states do not enroll the near-poor, uninsured children who qualify for SCHIP into Medicaid. For the latest SCHIP plans, see the official federal government map at <www.coms.hhs.gov/schip/chip-map.pdf>.

39. See National Conference of State Legislatures (NCSL). *State Health Tracking Reports* <www.ncsl.org/programs/pubs/shnmain.htm>.

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Appendix 1: The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers

Below are a set of questions for state officials, families, advocates, and practitioners that can help drive a strategic approach to strengthening social and emotional school readiness and building early childhood mental health capacity. No state has implemented all of these recommendations, but together they provide a framework for prioritizing state and local action.

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

1. Does your state have a cross-agency strategic planning group to build strategic early childhood mental health capacity? Does the planning group:
   - Include families? Providers?
   - Link to a larger early childhood/school readiness planning process?
   - Include a dedicated fiscal planning group?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

2. Does the state cross-agency strategic agenda include explicit efforts to build overall system capacity? Does your state:
   - Map how each system currently supports prevention, early intervention, and treatment services?
   - Map gaps in existing community-based programs or early childhood mental health initiatives across the state?
   - Create incentives for community-based, cross-agency training initiatives?
   - Implement targeted collaborations across IDEA Part C (Individuals with Disabilities Education Act), child welfare, and early childhood programs?
   - Build common definitions across programs for young children at risk of early school failure and/or developing social and emotional disorders?
   - Ensure family/two-generation treatment for the most vulnerable (e.g., promoting collaboration across child and adult mental health, substance abuse, and domestic violence programs)?
   - Pay for treatment for adults in the context of home visiting programs and comprehensive early childhood programs?
   - Use smaller grant programs strategically to promote system-building capacity (e.g., Foundations for Learning; Safe and Drug Free Schools; Early Learning Opportunities; and Good Start, Grow Smart)?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

3. Is your state maximizing the impact of Medicaid/SCHIP? Does your state:
   - Require/permit EPSDT age-appropriate screening and diagnostic tools for infants, toddlers, and preschoolers that are sensitive to social, emotional, and behavioral issues?
   - Pay for covered services delivered in a range of community-based settings?
   - Include separate definitions and billing codes for developmental assessment/screening and diagnostic evaluations?
   - Use state matching funds strategically with Medicaid to support behavioral and mental health consultation in child care and home visiting programs?
   - Provide reimbursement for parent-child therapy?
   - Cover necessary services for social and emotional needs under the SCHIP benefits package?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

4. Is your state maximizing the impact of Title V Maternal and Child Health Services Block Grant? Does your state:
   - Use Title V's flexible funding strategically to cover services and supports for families and other caregivers that cannot be provided through Medicaid (e.g., cross-training)?
   - Explicitly include children who are at increased risk for developmental, behavioral, or emotional challenges according to the state definition of Children with Special Health Care Needs (CSHCN)?
   - Maximize the potential of the State Early Childhood Comprehensive Systems (ECCS) planning grants, including a focus on the most vulnerable?
   - Use the flexibility under Title V to develop and/or finance programs for maternal depression or other two-generation treatment strategies?

Appendix 1: The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers *(continued)*

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

5. Is your state maximizing the impact of the Child Care and Development Fund (CCDF) to promote social and emotional health and school readiness? Does your state:
   - Define explicit strategies to promote social and emotional health and school readiness competencies in children and improve the skills of caregivers in the state's CCDF plan?
   - Use CCDF funds to support training for the early childhood community on social, emotional, and school readiness issues?
   - Ensure that the highest-risk young children are in high-quality child care settings?
   - Use CCDF funds to support early childhood mental health consultation through the quality set-aside? Use other funds?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

6. Is your state maximizing the potential of special education programs on behalf of infants and toddlers at risk of developmental delays and on behalf of preschoolers with identified disabilities? Does your state:
   - Ensure appropriate social and emotional assessments in IDEA Part C Child Find screening activities, as well as in comprehensive, developmental, multidisciplinary evaluations?
   - Use the option to extend IDEA Part C eligibility to at-risk infants and toddlers, with emphasis on social, emotional, and environmental risk factors?
   - Identify infants and toddlers exposed to substance abuse, domestic violence, and maternal depression as a high-risk group? Extend eligibility for Part C services?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

7. Is your state maximizing the impact of the new CAPTA amendments? Does your state:
   - Require collaboration across public health agencies, child protection systems, and community-based programs to provide child abuse and neglect prevention as well as treatment services?
   - Have a mechanism to ensure that screenings of young children at risk who have experienced abuse or neglect and/or witnessed domestic violence lead to interperiodic reviews, assessments, and/or referrals for early intervention?
   - Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program?

☐ Yes, done
☐ Under development _____
☐ Needs effort _____

8. Does your state maximize the impact of programs serving the most vulnerable families with young children? Does your state:
   - Use Title IV-B funding to create two-generation child mental health and behavioral interventions for families with young children in or at risk for foster care placement?
   - Use TANF grant dollars for family counseling, service coordination, substance abuse treatment, family support, and training activities?
   - Transfer TANF funds to the CCDF or the SSBG to jump-start behavioral and mental health early childhood consultation strategies?
   - Strategically use funds from family violence/domestic violence, substance abuse, prevention, treatment, and community-based family resource and support to promote treatment and two-generation strategies targeted to families with young children?

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
HEALTH AND MENTAL HEALTH PROGRAMS						
Medicaid/EPSDT	• Promote use of screening tools that are appropriate for identifying social and emotional concerns among young children. • Provide EPSDT screens (that include social, emotional, and behavioral components) for every child within 60 days of enrollment. Then, provide ongoing periodic screening, along with necessary interperiodic screening, diagnosis, and medically necessary treatment. • Differentiate developmental screening conducted as part of an EPSDT screen from a developmental diagnostic assessment (evaluation) conducted by a medical social worker, public health nurse, or developmental pediatrician.	• Finance more frequent interperiodic screening to monitor the status of children whose EPSDT periodic screening exams indicate high risk for social, emotional, or developmental problems.	• Use EPSDT to provide financing for a broad array of child development and mental health services for young children. • Finance early childhood mental health consultation for individual children. • Adopt clear language in Medicaid to denote parent-child treatment coverage in the case of children younger than age 6. • Clarify which services are covered under managed care and/or behavioral health contracts. • Define and finance medically necessary and appropriate services for young children with social, emotional, and behavioral risk factors. • Clarify the financing for at-risk children who may not yet qualify for mental health benefits. For example, define categories of at-risk children who may qualify for intensive home visits, child care consultation, or parent-child assessment. • Use billing codes tailored to young children's conditions (using DC: 0–3) to reduce unnecessary spending, minimize fraud, and maximize early intervention.	• Clarify which young children are eligible for services under Medicaid behavioral health "carve-outs." • Clarify financing (i.e., who pays for what) when children have dual eligibility in Medicaid and Part C.	• Medicaid funds are generally *not* available to finance training of professionals. • Include licensed psychologists and social workers who provide services to young children as "qualified providers." • Offer adequate compensation for developmental and mental health services for young children.	• Use state-level, interagency planning and rulemaking to clarify and coordinate Medicaid financing.

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
HEALTH AND MENTAL HEALTH PROGRAMS						
SCHIP—separate non-Medicaid			• Cover necessary services for social and emotional needs under the SCHIP benefit package. • Use a broad definition of medical necessity, as in Medicaid/EPSDT. • Adopt legislation or rules to ensure mental health parity in SCHIP coverage.	• Do not reduce eligibility when funds are low. If eligibility limits are necessary, maintain waiting lists and inform families when eligibility is reopened.	• SCHIP funds are not available to finance training of professionals.	
Title V Maternal and Child Health (MCH) Block Grant			• Use funds to support colocation of social work or child development staff in pediatric offices and clinics. • Use funds to support early childhood mental health program consultation. • Use the flexibility under Title V to develop or finance screening and/or treatment programs for maternal depression.	• Expand the definition of "special needs" to include young children with identified social and emotional risk factors.	• Use flexible funds for professional, cross-system training. • Promote use of the Bright Futures mental health guidelines for pediatric care. • When advancing the medical home concept, identify providers with the capacity to screen and coordinate services for young children with social and emotional risk factors.	• Apply for special project funding. • Use Title V role to integrate services better (e.g., combined training, pooled funding streams, and consolidated service contracts). • Where the same agency administers both the Part C Early Intervention program and the Program for Children with Special Need, use this opportunity to better integrate services (e.g., combined training, pooled funding streams, and consolidated service contracts). • If the Title V agency does not administer the Part C program, develop interagency linkages.

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
HEALTH AND MENTAL HEALTH PROGRAMS						
Community Health Centers	• Provide screening and assessment as part of or in addition to well-child exams. • Use nonphysician staff to offer more in-depth assessment of child development and social and emotional risk factors.	• Develop and use high-risk tracking projects. • Develop referral linkages to and from Part C, CAPTA, Head Start, and other programs.	• Identify families with parental risk factors (e.g., maternal substance abuse or depression) and parent-child interventions, for a two-generation strategy. • Colocate social work or child development staff in pediatric offices and clinics.	• Join efforts to develop and implement shared definitions of at-risk children.	• Participate in joint training efforts to augment capacity.	
Community Mental Health Services Block Grant (CMHS)	• Provide professional support and technical assistance for screening and diagnostic activities.		• Give priority to financing mental health services for young children and their parents. • Use a portion of state block grant funds to increase early childhood mental health capacity in community mental health centers. For example, block grant funds could be allocated for center-level awards to start early childhood mental health projects with parent-child assessment, intervention, and/or consultation services. • Designate a portion of state block grant funds to be used for early intervention and treatment of young children with mental health conditions. • Seek approval to use Child Mental Health Services Initiative funding for activities focused on prevention of severe emotional disturbance (SED) among young children.	• Clarify eligibility rules to include children starting at birth.	• Use flexible funds for professional, cross-system training. • Use funds to increase early childhood mental health capacity in community mental health centers.	

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
EARLY CHILDHOOD CARE AND EDUCATION PROGRAMS						
Head Start and Early Head Start	• Offer developmental and social and emotional screening on site. • Identify families at high risk through family-focused screening and assessment.	• Use and enhance the skills of parent-involvement coordinators, family resource staff, and parent educators. • Develop more intensive, augmentative strategies to assist children whose families have multiple risk factors beyond poverty (e.g., low parental education, contact with child welfare, older siblings with poor school performance).	• Increase the number of Head Start and Early Head Start programs with state supplemental funds, if necessary. • Use early childhood mental health consultation to improve competencies of the children and the skills of the teacher/caregivers in Head Start.	• If Head Start and Early Head Start enrollment is limited by lack of funding, include children and families at high social risk as high priority groups.	• Use flexible funds for professional, cross-system training. • Use Head Start training dollars to improve teacher skills in promoting social and emotional health.	
Child Care and Development Fund			• Use child care quality funds for early childhood mental health consultation.	• Give priority to children and families being simultaneously served by the child welfare system.	• Use flexible funds for professional, cross-system training.	• Blend federal, state, and local child care quality funds to promote services for social-emotional development and school readiness to low-income, high-risk children. • Where available, use state general revenue funds appropriated for child care as a match for federal Medicaid dollars to finance mental health consultation to individual children in child care settings.

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
Special Education Programs						
IDEA Part C	• Ensure age-appropriate social and emotional screening as part of Child Find. • Ensure quality of the social and emotional component of each multidisciplinary evaluation for every infant and toddler identified through screening as potentially eligible. • Require a Part C assessment for all children from birth to age 3 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.	• Strengthen mechanisms for referrals to Child Find for infants and toddlers with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system. • Offer reassessment at appropriate intervals for young children referred to Part C who have risk factors but not yet a delay sufficient to make them eligible. • For at-risk children not yet eligible for Part C, monitor their developmental status through identification, evaluation, referral, and ongoing periodic follow-up.	• Specify interventions for social and emotional needs in the Individualized Family Service Plan (IFSP), as appropriate. • Measure the percentage of infants and toddlers with Part C IFSPs who demonstrate improved positive social-emotional skills (including social relationships) and use of appropriate behaviors to meet their needs. Such measurement is part of a new indicator under Part C and will be required starting with FFY 2005.	• Use the option to extend eligibility to infants and toddlers at risk without early intervention, with emphasis on social and environmental risk factors. • Include "atypical development based on clinical judgment" as one eligibility category. • Part C regulations permit those states not serving at-risk children (all except nine states) to use IDEA money to identify, evaluate, refer, and conduct periodic follow-up to determine changes in children's status. • Clarify financing for children with dual eligibility in Medicaid and Part C.	• Use training funds from Part B as part of a blended funding strategy for cross-training professionals.	• Merge Part C and Part B preschool programs to provide a continuum of services and early interventions to all children ages birth to 5.
IDEA Part B Preschool Special Education	• Jointly, with Part C, monitor to ensure that appropriate social and emotional assessments are included as part of Child Find.	• Strengthen mechanisms for referrals to Child Find for children aged 3 to 5 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.			• Use flexible funds for professional, cross-system training. • Make funds available for training in early childhood mental health and social and emotional well-being.	• Merge Part C and Part B preschool programs to provide a continuum of services and early interventions to all children ages birth to 5.

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
OTHER PROGRAMS FOCUSED ON EARLY LEARNING AND SCHOOL SUCCESS						
Safe and Drug-Free Schools		• Build linkages to facilitate referrals among mental health, substance abuse, and early intervention programs.	• Working in partnership with local law enforcement, justice, and mental health agencies, local education authorities (LEAs) may request referrals and treatment of young children whose parents have identified substance abuse problems. • In community plans, include specific actions directed to serving children ages 3 to 5 with mental health needs attending preschool and preschool special education programs.		• Use flexible funds for professional, cross-system training.	• During the process of developing community-level plans and agreements for mental health services, review the availability of mental health services for young children at risk.
Even Start		• Use contacts with families as an opportunity to enhance caregiver skills and parent knowledge of child development.				• Use the required performance objectives process to set goals promoting social development along with literacy.
Foundations for Learning Grants				• Use to guide development of statewide definition for at-risk children.	• Use flexible funds for professional, cross-system training.	• Use community-level grants to deliver services, coordinate resources, and build toward a system of care.

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
PROGRAMS SERVING CHILDREN IN OR AT RISK OF INVOLVEMENT WITH CHILD WELFARE						
Child Abuse Prevention and Treatment Act (CAPTA)	• Require a Part C assessment for all children from birth to age 3 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system	• Strengthen mechanisms for referrals to Child Find for infants and toddlers with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.			• Use flexible funds for professional, cross-system training. • Contract with child mental health professionals to complete the social and emotional assessment of children referred to IDEA Part C Early Intervention programs under CAPTA rules. This is an approach states have used often for children with physical disabilities.	• Act on opportunity created by new CAPTA rules to develop a systematic approach to referral and assessment of young children at-risk who have experienced abuse or neglect and/or witnessed domestic violence. • Given overlapping eligibility, establish general rules regarding which services will be financed by child welfare, Medicaid, and Part C.
Title IV–B Child Welfare Services and Promoting Safe and Stable Families	• Provide EPSDT screening for children served under the Title IV-B program according to the state's schedule for periodic screening, along with additional necessary interperiodic screening, diagnosis, and medically necessary treatment.	• Establish new programs using a two-generation intervention model designed to provide parent-child mental health and behavioral interventions for families with young children.			• Use administrative funds as part of financing for professional, cross-system training.	• Include participating children birth to age 6 in a statewide early childhood high-risk tracking effort.
Title IV–E Foster Care and Adoption Assistance	• Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program to determine whether or not they meet eligibility rules. • Structure and finance EPSDT screens within 60 days after children enter foster care. Ongoing screening could then be provided according to a state's schedule for periodic screening, along with additional necessary interperiodic screening and medically necessary treatment.				• Use Title IV-E training funds as part of cross-system training efforts.	

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
OTHER PROGRAMS TO SERVE CHILDREN AND FAMILIES FACING SOCIAL AND ECONOMIC RISKS						
TANF		• Use TANF grant dollars for family outreach, service coordination, and family support activities (e.g., creation of family resource centers, funding home visiting programs).	• Use funds for early childhood mental health consultation. • Use TANF funds to assist parents in securing substance abuse treatment, as part of their efforts to reduce dependency and prepare for work.		• Use flexible funds for professional, cross-system training.	• Transfer TANF funds to the CCDF or the SSBG to fund additional activities in child care and family support.
Social Services Block Grant (SSBG)		• Use funds as part of financing for family resource centers, community action agencies, and other centers that can provide outreach and referrals for families and young children at risk.	• Use flexible funds for early childhood mental health consultation.		• Use flexible funds for professional, cross-system training.	• Transfer funds to the Title V MCH program, when it has been selected as a hub for planning, training, or coordination of the early childhood system of care. • Transfer funds to the state mental health agency, when it serves as the base for an early childhood mental health initiative.
Community-based Family Resource and Support Grants			• Create or augment community-based, family-centered, family resource programs, and child abuse and neglect prevention through innovative funding mechanisms and broad collaboration with educational, vocational, rehabilitation, health, mental health, employment and training, child welfare, and other social services in the state.			

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
OTHER PROGRAMS TO SERVE CHILDREN AND FAMILIES FACING SOCIAL AND ECONOMIC RISKS						
Violence Against Women Act of 2001			• Provide assistance for transitional housing, including short-term housing assistance and support services to locate and secure permanent housing, and to integrate the individual or dependent into a community through transportation, counseling, child care services, case management, employment counseling, and other assistance.		• Provide child abuse training to judicial personnel and practitioners.	
Substance Abuse Prevention and Treatment Block Grant	• Provide screenings to children whose parents have substance abuse problems to assess their developmental needs.	• Use funds for substance abuse treatment programs to provide therapy, activities, pediatric care, immunizations, and other services to children with parents in treatment programs. • Use funds for prevention programs for children at risk of substance dependence. • Use funds to disseminate outreach information (e.g., availability of prevention programs, effects of substance abuse on families and children).	• Create children's groups for children with parents who are substance dependent or abusers. • Treat women who are pregnant and/or who have dependent children or are attempting to regain custody of their children. Services should include medical care for women (e.g., prenatal), child care, therapeutic interventions (for both women and children), and case management and transportation to ensure women and their children have access to services. • Develop a clearinghouse, information resource center, resource director, and/or information line to provide information on available family treatment and child abuse and neglect prevention services.		• Use funds to provide continuing education and training to staff who work with substance abuse treatment and prevention programs.	• Enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Activities include organizing, planning, enhancing and efficiency collaboration, coalition building and networking.

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

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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				

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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

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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	**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	

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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** 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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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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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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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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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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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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Organization Name	***Programs and Descriptions***	***Population Served***	***Ages Served***	***Capacity***	***Access Points***	***Funding***
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

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***
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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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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Health and Safety						
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

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***
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	

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 (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						

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***
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
DRAFT Resource Map of Programs and Services

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

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***
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
DRAFT Resource Map of Programs and Services

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.					

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REGISTER OF WAGE DETERMINATIONS UNDER THE SERVICE CONTRACT ACT
By direction of the Secretary of Labor

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
WAGE AND HOUR DIVISION
WASHINGTON D.C. 20210

Shirley F. Ebbesen Division of
Director Wage Determinations

Wage Determination No.: 2005-2103
Revision No.: 8
Date Of Revision: 05/26/2009

States: District of Columbia, Maryland, Virginia

Area: District of Columbia Statewide
Maryland Counties of Calvert, Charles, Frederick, Montgomery, Prince George's, St Mary's
Virginia Counties of Alexandria, Arlington, Fairfax, Falls Church, Fauquier, King George, Loudoun, Prince William, Stafford

Fringe Benefits Required Follow the Occupational Listing

OCCUPATION CODE - TITLE	FOOTNOTE	RATE
01000 - Administrative Support And Clerical Occupations		
01011 - Accounting Clerk I		14.05
01012 - Accounting Clerk II		15.78
01013 - Accounting Clerk III		20.27
01020 - Administrative Assistant		28.55
01040 - Court Reporter		19.95
01051 - Data Entry Operator I		14.38
01052 - Data Entry Operator II		15.69
01060 - Dispatcher, Motor Vehicle		16.94
01070 - Document Preparation Clerk		14.21
01090 - Duplicating Machine Operator		14.21
01111 - General Clerk I		13.92
01112 - General Clerk II		15.32
01113 - General Clerk III		18.74
01120 - Housing Referral Assistant		25.29
01141 - Messenger Courier		12.38
01191 - Order Clerk I		14.85
01192 - Order Clerk II		16.29
01261 - Personnel Assistant (Employment) I		17.31
01262 - Personnel Assistant (Employment) II		19.36
01263 - Personnel Assistant (Employment) III		21.66
01270 - Production Control Clerk		22.03
01280 - Receptionist		14.12
01290 - Rental Clerk		16.55
01300 - Scheduler, Maintenance		17.49
01311 - Secretary I		17.49
01312 - Secretary II		19.70
01313 - Secretary III		25.29
01320 - Service Order Dispatcher		16.10
01410 - Supply Technician		28.55
01420 - Survey Worker		19.46
01531 - Travel Clerk I		12.92
01532 - Travel Clerk II		13.89
01533 - Travel Clerk III		14.92
01611 - Word Processor I		14.21
01612 - Word Processor II		16.65
01613 - Word Processor III		19.95
05000 - Automotive Service Occupations		

05005 - Automobile Body Repairer, Fiberglass	25.26
05010 - Automotive Electrician	23.51
05040 - Automotive Glass Installer	22.15
05070 - Automotive Worker	22.15
05110 - Mobile Equipment Servicer	19.04
05130 - Motor Equipment Metal Mechanic	24.78
05160 - Motor Equipment Metal Worker	22.15
05190 - Motor Vehicle Mechanic	24.78
05220 - Motor Vehicle Mechanic Helper	18.49
05250 - Motor Vehicle Upholstery Worker	21.63
05280 - Motor Vehicle Wrecker	22.15
05310 - Painter, Automotive	23.51
05340 - Radiator Repair Specialist	22.15
05370 - Tire Repairer	14.44
05400 - Transmission Repair Specialist	24.78
07000 - Food Preparation And Service Occupations	
07010 - Baker	13.48
07041 - Cook I	11.97
07042 - Cook II	13.28
07070 - Dishwasher	9.82
07130 - Food Service Worker	10.66
07210 - Meat Cutter	17.04
07260 - Waiter/Waitress	9.70
09000 - Furniture Maintenance And Repair Occupations	
09010 - Electrostatic Spray Painter	18.05
09040 - Furniture Handler	12.78
09080 - Furniture Refinisher	18.39
09090 - Furniture Refinisher Helper	14.11
09110 - Furniture Repairer, Minor	16.31
09130 - Upholsterer	18.05
11000 - General Services And Support Occupations	
11030 - Cleaner, Vehicles	10.50
11060 - Elevator Operator	10.50
11090 - Gardener	16.22
11122 - Housekeeping Aide	11.25
11150 - Janitor	11.25
11210 - Laborer, Grounds Maintenance	12.47
11240 - Maid or Houseman	11.03
11260 - Pruner	11.37
11270 - Tractor Operator	14.66
11330 - Trail Maintenance Worker	12.47
11360 - Window Cleaner	11.68
12000 - Health Occupations	
12010 - Ambulance Driver	19.46
12011 - Breath Alcohol Technician	18.55
12012 - Certified Occupational Therapist Assistant	21.01
12015 - Certified Physical Therapist Assistant	21.01
12020 - Dental Assistant	16.97
12025 - Dental Hygienist	40.68
12030 - EKG Technician	25.95
12035 - Electroneurodiagnostic Technologist	25.95
12040 - Emergency Medical Technician	20.41
12071 - Licensed Practical Nurse I	18.82
12072 - Licensed Practical Nurse II	21.09
12073 - Licensed Practical Nurse III	23.47
12100 - Medical Assistant	14.89
12130 - Medical Laboratory Technician	18.04
12160 - Medical Record Clerk	16.06
12190 - Medical Record Technician	18.27
12195 - Medical Transcriptionist	18.77
12210 - Nuclear Medicine Technologist	34.18

12221 - Nursing Assistant I		10.47
12222 - Nursing Assistant II		11.77
12223 - Nursing Assistant III		13.02
12224 - Nursing Assistant IV		14.62
12235 - Optical Dispenser		20.17
12236 - Optical Technician		14.41
12250 - Pharmacy Technician		16.47
12280 - Phlebotomist		14.62
12305 - Radiologic Technologist		28.28
12311 - Registered Nurse I		26.73
12312 - Registered Nurse II		32.41
12313 - Registered Nurse II, Specialist		32.41
12314 - Registered Nurse III		38.98
12315 - Registered Nurse III, Anesthetist		38.98
12316 - Registered Nurse IV		46.73
12317 - Scheduler (Drug and Alcohol Testing)		19.75
13000 - Information And Arts Occupations		
13011 - Exhibits Specialist I		19.86
13012 - Exhibits Specialist II		24.61
13013 - Exhibits Specialist III		30.09
13041 - Illustrator I		20.48
13042 - Illustrator II		25.38
13043 - Illustrator III		31.03
13047 - Librarian		30.80
13050 - Library Aide/Clerk		14.21
13054 - Library Information Technology Systems Administrator		27.82
13058 - Library Technician		19.89
13061 - Media Specialist I		18.73
13062 - Media Specialist II		20.95
13063 - Media Specialist III		23.36
13071 - Photographer I		16.14
13072 - Photographer II		18.90
13073 - Photographer III		23.67
13074 - Photographer IV		28.65
13075 - Photographer V		30.69
13110 - Video Teleconference Technician		19.35
14000 - Information Technology Occupations		
14041 - Computer Operator I		18.54
14042 - Computer Operator II		20.74
14043 - Computer Operator III		23.12
14044 - Computer Operator IV		25.69
14045 - Computer Operator V		28.45
14071 - Computer Programmer I	(see 1)	25.43
14072 - Computer Programmer II	(see 1)	
14073 - Computer Programmer III	(see 1)	
14074 - Computer Programmer IV	(see 1)	
14101 - Computer Systems Analyst I	(see 1)	
14102 - Computer Systems Analyst II	(see 1)	
14103 - Computer Systems Analyst III	(see 1)	
14150 - Peripheral Equipment Operator		18.54
14160 - Personal Computer Support Technician		25.69
15000 - Instructional Occupations		
15010 - Aircrew Training Devices Instructor (Non-Rated)		35.71
15020 - Aircrew Training Devices Instructor (Rated)		43.84
15030 - Air Crew Training Devices Instructor (Pilot)		52.55
15050 - Computer Based Training Specialist / Instructor		34.39
15060 - Educational Technologist		32.75
15070 - Flight Instructor (Pilot)		52.55
15080 - Graphic Artist		26.80
15090 - Technical Instructor		25.08

15095 - Technical Instructor/Course Developer	30.67
15110 - Test Proctor	20.20
15120 - Tutor	20.20
16000 - Laundry, Dry-Cleaning, Pressing And Related Occupations	
16010 - Assembler	9.44
16030 - Counter Attendant	9.44
16040 - Dry Cleaner	12.21
16070 - Finisher, Flatwork, Machine	9.44
16090 - Presser, Hand	9.44
16110 - Presser, Machine, Drycleaning	9.44
16130 - Presser, Machine, Shirts	9.44
16160 - Presser, Machine, Wearing Apparel, Laundry	9.44
16190 - Sewing Machine Operator	13.07
16220 - Tailor	13.90
16250 - Washer, Machine	10.41
19000 - Machine Tool Operation And Repair Occupations	
19010 - Machine-Tool Operator (Tool Room)	19.22
19040 - Tool And Die Maker	23.38
21000 - Materials Handling And Packing Occupations	
21020 - Forklift Operator	17.90
21030 - Material Coordinator	22.03
21040 - Material Expediter	22.03
21050 - Material Handling Laborer	12.92
21071 - Order Filler	13.87
21080 - Production Line Worker (Food Processing)	17.90
21110 - Shipping Packer	14.46
21130 - Shipping/Receiving Clerk	14.46
21140 - Store Worker I	11.44
21150 - Stock Clerk	16.46
21210 - Tools And Parts Attendant	17.90
21410 - Warehouse Specialist	17.90
23000 - Mechanics And Maintenance And Repair Occupations	
23010 - Aerospace Structural Welder	25.68
23021 - Aircraft Mechanic I	24.46
23022 - Aircraft Mechanic II	25.68
23023 - Aircraft Mechanic III	26.97
23040 - Aircraft Mechanic Helper	16.61
23050 - Aircraft, Painter	23.42
23060 - Aircraft Servicer	18.71
23080 - Aircraft Worker	19.90
23110 - Appliance Mechanic	21.62
23120 - Bicycle Repairer	14.43
23125 - Cable Splicer	25.61
23130 - Carpenter, Maintenance	20.99
23140 - Carpet Layer	19.33
23160 - Electrician, Maintenance	27.43
23181 - Electronics Technician Maintenance I	23.70
23182 - Electronics Technician Maintenance II	25.15
23183 - Electronics Technician Maintenance III	26.50
23260 - Fabric Worker	19.01
23290 - Fire Alarm System Mechanic	22.78
23310 - Fire Extinguisher Repairer	17.52
23311 - Fuel Distribution System Mechanic	22.81
23312 - Fuel Distribution System Operator	19.38
23370 - General Maintenance Worker	21.43
23380 - Ground Support Equipment Mechanic	24.46
23381 - Ground Support Equipment Servicer	18.71
23382 - Ground Support Equipment Worker	19.90
23391 - Gunsmith I	17.52
23392 - Gunsmith II	20.38
23393 - Gunsmith III	22.78

23410 - Heating, Ventilation And Air-Conditioning Mechanic	22.94
23411 - Heating, Ventilation And Air Contditioning Mechanic (Research Facility)	24.37
23430 - Heavy Equipment Mechanic	22.78
23440 - Heavy Equipment Operator	22.78
23460 - Instrument Mechanic	22.59
23465 - Laboratory/Shelter Mechanic	21.62
23470 - Laborer	14.27
23510 - Locksmith	21.11
23530 - Machinery Maintenance Mechanic	22.99
23550 - Machinist, Maintenance	21.78
23580 - Maintenance Trades Helper	16.61
23591 - Metrology Technician I	22.59
23592 - Metrology Technician II	23.80
23593 - Metrology Technician III	24.96
23640 - Millwright	28.19
23710 - Office Appliance Repairer	22.96
23760 - Painter, Maintenance	21.62
23790 - Pipefitter, Maintenance	23.19
23810 - Plumber, Maintenance	20.99
23820 - Pneudraulic Systems Mechanic	22.78
23850 - Rigger	22.78
23870 - Scale Mechanic	20.38
23890 - Sheet-Metal Worker, Maintenance	22.78
23910 - Small Engine Mechanic	20.38
23931 - Telecommunications Mechanic I	27.74
23932 - Telecommunications Mechanic II	29.24
23950 - Telephone Lineman	26.38
23960 - Welder, Combination, Maintenance	22.78
23965 - Well Driller	22.78
23970 - Woodcraft Worker	22.78
23980 - Woodworker	17.52
24000 - Personal Needs Occupations	
24570 - Child Care Attendant	12.79
24580 - Child Care Center Clerk	17.77
24610 - Chore Aide	10.52
24620 - Family Readiness And Support Services Coordinator	15.68
24630 - Homemaker	18.43
25000 - Plant And System Operations Occupations	
25010 - Boiler Tender	27.10
25040 - Sewage Plant Operator	20.73
25070 - Stationary Engineer	27.10
25190 - Ventilation Equipment Tender	19.08
25210 - Water Treatment Plant Operator	20.73
27000 - Protective Service Occupations	
27004 - Alarm Monitor	20.57
27007 - Baggage Inspector	12.66
27008 - Corrections Officer	22.25
27010 - Court Security Officer	23.33
27030 - Detection Dog Handler	20.57
27040 - Detention Officer	22.25
27070 - Firefighter	22.39
27101 - Guard I	12.66
27102 - Guard II	20.57
27131 - Police Officer I	26.14
27132 - Police Officer II	28.99
28000 - Recreation Occupations	
28041 - Carnival Equipment Operator	13.59
28042 - Carnival Equipment Repairer	14.63

28043 - Carnival Equpment Worker		9.24
28210 - Gate Attendant/Gate Tender		13.01
28310 - Lifeguard		11.59
28350 - Park Attendant (Aide)		14.56
28510 - Recreation Aide/Health Facility Attendant		10.62
28515 - Recreation Specialist		18.04
28630 - Sports Official		11.59
28690 - Swimming Pool Operator		18.21
29000 - Stevedoring/Longshoremen Occupational Services		
29010 - Blocker And Bracer		23.13
29020 - Hatch Tender		23.13
29030 - Line Handler		23.13
29041 - Stevedore I		21.31
29042 - Stevedore II		24.24
30000 - Technical Occupations		
30010 - Air Traffic Control Specialist, Center (HFO)	(see 2)	38.00
30011 - Air Traffic Control Specialist, Station (HFO)	(see 2)	26.21
30012 - Air Traffic Control Specialist, Terminal (HFO)	(see 2)	28.86
30021 - Archeological Technician I		18.93
30022 - Archeological Technician II		21.11
30023 - Archeological Technician III		27.56
30030 - Cartographic Technician		27.56
30040 - Civil Engineering Technician		24.01
30061 - Drafter/CAD Operator I		19.89
30062 - Drafter/CAD Operator II		22.25
30063 - Drafter/CAD Operator III		24.80
30064 - Drafter/CAD Operator IV		30.52
30081 - Engineering Technician I		21.63
30082 - Engineering Technician II		24.29
30083 - Engineering Technician III		27.17
30084 - Engineering Technician IV		33.66
30085 - Engineering Technician V		41.16
30086 - Engineering Technician VI		49.81
30090 - Environmental Technician		24.92
30210 - Laboratory Technician		23.38
30240 - Mathematical Technician		28.94
30361 - Paralegal/Legal Assistant I		21.36
30362 - Paralegal/Legal Assistant II		26.47
30363 - Paralegal/Legal Assistant III		32.36
30364 - Paralegal/Legal Assistant IV		39.16
30390 - Photo-Optics Technician		27.56
30461 - Technical Writer I		21.84
30462 - Technical Writer II		26.70
30463 - Technical Writer III		32.31
30491 - Unexploded Ordnance (UXO) Technician I		24.15
30492 - Unexploded Ordnance (UXO) Technician II		29.22
30493 - Unexploded Ordnance (UXO) Technician III		35.03
30494 - Unexploded (UXO) Safety Escort		24.15
30495 - Unexploded (UXO) Sweep Personnel		24.15
30620 - Weather Observer, Combined Upper Air Or Surface Programs	(see 2)	24.80
30621 - Weather Observer, Senior	(see 2)	27.56
31000 - Transportation/Mobile Equipment Operation Occupations		
31020 - Bus Aide		13.02
31030 - Bus Driver		18.95
31043 - Driver Courier		12.71
31260 - Parking and Lot Attendant		10.07
31290 - Shuttle Bus Driver		14.69
31310 - Taxi Driver		13.98
31361 - Truckdriver, Light		14.69
31362 - Truckdriver, Medium		17.18

31363 - Truckdriver, Heavy	18.42
31364 - Truckdriver, Tractor-Trailer	18.42
99000 - Miscellaneous Occupations	
99030 - Cashier	10.03
99050 - Desk Clerk	11.58
99095 - Embalmer	23.05
99251 - Laboratory Animal Caretaker I	11.30
99252 - Laboratory Animal Caretaker II	12.35
99310 - Mortician	31.73
99410 - Pest Controller	16.01
99510 - Photofinishing Worker	12.75
99710 - Recycling Laborer	16.82
99711 - Recycling Specialist	20.65
99730 - Refuse Collector	14.91
99810 - Sales Clerk	12.09
99820 - School Crossing Guard	13.43
99830 - Survey Party Chief	21.94
99831 - Surveying Aide	13.63
99832 - Surveying Technician	20.85
99840 - Vending Machine Attendant	14.43
99841 - Vending Machine Repairer	18.73
99842 - Vending Machine Repairer Helper	14.43

ALL OCCUPATIONS LISTED ABOVE RECEIVE THE FOLLOWING BENEFITS:

HEALTH & WELFARE: $3.35 per hour or $134.00 per week or $580.66 per month

VACATION: 2 weeks paid vacation after 1 year of service with a contractor or successor; 3 weeks after 5 years, and 4 weeks after 15 years. Length of service includes the whole span of continuous service with the present contractor or successor, wherever employed, and with the predecessor contractors in the performance of similar work at the same Federal facility. (Reg. 29 CFR 4.173)

HOLIDAYS: A minimum of ten paid holidays per year, New Year's Day, Martin Luther King Jr's Birthday, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day. (A contractor may substitute for any of the named holidays another day off with pay in accordance with a plan communicated to the employees involved.) (See 29 CFR 4174)

THE OCCUPATIONS WHICH HAVE NUMBERED FOOTNOTES IN PARENTHESES RECEIVE THE FOLLOWING:

1) COMPUTER EMPLOYEES: Under the SCA at section 8(b), this wage determination does not apply to any employee who individually qualifies as a bona fide executive, administrative, or professional employee as defined in 29 C.F.R. Part 541. Because most Computer System Analysts and Computer Programmers who are compensated at a rate not less than $27.63 (or on a salary or fee basis at a rate not less than $455 per week) an hour would likely qualify as exempt computer professionals, (29 C.F.R. 541. 400) wage rates may not be listed on this wage determination for all occupations within those job families. In addition, because this wage determination may not list a wage rate for some or all occupations within those job families if the survey data indicates that the prevailing wage rate for the occupation equals or exceeds $27.63 per hour conformances may be necessary for certain nonexempt employees. For example, if an individual employee is nonexempt but nevertheless performs duties within the scope of one of the Computer Systems Analyst or Computer Programmer

occupations for which this wage determination does not specify an SCA wage rate, then the wage rate for that employee must be conformed in accordance with the conformance procedures described in the conformance note included on this wage determination.

Additionally, because job titles vary widely and change quickly in the computer industry, job titles are not determinative of the application of the computer professional exemption. Therefore, the exemption applies only to computer employees who satisfy the compensation requirements and whose primary duty consists of:

(1) The application of systems analysis techniques and procedures, including consulting with users, to determine hardware, software or system functional specifications;

(2) The design, development, documentation, analysis, creation, testing or modification of computer systems or programs, including prototypes, based on and related to user or system design specifications;

(3) The design, documentation, testing, creation or modification of computer programs related to machine operating systems; or

(4) A combination of the aforementioned duties, the performance of which requires the same level of skills. (29 C.F.R. 541.400).

2) AIR TRAFFIC CONTROLLERS AND WEATHER OBSERVERS - NIGHT PAY & SUNDAY PAY: If you work at night as part of a regular tour of duty, you will earn a night differential and receive an additional 10% of basic pay for any hours worked between 6pm and 6am. If you are a full-time employed (40 hours a week) and Sunday is part of your regularly scheduled workweek, you are paid at your rate of basic pay plus a Sunday premium of 25% of your basic rate for each hour of Sunday work which is not overtime (i.e. occasional work on Sunday outside the normal tour of duty is considered overtime work).

HAZARDOUS PAY DIFFERENTIAL: An 8 percent differential is applicable to employees employed in a position that represents a high degree of hazard when working with or in close proximity to ordinance, explosives, and incendiary materials. This includes work such as screening, blending, dying, mixing, and pressing of sensitive ordance, explosives, and pyrotechnic compositions such as lead azide, black powder and photoflash powder. All dry-house activities involving propellants or explosives. Demilitarization, modification, renovation, demolition, and maintenance operations on sensitive ordnance, explosives and incendiary materials. All operations involving regrading and cleaning of artillery ranges.

A 4 percent differential is applicable to employees employed in a position that represents a low degree of hazard when working with, or in close proximity to ordance, (or employees possibly adjacent to) explosives and incendiary materials which involves potential injury such as laceration of hands, face, or arms of the employee engaged in the operation, irritation of the skin, minor burns and the like; minimal damage to immediate or adjacent work area or equipment being used. All operations involving, unloading, storage, and hauling of ordance, explosive, and incendiary ordnance material other than small arms ammunition. These differentials are only applicable to work that has been specifically designated by the agency for ordance, explosives, and incendiary material differential pay.

** UNIFORM ALLOWANCE **

If employees are required to wear uniforms in the performance of this contract (either by the terms of the Government contract, by the employer, by the state or local law, etc.), the cost of furnishing such uniforms and maintaining (by laundering or dry cleaning) such uniforms is an expense that may not be borne by an employee where such cost reduces the hourly rate below that required by the wage determination. The Department of Labor will accept payment in accordance with the following standards as compliance:

The contractor or subcontractor is required to furnish all employees with an adequate number of uniforms without cost or to reimburse employees for the actual cost of the uniforms. In addition, where uniform cleaning and maintenance is made the responsibility of the employee, all contractors and subcontractors subject to this wage determination shall (in the absence of a bona fide collective bargaining agreement providing for a different amount, or the furnishing of contrary affirmative proof as to the actual cost), reimburse all employees for such cleaning and maintenance at a rate of $3.35 per week (or $.67 cents per day). However, in those instances where the uniforms furnished are made of "wash and wear" materials, may be routinely washed and dried with other personal garments, and do not require any special treatment such as dry cleaning, daily washing, or commercial laundering in order to meet the cleanliness or appearance standards set by the terms of the Government contract, by the contractor, by law, or by the nature of the work, there is no requirement that employees be reimbursed for uniform maintenance costs.

The duties of employees under job titles listed are those described in the "Service Contract Act Directory of Occupations", Fifth Edition, April 2006, unless otherwise indicated. Copies of the Directory are available on the Internet. A links to the Directory may be found on the WHD home page at http://www.dol.gov/esa/whd/ or through the Wage Determinations On-Line (WDOL) Web site at http://wdol.gov/.

REQUEST FOR AUTHORIZATION OF ADDITIONAL CLASSIFICATION AND WAGE RATE {Standard Form 1444 (SF 1444)}

Conformance Process:

The contracting officer shall require that any class of service employee which is not listed herein and which is to be employed under the contract (i.e., the work to be performed is not performed by any classification listed in the wage determination), be classified by the contractor so as to provide a reasonable relationship (i.e., appropriate level of skill comparison) between such unlisted classifications and the classifications listed in the wage determination. Such conformed classes of employees shall be paid the monetary wages and furnished the fringe benefits as are determined. Such conforming process shall be initiated by the contractor prior to the performance of contract work by such unlisted class(es) of employees. The conformed classification, wage rate, and/or fringe benefits shall be retroactive to the commencement date of the contract. {See Section 4.6 (C)(vi)} When multiple wage determinations are included in a contract, a separate SF 1444 should be prepared for each wage determination to which a class(es) is to be conformed.

The process for preparing a conformance request is as follows:

1) When preparing the bid, the contractor identifies the need for a conformed occupation(s) and computes a proposed rate(s).

2) After contract award, the contractor prepares a written report listing in order proposed classification title(s), a Federal grade equivalency (FGE) for each proposed classification(s), job description(s), and rationale for proposed wage rate(s), including information regarding the agreement or disagreement of the authorized representative of the employees involved, or where there is no authorized representative, the employees themselves. This report should be submitted to the contracting officer no later than 30 days after such unlisted class(es) of employees performs any contract work.

3) The contracting officer reviews the proposed action and promptly submits a report of the action, together with the agency's recommendations and pertinent information including the position of the contractor and the employees, to the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor, for review. (See section 4.6(b)(2) of Regulations 29 CFR Part 4).

4) Within 30 days of receipt, the Wage and Hour Division approves, modifies, or disapproves the action via transmittal to the agency contracting officer, or notifies the contracting officer that additional time will be required to process the request.

5) The contracting officer transmits the Wage and Hour decision to the contractor.

6) The contractor informs the affected employees.

Information required by the Regulations must be submitted on SF 1444 or bond paper.

When preparing a conformance request, the "Service Contract Act Directory of Occupations" (the Directory) should be used to compare job definitions to insure that duties requested are not performed by a classification already listed in the wage determination. Remember, it is not the job title, but the required tasks that determine whether a class is included in an established wage determination. Conformances may not be used to artificially split, combine, or subdivide classifications listed in the wage determination.

PAST PERFORMANCE EVALUATION FORM

(Check appropriate box)

Performance Elements	**RATING** (See Rating Guidelines on Page 2)					
	5 – Excellent	**4** – Good	**3** – Acceptable	**2** – Minimally Acceptable	**1** – Poor	**0** – Unacceptable
Quality of Services/Work						
Timeliness of Performance						
Cost Control						
Business Relations						
Customer Satisfaction						

1. Name of Contractor being Evaluated: _____

2. Name & Title of Evaluator:_____

3. Signature of Evaluator:_____

4. Name of Evaluator's Organization:_____

5. Telephone Number of Evaluator:_____

6. Type of service received: _____

7. Contract Number, Amount and period of Performance _____

8. Remarks on Excellent Performance: Provide data supporting this observation. Continue on separate sheet if needed)

   _____

   _____

9. Remarks on unacceptable performance: Provide data supporting this observation. (Continue on separate sheet if needed)

   _____

   _____

RATING GUIDELINES

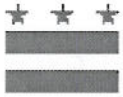
Summarize Contractor performance in each of the rating areas. Assign each area a rating of 0 (Unacceptable), 1 (Poor), 2 (Acceptable), 3 (Good), 4(Excellent), or ++ (Plus). Use the following instructions a guidance in making these evaluations.

	Quality Product/Service	**Cost Control**	**Timeless of Performance**	**Business Relations**
	-Compliance with contract requirements -Accuracy of reports -Appropriateness of personnel -Technical excellence	-Within budget (over/ under target costs) -Current, accurate, and complete billings -Relationship of negated costs to actual -Cost efficiencies -Change order issue	-Meet Interim milestones -Reliable -Responsive to technical directions -Completed on time, including wrap-up and -contract administration -No liquidated damages assessed	-Effective management -Businesslike correspondence -Responsive to contract requirements -Prompt notification of contract problems -Reasonable/cooperative -Flexible -Pro-active -effective contractor recommended solutions -Effective snail/small disadvantaged business Subcontracting program
0. Unacceptable	Nonconformances are comprises the achievement of contract requirements, despite use of Agency resources	Cost issues are comprising performance of contract requirements.	Delays are comprising the achievement of contract requirements, Despite use of Agency resources.	Response to inquiries, technical/ service/administrative issues is not effective and responsive.
1, Poor	Nonconformances require major Agency resources to ensure achievement of contract requirements.	Cost issues require major Agency resources to ensure achievement of contract requirements.	Delays require major Agency resources to ensure achievement of contract requirements.	response to inquiries, technical/ service/administrative issues is marginally effective and responsive.
2. Minimally Acceptable	Nonconformances require minor Agency resources to ensure achievement of contract requirements.	Costs issues require minor Agency resources to ensure achievement of contract requirements.	Delays require minor Agency resources to ensure achievement of contract requirements.	Responses to inquiries, technical/ service/administrative issues is somewhat effective and responsive.
3. Acceptable	Nonconformances do not impact achievement of contract requirements.	Cost issues do not impact achievement of contract requirements.	Delays do not impact achievement of contract requirements.	Responses to inquires, technical/ service/administrative issues is usually effective and responsive.
4. Good	There are no quality problems.	There are no cost issues.	There are not delays.	Responses to inquiries, technical/ service/administrative issues is effective and responsive,
5. Excellent	The contractor has demonstrated an exceptional performance level in some or all of the above categories.			

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Office of the Chief Financial Officer

Office of Tax and Revenue



TAX CERTIFICATION AFFIDAVIT

THIS AFFIDAVIT IS TO BE COMPLETED ONLY BY THOSE WHO ARE REGISTERED TO CONDUCT BUSINESS IN THE DISTRICT OF COLUMBIA.

Date

Authorized Agent
Name of Organization/Entity
Business Address (include zip code)
Business Phone Number

Authorized Agent
Principal Officer Name and Title
Square and Lot Information
Federal Identification Number
Contract Number
Unemployment Insurance Account No.

I hereby authorize the District of Columbia, Office of the Chief Financial Officer, Office of Tax and Revenue to release my tax information to an authorized representative of the District of Columbia agency with which I am seeking to enter into a contractual relationship. I understand that the information released will be limited to whether or not I am in compliance with the District of Columbia tax laws and regulations solely for the purpose of determining my eligibility to enter into a contractual relationship with a District of Columbia agency. I further authorize that this consent be valid for one year from the date of this authorization.

I hereby certify that I am in compliance with the applicable tax filing and payment requirements of the District of Columbia. The Office of Tax and Revenue is hereby authorized to verify the above information with the appropriate government authorities.

Signature of Authorizing Agent **Title**

The penalty for making false statement is a fine not to exceed $5,000.00, imprisonment for not more than 180 days, or both, as prescribed by D.C. Official Code §47-4106.

"THE LIVING WAGE ACT OF 2006"

Title I, D.C. Law No. 16-118, (D.C. Official Code §§ 2-220.01-.11)

Effective June 9, 2006, recipients of new contracts or government assistance shall pay affiliated employees and subcontractors who perform services under the contracts no less than the current living wage.

Effective January 1, 2008, the living wage rate is $12.10 per hour.

The requirement to pay a living wage applies to:

- All recipients of contracts in the amount of $100,000 or more; and, all subcontractors of these recipients receiving $15,000 or more from the funds received by the recipient from the District of Columbia, and,
- All recipients of government assistance in the amount of $100,000 or more; and, all subcontractors of these recipients of government assistance receiving $50,000 or more in funds from government assistance received from the District of Columbia.

"Contract" means a written agreement between a recipient and the District government.
"Government assistance" means a grant, loan or tax increment financing that result in a financial benefit from an agency, commission, instrumentality, or other entity of the District government.
"Affiliated employee" means any individual employed by a recipient who received compensation directly from government assistance or a contract with the District of Columbia government, including any employee of a contractor or subcontractor of a recipient who performs services pursuant to government assistance or contract. The term "affiliated employee" does not include those individuals who perform only intermittent or incidental services with respect to the contract or government assistance or who are otherwise employed by the contractor, recipient or subcontractor.

Certain exceptions may apply where contracts or agreements are subject to wage determinations required by federal law which are higher than the wage required by this Act; contracts for electricity, telephone, water, sewer other services delivered by regulated utility; contracts for services needed immediately to prevent or respond to a disaster or eminent threat to the public health or safety declared by the Mayor; contracts awarded to recipients that provide trainees with additional services provided the trainee does not replace employees; tenants or retail establishments that occupy property constructed or improved by government assistance, provided there is no receipt of direct District government assistance; 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 residential facility or a group home for mentally retarded persons; and contracts or other agreements between managed care organizations and the Health Care Safety Net Administration or the Medicaid Assistance Administration to provide health services.

Exemptions are provided for employees under 22 years of age employed during a school vacation period, or enrolled as a full-time student who works less than 25 hours per week, provided that other employees are not replaced, and for employees of nonprofit organizations that employ not more than 50 individuals.

Each recipient and subcontractor of a recipient shall provide this notice to each affiliate employee covered by this notice, and shall also post this notice concerning these requirements in a conspicuous site in the place of business.

All recipients and subcontractors shall retain payroll records created and maintained in the regular course of business under District of Columbia law for a period of at least 3 years.

This is a summary of the "Living Wage Act of 2006". For the complete text go to:
www.does.dc.gov *or* www.ocp.dc.gov

To file a complaint contact: **Department of Employment Services**
Office of Wage-Hour
64 New York Avenue, N.E., Room 3105, Washington, D.C. 20002
(202) 671-1880

"LIVING WAGE ACT OF 2006"

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*.), as amended, ("Living Wage Act of 2006") applies to all contracts for services in the amount of $100,000 or more in a 12-month period.

The Living Wage Act of 2006 requires a contractor to:

1. pay its employees and subcontractors who perform services under the contract no less than the current living wage rate;
2. 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;
3. provide a copy of the Living Wage Act Fact Sheet to each employee and subcontractor who performs services under the contract;
4. post the Living Wage Act Notice in a conspicuous place in its place of business;
5. include in any subcontract for $15,000 or more a provision requiring the subcontractor to post the Living Wage Act Notice in a conspicuous place in its place of business;
6. 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
7. require its subcontractors with subcontracts for $15,000 or more under the contract to 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.

EFFECTIVE JANUARY 1, 2008, THE CURRENT LIVING WAGE RATE IS $12.10.

Starting in 2008, the Department of Employment Services may adjust the living wage annually. The OCP will publish the current living wage rate on its website at www.ocp.dc.gov.

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*.

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 (i.e., if a contract is subject to the Service Contract Act and certain wage rates are lower than the District's current living wage, the contractor must pay the higher of the two rates);

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.

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 Act.

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.

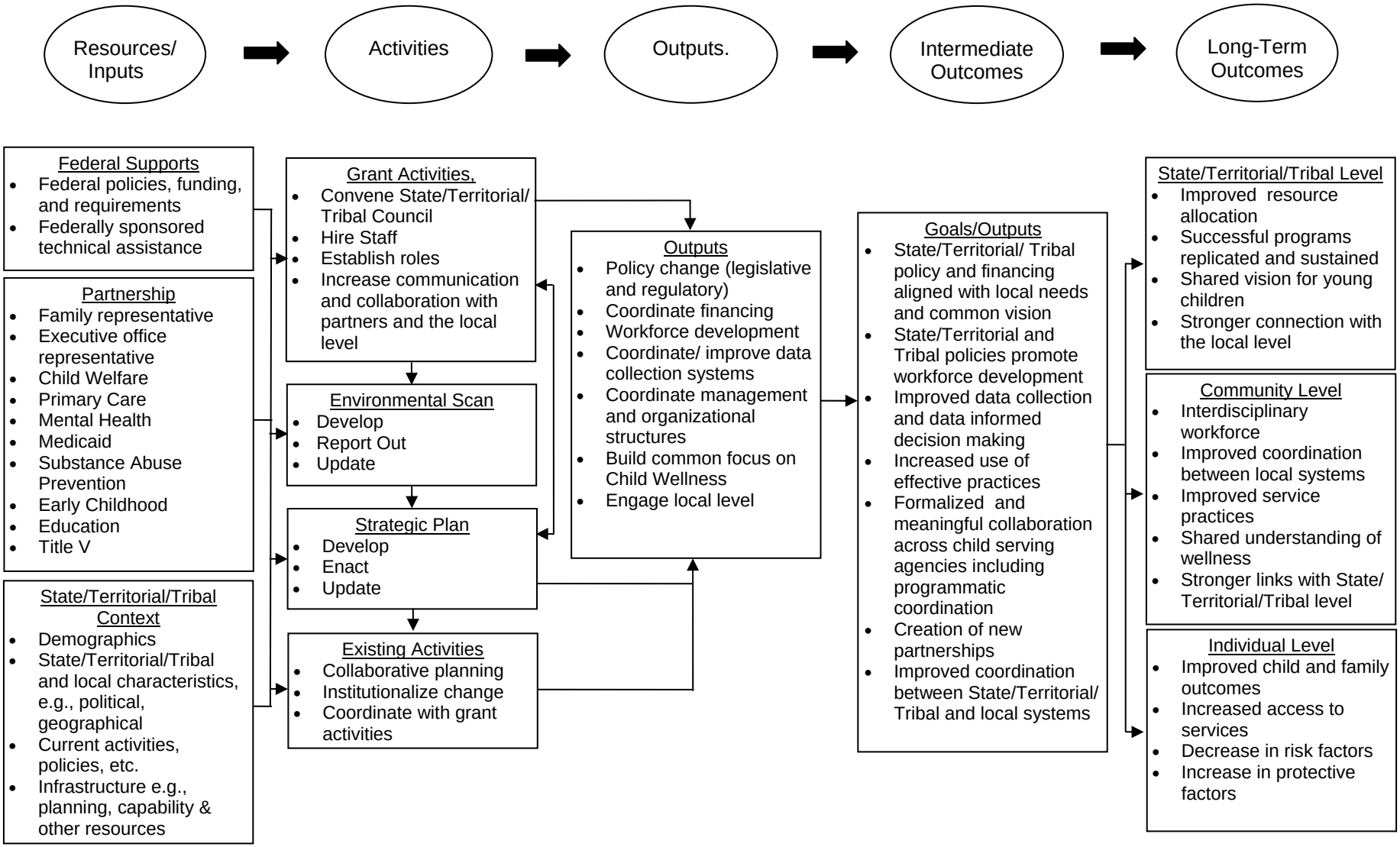
Sample Local Logic Model - Services

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.

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 **SUBMIT PROGRESS REPORT**		**Q4** **Q4**	**Q4** **Q4**	**Q4** **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

Integration grant in the effort to pilot a medical home initiative. *Primary Project*, which is an initiative of ICSIC, will use the screening tool T-CRS.

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.

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(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

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(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

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	