



**First Five Ventura
Annual Evaluation Report
Fiscal Year 2007 – 2008**

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EXECUTIVE SUMMARY

Introduction

The First 5 Ventura County (F5VC) FY 2007-2008 Annual Evaluation Report covers activities funded under the Commission's three strategic areas: (1) Early Learning; (2) Family Strengthening; and, (3) Health. These strategic areas are linked to desired outcomes and to a selected set of evaluation focus areas.

STRATEGIC AREAS, DESIRED OUTCOMES, AND EVALUATION FOCUS AREAS FOR 07-08		
Early Learning	<ul style="list-style-type: none"> Children are ready for kindergarten. 	⇒ Preschool ⇒ Early Learning for Parents and Children Together
Family Strengthening	<ul style="list-style-type: none"> Families are nurturing and supportive of their children. 	⇒ Service Coordination and Case Management ⇒ Mental Health
Health	<ul style="list-style-type: none"> Children have access to regular doctor/dentist for preventive care and treatment of chronic medical conditions. 	⇒ Health Insurance (Outreach, Enrollment, Utilization, and Retention) and Oral Health
	<ul style="list-style-type: none"> Children have access to developmental screenings as early as possible. Children have access to early intervention for identified special needs.¹ 	⇒ Developmental Screening

This report synthesizes information collected and maintained within the F5VC Grant Evaluation and Management Solution (GEMS) database; these data are supplemented with data received from the Ventura County Public Health and Behavioral Health Departments. After a description of the participants served by F5VC, the report addresses the selected evaluation focus areas, answering evaluation questions deemed important by F5VC staff and commissioners.

Data

F5VC programs collect information related to participant characteristics, service use and outcomes. This information, collected on paper forms, is entered into GEMS by program staff. Staff use different data collection procedures depending upon the type of services a participant receives. Services are considered *more-intense (more frequent)* or *less-intense (less frequent)*. More-intense services (e.g., preschool, developmental services) occur at least three times, require more fiscal and staff resources, and are associated with individual-specific data collection. Less-intense services (e.g., parent education workshops) occur once or twice, require fewer resources, and are associated with group-level data collection. In addition to data maintained in GEMS, summarized data reports were provided by Ventura County Behavioral Health and Ventura County Public Health Departments.

Participants

This year, 5,650 families received more-intense services from service providers.

- Nearly two-thirds (63.9%) had an annual family income of less than \$30,000.
- In one-tenth of families (10.5%) starting F5VC services, there was an expectant mother.
- On average, there were 1.6 children ages 0 - 5, and 4.3 family members per household.

Further, a total of 14,310 children were served.

- 4,433 children received more-intense services; 9,877 children received less-intense services.
- 52% of children receiving more-intense F5VC services were male and half were 3 years old or younger.
- 27.9% of children served were reported at intake to be uninsured.
- 74.2% were Latino; the next largest racial/ethnic group was White (13.2%).
- 5.8% of children had a disability or special need.

Finally, 612 providers received services offered at the Neighborhoods for Learning (NfL) programs and also through the CARES program. In services provided to programs outside of CARES, the largest group of provider participants consisted of Center-based Early Childhood Education (ECE) providers (32.5%), followed by Pediatric Health Care providers (29.5%).

Findings

Evaluation findings are organized by six evaluation focus areas. Within each area, offered services reflect local needs and environment. Generally, there is research evidence to support the use of such services to aid in the healthy development of young children, as outlined in this report. Evaluation questions and related benchmarks were established by F5VC and represent new aspects of the evaluation that were not present previously. Evaluation questions represent a focus on those aspects of service process and outcomes that are most important. The use of benchmarks is consistent with an approach where data guide improvement and change efforts. Answers to the evaluation questions and comparisons to the benchmarks are intended to help program staff, F5VC staff, and F5VC commissioners to identify services that are working as expected and to detect areas for program improvement. Data are then used to track the effect of program changes.

In each investment area, most goals are achieved and positive outcomes are demonstrated.

Preschool

- Providers are exceeding target numbers of children served (1,062 vs. 1,002, actual vs. target).
- Preschool spaces have been expanded in the County (68 vs. 48 newly created preschool spaces, actual vs. target).
- Preschool children are showing improvements in development after receiving preschool services (78% vs. 75% at 'building' or 'integrating' developmental levels, actual vs. target).
- Most providers (82%) are meeting their targeted number of preschool spaces in their program.

Early Learning for Parents and Children Together

- Several thousand parents/caregivers and children are receiving early learning activities to promote early learning, literacy, and parent/caregiver attachment/bonding (5,303 vs. 3,361 parents/caregivers and children, actual vs. target).
- Programs are serving the youngest children, those aged 0 – 3 years (832 vs. 590 0-3-year-old children, actual vs. target).
- Family literacy outcomes are positive – parents who receive services read at rates higher than state estimates (94% vs. 76% of parents are book-sharing at least 3 days/week, actual vs. state).

Service Coordination and Case Management

- Through service coordination and case management activities, a large number of children (2,049) and parents/caregivers (1,851) are receiving assistance in obtaining needed health and social services.
- Outcomes appear promising, though respondent data are limited. All respondents (n=16) indicated that, as a result of coordination and management support, they were able to access the services that they needed.

Mental Health

- Children are benefiting from mental health services.
 - Increases in social skills (from 17th percentile to 51st percentile) and decreases in problem behaviors (from 76th percentile to 54th percentile) are seen in children receiving preschool-based intervention.
 - Clinicians of children receiving community-based mental health services report fewer symptoms in children after services (social workers report 62% of children with fewer symptoms after treatment).
- Partnerships with Ventura County Behavioral Health (VCBH) and the Human Services Agency result in the successful implementation of needed mental health services.
 - 309 families were referred for mental health services through VCBH
 - 201 referred families went on to use mental health services by VCBH (65% vs. 40% of referred families, actual vs. target).

Health Insurance Enrollment and Oral Health

- Families are receiving oral health treatment services for their young children.
- Many children are being given fluoride varnish, effectively preventing tooth decay and promoting dental hygiene in young children (3,635 vs. 4,000 children, actual vs. target).
- Countywide, F5VC families are obtaining health insurance, facilitating access and utilization of health services by their children (1,123 vs. 1,265 children, actual vs. target).

Developmental Screening

- Over 900 children have had a developmental screening.
- Children whose developmental screening results suggest possible delay (243 out of 909, 27%) are being referred for further assessment.
- Of children with positive screens, the majority was referred to school districts (35%), Early Start (20%), Ventura County Public Health (17%), or Ventura County Behavioral Health (13%).

Conclusions

F5VC is meeting or exceeding most established benchmarks. Where benchmarks are missed, focused program improvement efforts that are informed by FY 07-08 evaluation results will help programs achieve their targets next year. There is evidence that some programs experienced challenges when implementing new services this year and this affected their ability to achieve service targets. It is expected that these barriers will not be experienced in the next fiscal year. The availability of data to address all evaluation questions and benchmarks must be addressed, in order to take full advantage of the evaluation framework. A plan to optimize data collection may require revisions to data collection instruments, procedures, and the introduction of new data collection strategies. Lastly, targeted benchmarks may need to be adjusted in accordance with most recent service experiences.

INTRODUCTION

Overview

The following serves as the First 5 Ventura County (F5VC) FY 2007-2008 Annual Evaluation Report, covering selected activities funded under the Commission's three strategic areas: (1) Early Learning; (2) Family Strengthening; and, (3) Health. The current report synthesizes information collected and maintained within the F5VC Grant Evaluation and Management Solution (GEMS) database; these data are supplemented with data received from the Ventura County Public Health and Behavioral Health Departments. Findings are organized into six evaluation focus areas. This year, a new evaluation framework was utilized to assess program progress toward goals set forth by the Strategic Plan. Priority was assigned to six programmatic areas (i.e., Preschool; Early Learning for Parents and Children Together; Service Coordination and Case Management; Mental Health; Health Insurance, Outreach, Enrollment, Utilization, and Retention and Oral Health; and Access to Developmental Screenings). F5VC invests in other activities (e.g., parent education workshops, child care provider training), though their progress and outcomes will not be presented in this report.

Background

Ventura County is home to approximately 794,412 residents, including an estimated 68,396 children aged 0-5 (2007). Many ethnic groups are represented in Ventura County. According to 2000 Census data, 47% of children 0-5 are Hispanic, 43% are Caucasian, 4% are Asian, 2% are African American, and approximately 4% are multi-racial.

Agriculture is prominent in shaping the culture, economy, and landscape within the County. Ventura County has a lower rate of unemployment and higher median income than statewide averages; however, a considerable number of children and their families are living in poverty (i.e., approximately 27% of children 0-5). Moreover, many more families considered "low to moderate income" struggle to meet basic needs and/or maintain economic self-sufficiency given the high costs of living in Ventura County, particularly related to housing (2005).

According to data collected in recent years through a parent survey, preschool and childcare are the two most frequently reported unmet needs. Parents of young children in Ventura County consistently cited three priorities: preschool, parent education, and access to services. Although significant progress had been made in Ventura County, many children start kindergarten without the basic social, emotional, and cognitive skills needed for success. Preschool participation rates in low-performing school districts, in particular, are well below average, and overall, preschool participation rates are low (less than 50%) (2005).

To address identified needs both locally and countywide, F5VC established funding priorities following a comprehensive and systematic planning and review process.

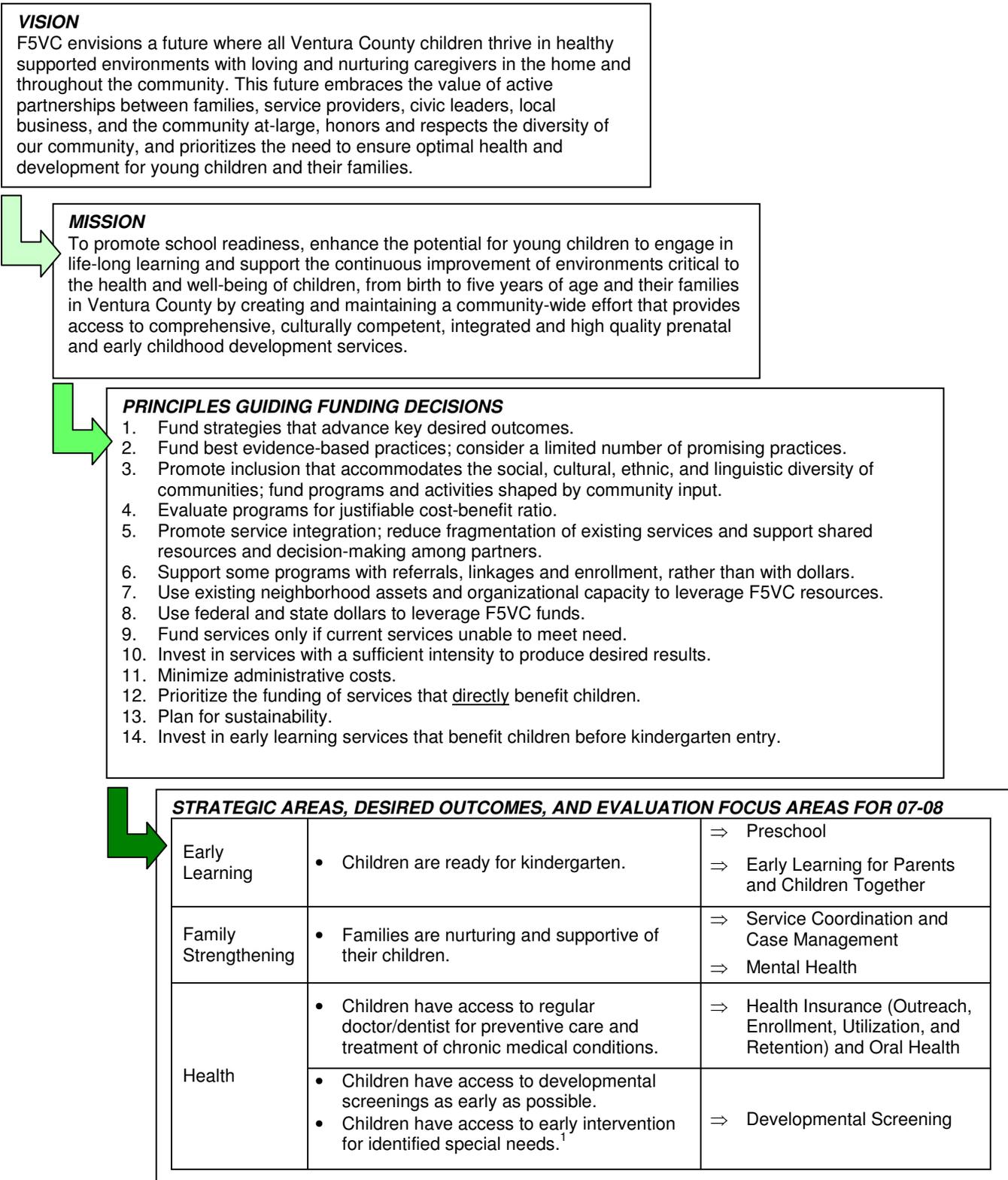
Planning

Governed by a nine-member Commission, which is appointed by the Ventura County Board of Supervisors, F5VC funding decisions are guided by a strategic planning process. The initial strategic plan for F5VC was adopted in 2000 with a renewal of strategic plan objectives in 2003. In 2005, the Commission embarked on an additional comprehensive strategic planning process, designed to re-evaluate all of its prior investments and to develop a new plan for 2005 – 2010. The Commission recognized that tobacco tax revenues were declining and likely would continue to decline; thus, it was determined that it was important to examine lessons learned, identify best practices, and ensure that available resources would be maximized and invested in those areas to ensure that desired outcomes are achieved.

In order to inform their planning process, the Commission looked at several key sources of information and existing research. First, the Commission examined the results from F5VC Annual Evaluation Reports, targeted studies conducted by the Commission's Center for Excellence, and the contributions of all of their funded partners. As noted above, a recent parent survey suggested three important family concerns: preschool, access to services and parent education. The Commission reviewed the body of relevant research to identify nationally recognized best practices that have been proven effective (the Pathways Mapping Initiative was used as a foundation) (Schorr 2005). Additionally, Commission committees provided valuable input and helped to develop new models of service delivery to best serve Ventura County's children and their families.

The F5VC Five-Year Strategic Plan (FY 2005 – 2010) was built upon past learning and practice, and further defines the specific outcomes that the Commission intends to achieve within broad-based strategy areas (2005). Based on research and evidence-based practices, investments were recommended for each desired outcome. Finally, an implementation strategy was outlined based on existing community capacity and the successes evidenced since the Commission was established. Excerpted from the 2005 – 2010 Strategic Plan, Figure 1 provides an overview of F5VC's Vision, Mission, and Principles Guiding Funding Decisions, as well as Strategic Areas, Desired Outcomes, and Evaluation Focus Areas for 07-08.

Figure 1: Moving from Vision to Desired Outcomes to Evaluation Focus Areas: 2005 – 2010



¹ In the strategic plan, this outcome is listed under the Early Learning strategic area. In the evaluation framework, this outcome is organized under the evaluation focus area of Developmental Screening, which is in the Health strategic area. For the purposes of this report, the outcome is presented per the evaluation framework.

F5VC Strategic Areas and Evaluation Focus Areas for 07-08

F5VC identified three strategic areas – Early Learning, Family Strengthening, and Health – and determined the desired outcomes for children 0-5 and their families. Within each strategy area, there are associated Best Investments – programs and activities that F5VC staff and the Commission believed would yield desired outcomes if supported. For 07-08, two evaluation focus areas were linked to each strategic area to help guide the annual evaluation and direct the assessment of program outcomes. It is important to note that there are many more programs and activities that are funded by F5VC that were not selected for this annual evaluation.

Early Learning

F5VC wants children to be ready for kindergarten. For the 07-08 year, progress toward this desired outcome has been facilitated by investment in

- Preschools
- Early learning opportunities for parents and children together/Family literacy

Family Strengthening

F5VC believes that children should live in families that are nurturing and supportive. For the 07-08 year, progress toward this desired outcome has been facilitated by investment in

- Service coordination and case management
- Mental health services

Health

F5VC prioritizes child access to health-related services including regular medical and dental care, developmental monitoring, and early intervention. For the 07-08 year, progress toward these desired outcomes has been facilitated by investment in

- Health insurance and oral health care
- Developmental screening

Evaluation Framework

To support effective funding decisions for its initiatives, F5VC developed and implemented a results-based accountability evaluation framework, which involves regular, periodic, and strategic data collection and analysis that allows F5VC to conduct evaluations. To this end, F5VC continues to use its data collection system software *Grant Evaluation and Management Solution* (GEMS), which organizes data on participants, services, and outcomes so that program-level contract monitoring and countywide evaluation can be conducted. Funded partners collect and enter data in GEMS, tracking the performance of their programs. Collected information includes participant socio-demographic data, services data, and outcomes data. Such quantitative data are collected at individual and group levels.

A key feature of the data collection system is that it supports *process evaluation* as well as *outcome evaluation* to examine the quantity and quality of services, and to explore trends over time. Outcomes measures reflect the desire of F5VC to demonstrate success in achieving its mission of school readiness, enhancing the potential of young children to engage in lifelong learning, and supporting the improvement of environments that influence child health and well-being.

In past reports, the evaluation framework highlighted participants (how many were served and their characteristics), services (what type of service and how much of that service was provided), and outcomes (improvements in early learning, family functioning, and health, as well as participant satisfaction levels). After the dissemination of the 2006-2007 Annual Evaluation Report in Winter 2008, F5VC program staff embarked on an effort to revise the current evaluation design and re-focus the evaluation questions to better address established priorities within the County. In collaboration with the F5VC Commission, a new evaluation framework was developed. This provides a new structure for the evaluation, and specific outcomes to the results-based accountability intention of the 2005-2010 Strategic Plan.

This report is structured to reflect the new evaluation framework. This framework was developed in the middle of the Fiscal Year 2007-2008 (FY 07-08), but was applied to services from the same fiscal year. No changes to data collection methods were implemented to accommodate for additional demands of this new evaluation framework. In instances where there was a mismatch between new data demands and existing data collection methods, it is noted in the report.

After a summary of data sources and participants served by F5VC, the findings are organized by evaluation focus areas, which are linked to the strategy areas and desired outcomes of the Strategic Plan. Within each evaluation focus area, relevant services are examined by key evaluation questions and benchmarks as established by the F5VC Commission and F5VC program staff. It is believed that the changes in this evaluation framework and report will produce a more informative document that will help to shape decisions about resource allocation and program development.

FY 2007-2008 Expenditures

According to the Annual Report Submittal – County Commission Revenues and Expenditures Summary for Fiscal Year 2007-2008 (July 1, 2007 – June 30, 2008), F5VC expended approximately \$11.4 million on program services in FY 07-08 compared with \$9.8 million in FY 06-07, reflecting an increase of \$1.6 million. The Commission completed its second year of its five-year strategic plan. Last year, lower amounts were expended as a result of new strategies that were implemented though issues related to start-up did not allow for programs to spend their full allocation by the end of the year. Higher expenditures were realized in FY 07-08 as a result of funding new programs and higher spending among grantees as programs reached full implementation in the second year of the strategic plan.

DATA

Data quality is dependent on a number of factors including staff, time, and training. These resources are precious and can be limited in service programs. It is rare to find a service organization where data are collected without error in procedure, or entered without inaccuracies. Data quality is an ongoing issue in agencies small and large, and can be particularly difficult across organizations, even when databases and tools are equivalent. Challenges associated with data activities (e.g., data collection, data entry, data uploads) can impact the overall quality of data within an agency, and ultimately across agencies.

Many agencies monitor data quality through quality improvement programs and staff who are dedicated specifically to maintaining and ensuring high data quality. Such programs require resources, which may be seen as 'taking away' from direct service provision; however, the maintenance of high data quality is vital for any planning and decision-making that is data-based. F5VC has made steps toward improving data quality by dedicating a staff person to train and support all funded partners in their efforts to collect and enter data. Furthermore, improvements in the completeness of data collected and entered has been seen in data used for this annual report. It is expected that continuing support and training as well as modifications to data collection and entry procedures will help to further improve data quality over the next few years.

Grant Evaluation Management System (GEMS)

In 2004, Mosaic Network, Inc. developed a database called GEMS to aid F5VC in collecting data across funded partners to inform stakeholders about the nature and outcomes of services. Funded partners collect program-level data including information specific to participants, services, satisfaction, and outcomes, and enter the data into GEMS. These data are then uploaded to a server held by Mosaic Network where data from all partners are merged together. These data are utilized by funded partners and F5VC for different purposes. Funded partner staff use GEMS for quarterly reporting to F5VC, grant writing, quality improvement, and program planning and evaluation activities. F5VC uses data from GEMS for contract monitoring and evaluation purposes, including the capture of information required as part of ongoing statewide evaluation and reporting efforts. Data contained in GEMS also can be useful for informing F5VC cross-initiative evaluation efforts.

Details concerning data collection instruments, data exports and data cleaning are provided in Appendix A. This evaluation employs descriptive and inferential statistics to analyze data entered into GEMS by funded programs. Specific descriptions of statistics utilized also are presented in Appendix A. FY 07-08 data were similar to FY 06-07 data in that outcome-specific data typically represented larger sample sizes. Greater numbers of data points are beneficial and accommodate inconsistencies, errors, or "noise" in the GEMS data set.

Comparisons to FY 06-07 were conducted only for data related to participants' demographic information. Significant changes in the evaluation design for FY 07-08 limited the number of comparisons to FY 06-07 service and outcomes data.

Participant-Level Data Collection

F5VC programs collect information related to participant characteristics, service use and outcomes. This information, collected on paper forms, is entered into GEMS by program staff. Staff use different data collection procedures depending upon the type of services a participant receives. Services are considered *more-intense* or *less-intense*. Typically, more-intense services occur three or more times and require more fiscal and staff resources (e.g., preschool, case management, developmental services). For more-intense services, demographic data are collected and a unique identifier is assigned to the recipient. This approach allows for a unique, or unduplicated, count of those participants who receive more-intense services. In addition, service use is recorded for each participant and outcome measures are collected, all of which are labeled with his/her unique identifier.

For those participants who receive less-intense services, no unique identifier is assigned and individual demographic data are not collected. The intention of less-intense services is to serve a large audience (e.g., distribution of Kits for New Parents). Collecting individual-level data would be burdensome for both participants and program staff as the intake process requires time and staff effort beyond what is required to provide the less-intense service itself. As such, limited demographics (e.g., age, ethnicity, family member type) are reported on a group level for each less-intense service activity. This method can produce duplicated data (i.e., individuals who receive a less-intense service more than once, or who receive other less-intense services). Because the data are collected in an aggregated way, individuals cannot be tracked or counted. Therefore, analyses of participant demographics are restricted to individuals who received more-intense services. In contrast, data presented related to the numbers of individuals who are served within each evaluation focus area include both more- and less- intensely served participants.

Though less-intense service recipients are not tracked individually, outcome measures are still collected and recorded for these services. Analyses of outcome data include participants who received more-intense services as well as those who received less-intense services when available.

Data Collection Instruments

Surveys designed for specific services were used when needed to address benchmarks within each best investment area. Previous evaluators developed these outcome surveys for the purpose of the countywide evaluation. In addition, several standardized measures were used for specific services this year: the Desired Results Developmental Profile, Revised (DRDP-R); the Ohio Scales (Ogles & Southern Consortium for Children, 2000), and the Preschool Kindergarten Behavior Scales, Second Edition (PKBS-2). These tools are used to measure the impact of preschool and mental health services and described in this report within the best investment areas where the measures were used.

Additional Data Sources

In FY 07-08, F5VC launched two new partnerships to provide mental health services and developmental screenings across the County. Ventura County Behavioral Health and Ventura County Public Health Departments, respectively, are now partners with F5VC and deliver these

important services to young children in the community. Both agencies provided summarized data reports rather than individual-level data on various aspects of their services. Data for the Ohio Scales, collected by Ventura County Behavioral Health staff, were provided for individual cases and supplemented with participant information from GEMS. For developmental screening services offered by the Ventura County Public Health Department, limited analyses of participant characteristics and outcomes data were performed.

PARTICIPANTS

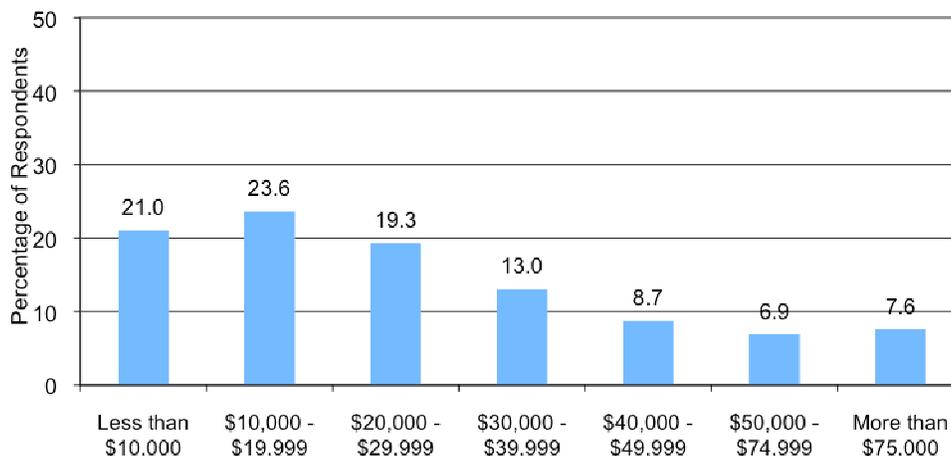
Children, parents/caregivers, and service providers receive different levels of service at F5VC-funded programs. The data presented in this section represents participants who received a more-intense level of service; that is, services that are provided three or more times. For more-intensely served participants, data are collected via the intake process. The intake includes documentation of demographic information (e.g., name, address, race/ethnicity, primary language used at home). In the case of less-intense services (where participants usually receive one-time assistance), program staff does not perform a formal intake where demographics are collected.

Findings presented below demonstrate that F5VC programs are reaching the children and families who are at greatest risk for not receiving needed services. In general, families have lower income and parents/caregivers have less education compared to the general population of the County. These factors place families at risk; that is, there are more obstacles to accessing and using services when a family has limited resources.

Families

Whether a single child is served, or multiple siblings and parents are served, programs collect family-level information at intake. This year, 5,650 families received more-intense services from service providers.² Of the families served who reported their family income (n=4,523), nearly two-thirds (63.9%) had an annual family income of less than \$30,000. Only 7.6% of families reported a family income of over \$75,000 (Figure 2). Based on 2007 inflation-adjusted U.S. Census information, the median household income in Ventura County was \$72,984.³ Thus, F5VC is serving a comparatively lower income population.

Figure 2. Distribution of Family Income FY 07-08 (n = 4,523⁴)



² Number of families served is an unduplicated count of families in which a child, a family member, or both received a service in FY 07-08.

³ Table B19013 of the 2005 – 2007 American Community Survey 3-Year Estimates, downloaded from <http://factfinder.census.gov/> on 1-15-09.

⁴ 1,127 families did not report their family income.

In about one-tenth of families (10.5%) that started F5VC services, there was an expectant mother. Families reported an average of 1.6 children ages 0 - 5, and an average of 4.3 family members per household.

In the next section, each type of participant group (child, family member or service provider) served by F5VC is described.

Child Participants

During FY 07-08, a total of 14,310 children were served. Based on data entered into GEMS, 4,433 children received more-intense services. According to F5VC records, an additional 9,877 children received less-intense services.

In FY 07-08, slightly more of the children receiving more-intense F5VC services were male (51.7%) than female; this distribution closely mirrors the make-up of the County per U.S. Census 2000 estimates (Table 2). More than one in five children served (27.9%) were reported at intake by their parent/caregiver to be uninsured. This is higher than county-wide findings from the California Health Interview Survey, which documented that about 10% of children 0 - 5 were uninsured at some point within the past year⁵. Three-quarters of the young children served by F5VC were Latino (74.2%), the next largest racial/ethnic group was White (13.2%); this compares to 47% Latino and 43% White countywide (as estimated by the U.S. Census 2000).

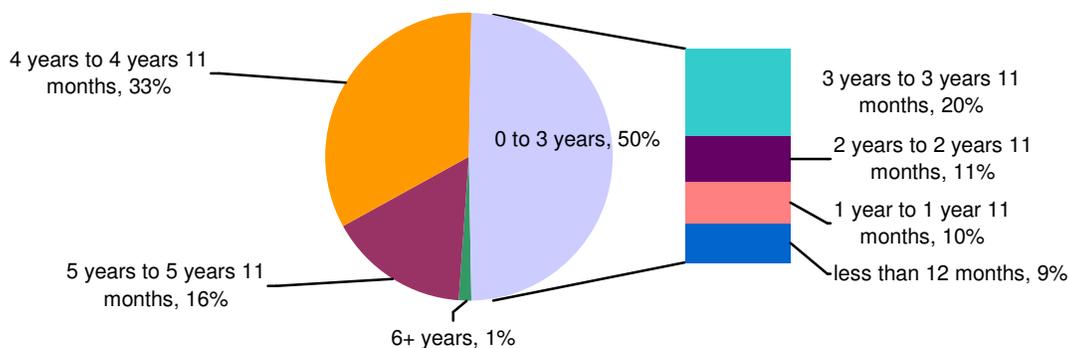
Within F5VC service programs, a majority of children (69.0%) are reported by a parent to speak a language other than English at home (this includes children who are bilingual); in these families, Spanish is most commonly spoken (92.9%). Four-year-olds account for one-third of child participants served by F5VC during the 07-08 fiscal year (Figure 3).

⁵ Data from California Health Interview Survey (CHIS), 2007, University of California, Los Angeles. Percent reflects the proportion of respondents who reported having less than 12 months of insurance coverage during the past year for their child aged 0-5. This percentage may be statistically unstable and interpretation should be made with caution.

Table 1. Demographics of Children Who Received More-intense Services FY 07-08

		F5VC	County ⁶
Total children served		4,433	68,367
Gender	Males	51.7%	51.3%
	Females	48.3%	48.7%
Insurance Status	Uninsured	27.9%	9.6% ⁴
Race/Ethnicity	Latino	74.2%	46.7%
	White	13.2%	43.3%
	Multi-racial/Other	7.0%	3.9%
	Asian/Pacific Islander	3.5%	4.2%
	African American	0.6%	1.5%
	Alaska Native/American Indian	0.2%	0.3%
	(included in Latino - Mixteco)	(0.3%)	-
Primary Language	Other language	47.1%	-
	Mostly/all English	31.0%	-
	Bilingual (English and other language)	21.5%	-
	Unknown	0.4%	-
	Most common language spoken other than English	Spanish (92.9%)	-

Figure 3. Age of Child Participants at First Service Delivered in FY 07-08



During the intake process, a parent/caregiver is asked whether a doctor or other health professional had said that the child was developmentally delayed. In FY 07-08, 5.2% of parents indicated that they were told their child had a developmental delay, which is somewhat higher than the national estimates for preschoolers (i.e., 3.2% with developmental delay⁷).

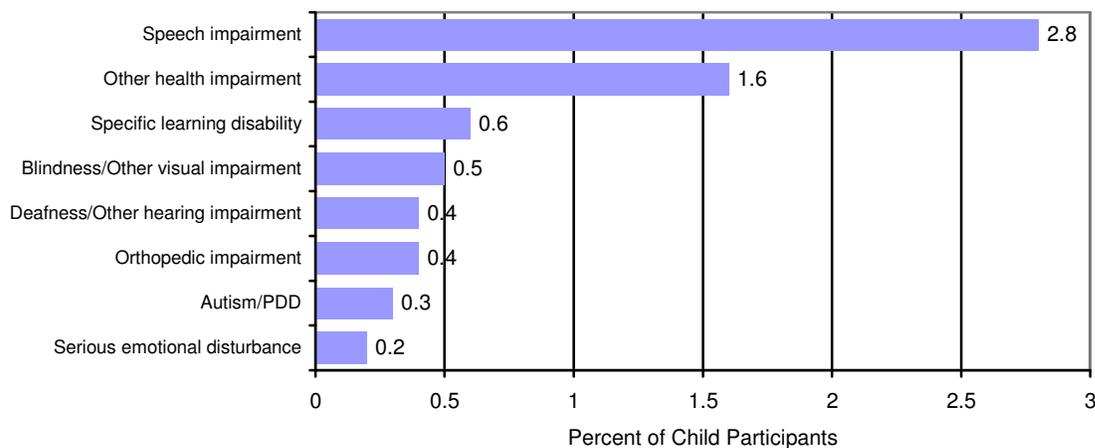
The parent/caregiver also is asked if a doctor or other health professional had said that the child had a disability or other special need, and to indicate which disability or special need, using a

⁶ Data from Summary Files, U.S. Census 2000, Ventura County, children 0-5 years old, except where noted.

⁷ Blanchard, L.T., Gurka, M.J., & Blackman, J.A. (2006). Emotional, developmental, and behavioral health of American children and their families: a report from the 2003 National Survey of Children's Health. *Pediatrics*, 117, 1202-1212.

list of potential items. For 5.8% of children, the parent/caregiver indicated that the child had a disability or special need. The most commonly reported disability or special need was ‘speech impairment’; this was reported by 2.8% of parents. The next most commonly reported disability or special need was ‘other health impairment’ (1.6%). Other disabilities were reported by parents at rates less than 1% (see Figure 4).

Figure 4. Disabilities or Other Special Needs FY 07-08



Programs may modify their focus or delivery of service in response to changing community needs; with such adjustments, there may be shifts in populations targeted for service. Using demographic data available for participants from the last two fiscal years, changes in the population of children served by F5VC were examined. Statistically significant differences ($p < .05$) from these comparisons are reported below (relevant tables and figures can be found in Appendix C).

- More children were more-intensely served in FY 07-08 compared to the prior two years (3,255 in FY 05-06, 3,487 in FY 06-07, and 4,433 in FY 07-08)(Table C.1).
- A larger proportion of children served in FY 07-08 were uninsured at intake (27.9%) compared to last year (18.3%) (Table C.1).
- Spanish continues to be the most commonly spoken language when English is not the primary language used at home (93.2% in FY 05-06, 93.9% in FY 06-07 and FY 07-08) (Table C.1).
- The proportion of children served who are ≤ 3 years of age has been increasing over the past three years (22.1% in FY 05-06, 22.5% in FY 06-07, and 29.3% in FY 07-08) (Table C.2).

Several programmatic changes were identified by F5VC staff to explain changes seen in demographics of children served:

- Programs providing more-intense services to children are doing better at obtaining parent consent to collect demographic data on their children, thus, more data are available.
- Expansion of health insurance enrollment and utilization services result in a higher number of children entering services who need help enrolling in public insurance.
- Increased early learning activities for children 0-3 at NfLs has resulted in a greater capacity to serve these young children.

Family Member Participants

F5VC provides a range of services for parents and caregivers (related or not) of young children, referred to in this report as family members. A total of 3,263 family members received more-intense services in FY 07-08. Most family members who received services are the parent/guardians of children 0-5 (93.2%, see Table 2).

Table 2. Family Members Who Received More-intense Services FY 07-08

Total family members served	3,263
Parent/Guardian	93.2%
Foster parent	2.0%
Grandparent	2.0%
Expecting parent	1.6%
Other relative of child 0-5	1.2%

A majority of households (67.9%) uses a language other than English at least half of the time; of those, most (88.8%) use Spanish. Females comprise 86.4% of family members served. In FY 07-08, most family members reported being Latino (71.2%, including 1.8% Mixteco) with a smaller percentage being White (17.5%). These proportions are different from countywide distribution, where 33.4% of adults are Latino and 56.8% are White (U.S. Census 2000 estimates, see Table 3).

Table 3. Demographics of Family Members FY 07-08

	F5VC	County ⁸
Gender		
Male	13.6%	49.9%
Female	86.4%	50.1%
Race/ethnicity		
Latino	72.0%	33.4%
White	17.5%	56.8%
Asian/Pacific Islander	5.1%	5.4%
Multi-racial/Other	4.4%	2.2%
African American	0.7%	1.8%
Alaska Native/American Indian	0.1%	0.4%
(included in Latino - Mixteco)	(1.8%)	-
Education		
High school diploma/GED	56.1%	80.1%

About half of family members (56.1%) indicated they had a high school diploma or equivalent, which is far below the countywide percentage of adults reporting high school completion. According to 2000 U.S. Census data, about 80% of adults 18 and older across Ventura County indicated having at least a high school diploma or equivalent (Table 4).

Over 40% of the family members who received more-intense services reported being employed. Of these, about one-quarter worked full-time (25.8%), and the remainder worked part-time (11.8%), or as seasonal (2.8%) or temporary workers (2.0%).

⁸ Data from Summary Files, U.S. Census 2000, Ventura County, persons 18 years of age and older.

Using demographic data available from prior fiscal years, changes in population characteristics of family members served by F5VC were examined. Statistically significant differences ($p < .05$) from these comparisons are reported below (relevant tables and figures can be found in Appendix C).

- About 15% fewer family members were served in FY 07-08 compared to FY 06-07 (3,812 in FY 06-07 and 3,263 in FY 07-08)(Table C.3).
- An increase in the percent of male family members is seen across fiscal years (10.3% in FY 05-06, 12.7% in FY 06-07, and 13.6% in FY 07-08) (Table C.3).
- The distribution of other racial/ethnic groups has seen slight changes over the past three fiscal years; Latinos continued to be the highest proportion of family members served with a slight decrease in FY 07-08 (77.1% in FY 05-06, 75.9% in FY 06-07, and 72.0% in FY 07-08), while the numbers of White and Asian/Pacific Islander family members have increased (18.1% in FY 05-06, 20.1% in FY 06-07, and 22.8% in FY 07-08)(Table C.3).
- The proportion of parents/guardians who report having a high school diploma/GED has increased over the past three years (46.9% in FY 05-06, 51.6% in FY 06-07, and 56.1% in FY 07-08) (Table C.3).

No specific programmatic changes were identified by F5VC staff to explain changes seen in demographics of family members served.

Provider Participants

In FY 07-08, F5VC programs that increase the capacity and professional development of child care providers were expanded to recruit and train providers to offer culturally competent services across the County. A significant commitment was made to train pediatric health care providers in fluoride varnishing and developmental screening. Provider demographics demonstrate that recruited providers are ready to meet the needs of F5VC children and families, as evidenced by the proportion of providers who are bi-lingual and Latino.

A total of 612 providers received services in FY 07-08⁹ through services offered at the Neighborhoods for Learning (NfL) programs and also through the Comprehensive Approaches to Raising Educational Standards (CARES) program. Most providers were female (89.5%). Almost two-thirds of the providers (60.9%) were bilingual or spoke another language. The racial/ethnic group represented most substantially by provider participants was Latino (46.9%) followed closely by White (43.4%, see Table 4).

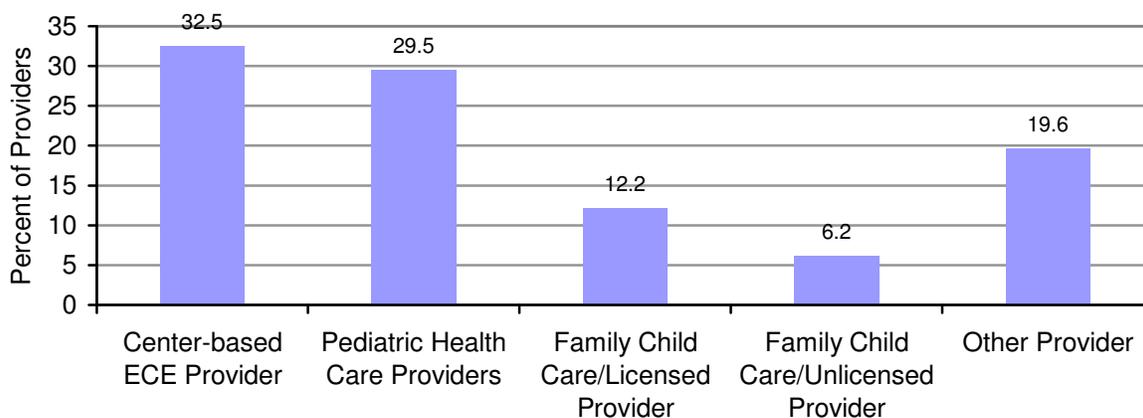
⁹ Data for the 243 participants in the CARES program are included in this number and in demographic characteristics.

Table 4. Demographic Characteristics of Providers FY 07-08

Total providers served	612
Females	89.5%
Males	10.5%
Language	
Mostly/all English	39.1%
Bilingual (English and other language)	50.8%
Mostly other language	10.1%
Ethnicity	
Latino	46.9%
White	43.4%
Asian/Pacific Islander	4.7%
African American	2.2%
Multi-racial/Other	1.8%
Alaska Native/American Indian	1.0%
(included in Latino – Mixteco)	0.1%

In services provided to programs outside of CARES, the largest group of provider participants consisted of Center-based Early Childhood Education (ECE) providers (32.5%), followed by Pediatric Health Care providers (29.5%, see Figure 5). Two new programs implemented in FY 07-08 focused on building the capacity of pediatric health care providers. Pediatricians were engaged in training for developmental screening efforts in one program while in another program, pediatricians were recruited to provide fluoride varnishes to children 0-5.

Figure 5. Distribution of Provider Types FY 07-08 (n=369)¹⁰



¹⁰ CARES providers are not included.

Changes in provider populations served by F5VC were examined using data from prior fiscal years. Statistically significant differences ($p < .05$) from these comparisons are reported below (relevant tables and figures can be found in Appendix C).¹¹

- There were more providers served in FY 07-08, compared to the last two fiscal years (215 in FY 05-06, 189 in FY 06-07, and 369 in FY 07-08; Table C.4). A large proportion of FY 07-08 service providers were pediatric health care providers (29.5%) unlike prior years where no pediatric health care providers were reported (Table C.5).
- More bilingual providers received F5VC services in FY 07-08, compared to the last two fiscal years (23.7% in FY 05-06, 44.9% in FY 06-07, and 53.2% in FY 07-08; Table C.4).
- The percentage of providers identifying as White increased this year (29.1% in FY 05-06, 19.9% in FY 06-07, and 49.6% in FY 07-08; Table C.4).

Changes in the number of pediatric health care providers, males, and Whites is likely due to the new programs recruiting physicians in the community, many of whom are male and White, as reported by F5VC program staff.

¹¹ Data for CARES providers were not included in comparison analyses.

FINDINGS

Findings include a section on service satisfaction and followed by six evaluation focus areas based on six Best Investment Areas selected for this annual evaluation. As mentioned previously, F5VC staff developed a new evaluation framework during the FY 07-08, revising evaluation questions and establishing benchmarks for expected outcomes. Benchmarks represent a new aspect of the evaluation that was not present previously; the benchmarks are intended to help program staff and F5VC staff and Commission to identify services that are working as expected and to detect areas for program improvement. Ultimately, benchmarks can be used to guide improvement and change efforts. Data are then used to track the effect of program changes.

This is the first year using the new evaluation framework; thus, it was expected that programs would not have collected all of the data needed to address all benchmarks (the framework was implemented as the model for the Annual Evaluation after the end of FY 07-08). In essence, this Annual Report is a “demonstration project” reflecting the new evaluation framework. Nonetheless, despite the newness of this process, F5VC-funded partners and programs are demonstrating positive outcomes for the children and families served.

Brief reports for the Preschool for All and School Readiness initiatives were developed for the purpose of sharing information with the state about outcomes associated with these programs (see Appendix D and E, respectively). Evaluation questions and benchmarks were not established for these initiatives and thus, are not presented in the body of this annual report.

Service Satisfaction

Parents/family members are asked to complete a brief satisfaction survey to assess overall levels of satisfaction with First 5 Ventura County services received. Almost 1,000 parents and other family members (n=999) completed satisfaction surveys in FY 07-08.¹²

Overall, family member satisfaction with program services was very positive.

- Almost all family members (99.5%) in were somewhat or very likely to recommend the program to a friend or family member.
- Parents/family members also reported being satisfied with the services that they (or their child) received from the program (98.70% indicated that they were somewhat satisfied or very satisfied).

Regarding the program environment, location and hours, responses from parents/family members were favorable as well. (Table 5). Findings from last year are very similar to responses from this year.

¹² Surveys may have been administered in English or Spanish.

Table 5. Satisfaction of Program Services FY 07-08 (n=999)

	Somewhat satisfied or Very Satisfied FY 06/07	Somewhat satisfied or Very Satisfied FY 07-08
Would you recommend this program to a friend or family member?	99.0%	99.5%
How satisfied are you with the services you or your child received from this program?	97.0%	98.7%
How satisfied or dissatisfied are you with the program location?	97.0%	95.7%
How satisfied or dissatisfied are you with the hours that the program is open?	97.0%	96.4%

Best Investment Area: Preschool

Over the past four decades, there has been convincing evidence that improving school readiness and children’s development reduces poverty-related disparities (Zigler, Gilliam et al. 2006). Interventions that specifically attempt to improve children’s school readiness or family support for schooling include preschool interventions (as well as family-based safety net programs, programs to improve parents’ ability to support early learning, and comprehensive development programs). Associated scientific literature suggests that providing high-quality preschool experiences, combined with parent involvement and improvement of health status, can have significant beneficial effects on children’s language and cognitive skills by age 5 (Engle and Black 2008). However, in a recent comprehensive study of early care and education for preschool-age children in California, researchers found that the children who could benefit most from preschool are least likely to be in it. More specifically, less than 50% of 3 and 4 year olds in economically disadvantaged families in California are in preschool centers of any quality, compared to 70% of those in more well-off families. Furthermore, 45% of children whose mothers have less than a high school degree are in preschool centers, compared to 80% of children whose mothers have a graduate or professional degree (Karoly, Ghosh-Dastidar et al. 2008).

Evaluation Question: How many children are attending preschool as a result of F5VC funding?

Benchmark: F5VC funds 1,002 preschool spaces.

Benchmark: 1,002 children, age 3 years to 5 years attend F5VC-funded preschools.

Based on data available in GEMS, 1,062 children received preschool services in FY 07-08. Preschool services are provided to children between the ages of 3 to 5 years in the programs funded by F5VC.

*Evaluation Question: To what extent are we serving the people who need it the most?
Benchmark: 70% of children in F5VC-funded preschools are from at-risk families.*

A number of factors may be associated with a child's potential for success in US schools; these include child race/ethnicity, language use in the home, level of parent education, level of family income, and child special health care needs. GEMS data indicate that most of the families served by F5VC-funded preschools have sociodemographic characteristics that have been associated with child difficulties in school. A significant majority (74.8%) of children served is Latino. More importantly, 43.0% of children live in homes where languages other than English are the primary languages spoken (Table 6). These children can have a more difficult time entering school environments where English is the language used by teachers and peers.

Maternal education has been shown in the research literature to be a good predictor of a child's academic performance. Just over 40% of children enrolled in F5VC-funded preschools have a mother who does not have a high school diploma or its equivalent (Table 6). This may impact a child's readiness for school and his/her academic achievement over time.

Also, two-thirds of children come from homes where the annual household income is less than \$30,000 (Figure 6). As mentioned previously, poverty can limit access to needed health and other social services resulting in impediments to the educational and developmental progress of young children.

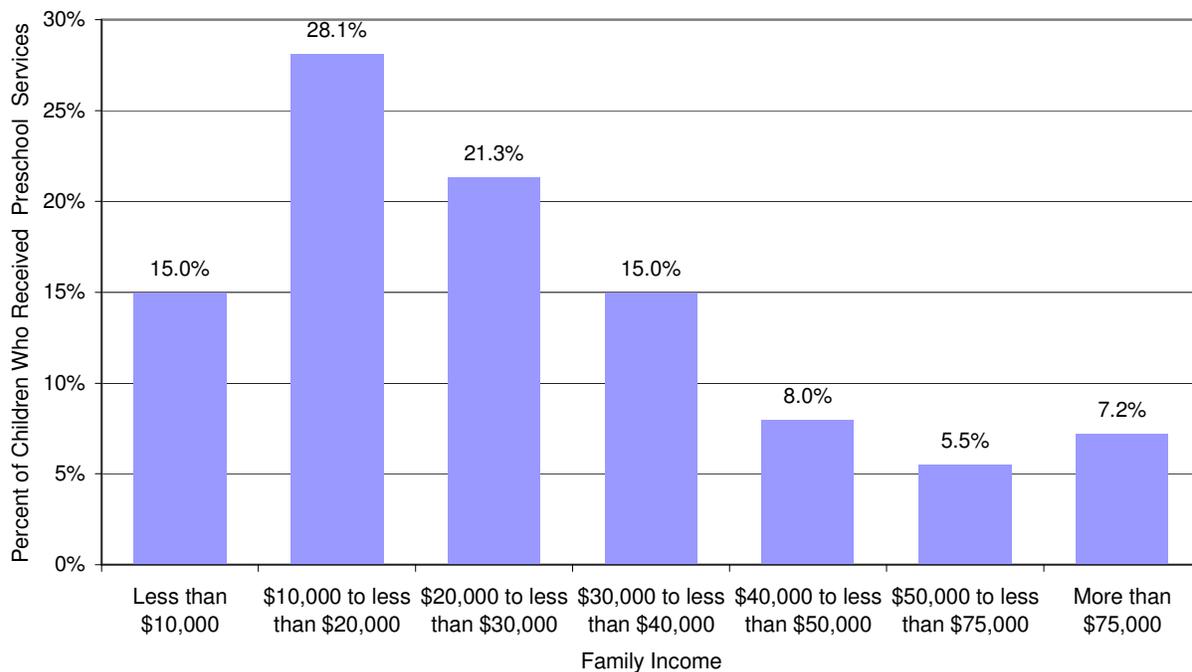
The prevalence of disability/special needs in children enrolled in preschool is 5.7%. This mirrors the prevalence of disability/special needs for children receiving any F5VC services in this fiscal year (5.8%, as reported by parents at intake). This congruence suggests that children with special needs are being appropriately served in F5VC-funded classrooms (Table 6).

Preschool services, especially when introduced at a young age, may help to mitigate the effects of language barriers, poverty, and sociological factors that can impair school readiness.

Table 6. Demographics of Preschool Children Who Received Preschool Services FY 07-08

		F5VC ¹³
Gender	Males	49.7%
	Females	50.3%
Race/Ethnicity	Latino	74.8%
	White	12.5%
	Multi-racial	5.3%
	Asian/Pacific Islander	3.8%
	Other	2.3%
	African American	1.0%
	Alaska Native/American Indian	0.3%
Primary Language	Other language	43.6%
	Mostly/all English	31.5%
	Bilingual (English and other language)	24.9%
Maternal Education Level	Has High School Diploma/GED	57.9%
	No High School Diploma/GED	42.1%
Disability/Special Needs	Yes	5.7%
	No	94.3%

Figure 6. Family Income of Children Who Received Preschool Services FY 07-08



¹³ Data represent 1,032 children. Intake data were not available for 30 preschool students.

*Evaluation Question: Is F5VC expanding preschool spaces?
Benchmark: 48 new preschool spaces are created.*

During FY 07-08, 68 new preschool spaces were created in Hueneme and Ocean View through the Preschool for All and Ocean View NfL. All necessary licensing and program preparations were completed by June 2008 and the spaces became operational on July 1, 2008.

*Evaluation Question: Are families utilizing the services?
Benchmark: Children attending preschool have 95% attendance.*

Examination of this benchmark was challenging. First, data entry issues greatly impact the ability to understand a child's attendance in preschool. Program staff may not document the exact start or end date of enrollment. For example, a child may have enrolled in preschool on August 15 and attended 7 days for the rest of the month. Program staff may enter into GEMS the attendance of that child for the month of August, reporting that the child attended 7 days between August 1 and August 31. Based on the data entered, data analyses must assume the child was there for the entire month if the start date was August 1 and end date was August 31. This threatens the accuracy and quality of any analyses based on this data. The F5VC program staff noted that use of this reporting method is common.

Additionally, different preschool programs have varying program calendars with a range of expected attendance days each year. As these data were not available for each participant, it was not possible to calculate the number of days a child was expected to attend. Preschool programs also vary in the number of days they provide preschool programming each week. For example, some preschool programs provide two-to-three school days per week while others provide four-to-five school days per week. As for program calendars, participant-specific data on the number of expected school days per week were not available. Of note, prior to this evaluation framework, attendance information was not sought for use in evaluative or program improvement efforts. Therefore, this benchmark was not assessed for this annual evaluation.

It must be noted that the calculation of attendance rates is based on the assumption that preschools are open and available to each child for the entire length of enrollment. Thus, holiday closures and other breaks are not accounted for in these analyses. In the future, more accurate data may be reported if preschools determine the child's attendance rate directly and enter that into GEMS.

*Evaluation Question: Are children better off as a result of attending preschool?
Benchmark: 75% of children achieve "building or integrating" levels as measured by the DRDP-R.*

Teachers from programs providing preschool services were asked to complete the Desired Results Developmental Profile - Revised (DRDP-R), an instrument designed by the California Department of Education. The DRDP-R was completed at two points during children's participation in preschool (i.e., near the beginning and end of their enrollment). The DRDP-R is a behavior-based measure by which teachers observe and rate child developmental skill in several age-specific domains or competencies. The DRDP-R has age-specific versions. The Infant/Toddler version is used for two-year-olds and the Three Years to Kindergarten version is

used for three- to five-year-olds. Though all F5VC-funded teachers were trained in the use of the DRDP-R, ratings of the same child may vary from teacher to teacher as a result of different levels of experience with the measure.

Within each age-specific domain, each item is scored by the teacher. The DRDP-R yields several indicators representing a number of competency areas for each desired outcome. An aggregated indicator score is derived by summing the number of students who achieved a certain competency level for each item; that sum is divided by the number of items that make up the indicator. Thus, for each indicator, the distribution of students across competency levels can be calculated. After an effective intervention, it would be expected that the proportion of children at lower levels of competency would decrease and the proportion of children with higher levels of competency would increase.

The DRDP-R was designed to provide a rating of a child’s skill level on specific items and indicators so that an educational approach can be tailored for the unique needs of that child. The California Department of Education typically reports the percent of change in response categories from before and after services as a way to assess improvements in children over time.

An analysis of DRDP-R performance of preschoolers four years of age and older is presented to assess F5VC’s progress toward this criterion for success (i.e., 75% of children will function at a “building or integrating” level). Younger children were excluded, because a child three years of age or younger is unlikely to be rated as building or integrating on these items.

Matched pre-/post-service data were available for 387 children ages four years or older (this represents 59.4% of all matched DRDP-R data across ages). Across all items, 77.6% of responses after service were at the “building” or “integrating” levels, compared to only 28.3% before services (Table 7). This shows an improvement of 49.3%. Also, reductions in the proportion of lower ratings (i.e., “exploring” or “developing”) are seen after services. Taken together, these findings suggest that children are improving with regard to school readiness.

Table 7. Comparison of Percent of DRDP-R Responses Before and After Preschool Services FY 07-08 (n=392)

	Exploring	Developing	Building	Integrating
	<i>Lowest level of competency</i>			<i>Highest level of competency</i>
Before Services	26.2%	45.5%	23.5%	4.8%
After Services	4.6%	17.7%	34.0%	43.6%

It should be noted that the benchmark includes the two highest ratings; *building* and *integrating*. The DRDP-R is a developmental measure designed for use in children up to six years of age. It is not expected that a three-year-old would perform at the highest levels of skills. As a developmental measure, it is expected that children will increase their skills over time via a combination of maturation, biological potential, and environmental stimulation and thus, the measure must be able to measure the development of skills over time. Unfortunately, there are no norms for this measure, and no expected performance information for different ages.

The appropriateness of this measure for the purposes of this evaluation question and benchmark should be considered for future program years. Another measure, or combination of

tools, may be more sensitive to the changes expected in children who attend F5VC-funded preschools.

*Evaluation Question: Do some providers perform better than others?
 Benchmark: Providers will meet 95% of targeted capacity levels.
 Benchmark: 80% of providers meet DRDP-R benchmarks.*

For those programs providing preschool services, the expected numbers of spaces were established at the beginning of the fiscal year. As demonstrated below, nine of the 11 preschool providers were able to meet their target number of spaces, thus meeting or exceeding the benchmark of 95% of targeted capacity (Table 8). In the remaining two programs, providers fell short of that benchmark.

The number of children who were served typically exceeds the number of operational spaces at these preschools. This is a reflection of student turnover; a child may not remain enrolled for the entire year, and the vacated space is refilled with a new student. Also, varying program calendars may explain instances where the number of children exceeds the available spaces. In some programs, preschool is a partial year rather than a full year, so turnover of students is expected.

Where programs served fewer children than the number of operational spaces, challenges related to recruitment may have resulted in operational spaces going unfilled. Also, “missing” data may explain this discrepancy – if a parent/caregiver does not allow consent to have their data shared with evaluators, data reflecting their child’s participation in the program cannot be included in analyses.

Table 8. Comparison of Preschool Providers’ Target Number of Spaces, Operational Spaces, and Total Number Served in the Spaces by NfL FY 07-08

Provider	Target Number of Spaces	Number of Operational Spaces	Number Served	Percent of Target Spaces that Became Operational
Conejo NfL	140	140	158	100.0%
Hueneme/South Oxnard NfL	56	56	63	100.0%
Moorpark/Simi Valley NfL	140 ¹⁴	124	99	88.6%
Oak Park NfL	36	36	36	100.0%
Ocean View NfL	80	80	82	100.0%
Ojai Valley NfL	45	45	41	100.0%
Oxnard NfL	186	186	205	100.0%
Pleasant Valley NfL	49	49	52	100.0%
Preschool for All	214 ¹⁵	164	177	76.6%
Rio NfL	48	48	31	100.0%
Santa Clara Valley NfL	114	116	118	100.0%

¹⁴ It was projected that 140 space would become available through the Moorpark/Simi Valley NfL; however, of those spaces, only 4 out of 20 projected spaces at the Moorpark Unified School District became operational due to implementation challenges

¹⁵ It was projected that 214 spaces would become available through Preschool for All; however, 48 did not become operation during FY 07-08. By July 2008, these 48 spaces became operational.

To assess provider performance in a different way, the percent of change in DRDP-R responses rated as “building” or “integrating” is used. Across all programs, there is a 49.3% change from before-service to after-service (see analysis for prior benchmark). An analysis of providers shows that the average percent change is 39.7%, ranging from 0.7% to 70.1% (Table 9). This is a large range, most falling with the range of 40 to 70%. Ojai Valley NfL shows the least amount of change; however, this seems to be a ‘ceiling effect’, as before-service ratings were high (84.1%) and left little room for upward change. This program reports only 11 matched DRDP-Rs. Though this meets the minimum criteria of 10 measurements required to be examined as an individual program, it is still a small number and may not be representative of all children served in the preschool there.

The variability in DRDP-R rating change from before- to after-service can be the result of a number of factors. As mentioned earlier, less experienced teachers may not rate children in the same manner as more experienced teachers. Also, the composition of child populations in these preschool programs is variable and may affect observed outcomes. Child and family characteristics may influence individual child performance at entry and after receiving services. A linear regression analysis was performed to determine the degree to which these characteristics influenced change in DRDP-R scores from before- to after- service (regression models take into account the effects of multiple factors on a single outcome). The effects of child age, ethnicity, language spoken at home, presence of developmental delay, insurance status, and family income were measured in this analysis. A statistically significant model was found ($p < .05$), with family income a significant predictor – thus, when all other child/family factors are considered, lower family income is associated with greater changes in DRDP-R scores.

Data related to provider characteristics, such as student-teacher ratio, curriculum type, and teacher credentials were not available to inform observed changes in DRDP-R ratings for this report. It is expected that in the future, these data will be available and will facilitate the assessment of provider differences. At that time, it also will be important to include environmental variables such as median household income and rate of poverty in the program region; these may have an additional effect on outcomes.

Table 9. Comparison of Percent of DRDP-R Responses Before and After Preschool Services FY 07-08

	Number of Participants with Matched Pre-/Post DRDP-R ¹⁶	Percent of Responses Rated as Building or Integrating Before Service	Percent of Responses Rated as Building or Integrating After Service	Percent Change
Conejo NfL	44	44.2%	84.6%	40.4%
Hueneme/South Oxnard NfL	5	Too few to report	Too few to report	Too few to report
Moorpark/Simi Valley NfL	25	21.8%	91.9%	70.1%
Oak Park NfL	7	Too few to report	Too few to report	Too few to report
Ocean View NfL	21	29.2%	82.7%	53.5%
Ojai Valley NfL	11	84.1%	84.8%	0.7%
Oxnard NfL	135	26.2%	82.0%	55.8%
Pleasant Valley NfL	23	26.5%	82.0%	55.5%
Preschool for All	96	18.7%	59.8%	41.1%
Rio NfL	6	Too few to report	Too few to report	Too few to report
Santa Clara Valley NfL	35	12.2%	40.9%	28.7%

*Evaluation Question: Are parents satisfied with preschool services?
Benchmark: 90% of parents indicate high satisfaction levels.*

At this time, satisfaction survey data are entered into GEMS with a program identification (i.e., Contract Identification number) but without a specific service identification. In the future, it is expected that service-specific surveys will capture data related to parent satisfaction so that this criterion can be addressed. Satisfaction data suggest that participants are satisfied with services provided by F5VC (see pages 4-1 and 4-2)

Best Investment Area: Early Learning for Parents and Children Together

Families in Ventura County want their children to start school ready to learn. It has been suggested that the path to school readiness is encouraged by preparedness for reading instruction and strong family attachment. Early learning activities for parents and children represent a wide variety of services that intend to promote these factors, as well as to educate parents on different aspects of child development and healthy parent-child interactions. F5VC Early Learning programs are typically intensive age-appropriate educational activities and experiences for parents and children to promote parent-child interaction while promoting early learning.

¹⁶ Where fewer than 10 matched, pre-/post-service DRDP-Rs were available, no data are reported due to instable estimates that would be produced by analyses.

Children who begin school less prepared to read are more likely to (1) live in low-income communities; (2) have limited English proficiency; (3) suffer from cognitive, hearing, or language impairment; or (4) have parents with reading problems (Pan, Rowe et al. 2005). Emergent literacy problems can be addressed via family literacy programs. Such programs are based on the belief that children's early learning is greatly influenced by their parents, that parents must develop and value their own literacy skills in order to support their children's educational success, and that parents are their children's first and best teachers (Smith 1995).

Most family literacy programs offer instructional services that include early childhood education, adult literacy education, parenting education, and structured literacy interaction between parents and their children. One supposition of the family literacy model is that a child will benefit more from being in a family that is involved in each family literacy service (early childhood education, adult education, parenting education, and parent-child literacy activities) than from participating solely in an early childhood program (St.Pierre and Layzer 1996).

Healthy attachment to primary caregivers early in life can influence the development of a child. Attachment theory suggests that the relationship that the child establishes with his/her caregiver will either help or hinder the child's ability to adapt to different situations during development. Socio-emotional and cognitive development are related to early attachment (Tarabulsky, Pascuzzo et al. 2008). In fact, studies have linked insecure attachment in the preschool years to externalizing problems with peers and teachers in school (DeMulder, Denham et al. 2000).

Interventions that focus on both family literacy and/or parent-child interactions are of primary focus in this best investment area of early learning. The services at F5VC program that aim to encourage early learning and attachment are diverse. There are services that are more didactic in nature, teaching parents (including pregnant parents) about child development, nutrition, and how to use everyday opportunities to interact with and teach their child. Other services use modeling and interactive learning approaches with parents and children to demonstrate how to interact and read with a young child. Services focused on attachment and bonding are also provided, typically by providing activities for children and caregivers to interact and bond with the help of a facilitator, with the intent that parents and caregivers will use the activities at home.

Evaluation Question: How many parents or caregivers are accessing services with their children as a result of F5VC funding?

Benchmark: 3,800 parents/caregivers participate with their children in F5VC-funded early learning activities.

Early learning and family literacy activities were provided to 2,759 parents/caregivers in FY 07-08. Many other children are positively affected by these services, as participants may apply what they learned to older siblings, or to their future young children.

Evaluation Question: Are we reaching children in their early years?

Benchmark: 590 children in F5VC-funded early learning activities are ages 0 – 3.

A total of 2,558 children received early learning activities that included their parent/caregivers. F5VC-funded programs exceeded the benchmark, with 832 children ages 0 – 3 years receiving such services. Programs were successful in serving very young children and their

parents/caregivers in the years where emphasizing and encouraging reading and school readiness activities may be the most important.

*Evaluation Question: Are parents/caregivers reading more often with their children?
Benchmark: 80% of parents/caregivers read with their children 4-6 times per week.
Benchmark: 80% of parents/caregivers know that the best time to start reading to their children is within the first year of life.*

Parents/caregivers are asked to complete a questionnaire after completing early learning/family literacy activities. Of the 427 parents/caregivers who completed the measure, 88.4% indicated that they read with or show picture books to their children at least four days per week. Data from this sample of participants provide evidence that the first benchmark was met. This is slightly higher than reports from last year, as 82.7% indicated that they read with or showed picture books to their children at least four days a week. Also, statewide data collected in 2003 demonstrate that 76.4% of parents with a child 0 – 5 read to their child three more or days per week (Child and Adolescent Health Measurement Initiative). F5VC data exceeds the state percentage, with 94.5% of parents/caregivers reading at least three days per week. This compares to 93.0% of parents/caregivers last year.

One objective of activities where parents/caregivers and children are learning and book-sharing together is to educate family members about the importance of these activities and their potential impact on a child's educational and social trajectories. A shared tenet of all F5VC programs providing this service is that the earlier a caregiver reads to a child, the greater the child's potential for successful emotional and educational outcomes. After receiving these services, 82.1% of parents/caregivers correctly reported that the best time to start reading to a child is within the first year of life, thus meeting the second benchmark. This compares to slightly lower levels reported last year (79.9% of parents/caregivers).

Most programs collected post-activity outcome data related to book-reading frequency and parent knowledge about when to start reading to children. Analyses are presented from the programs that provided data from at least 10 participants. Of those that did, an analysis of expected outcomes shows that all programs, except one, met the benchmark related to book reading and knowledge about when to start reading (Figure 7 and 8).

Figure 7. NfL Differences in Percentage of Clients Reporting Book-reading 4-7 Days per Week FY 07-08

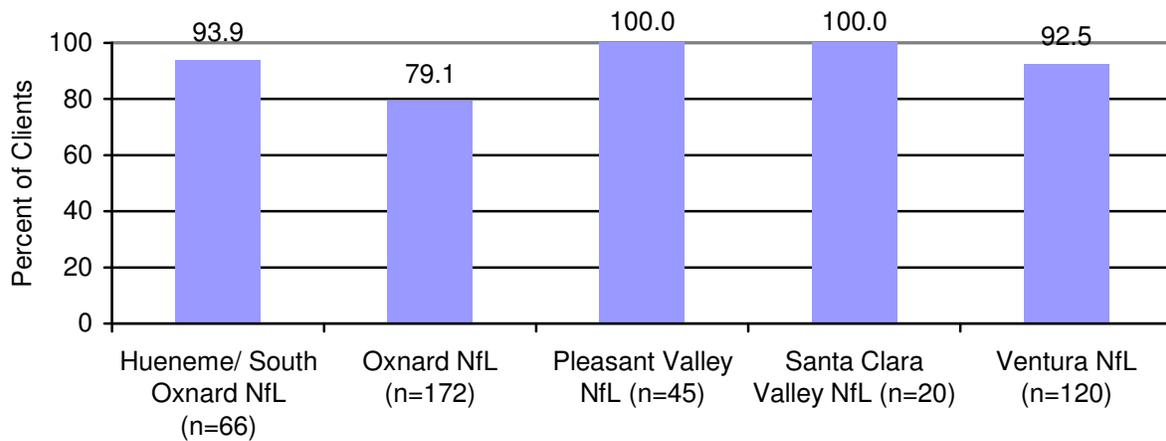
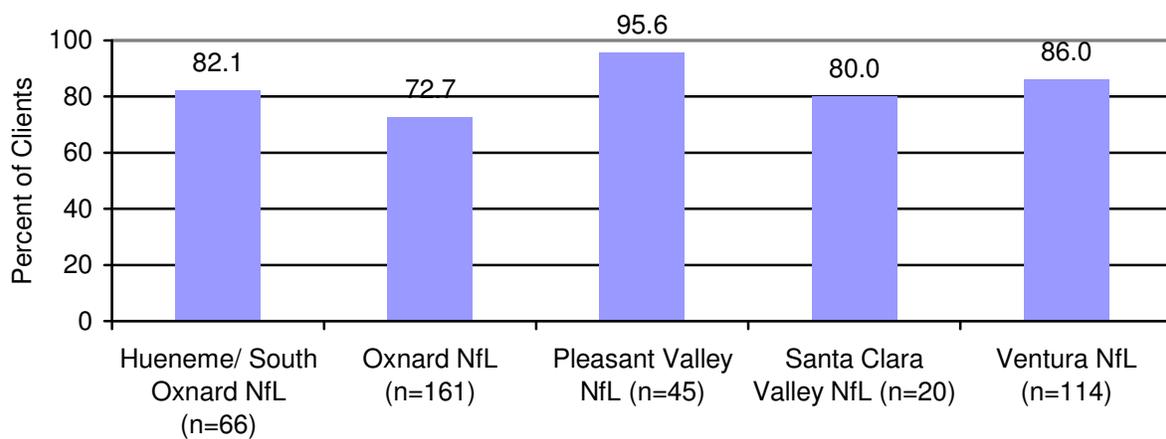


Figure 8. NfL Differences in Percentage of Clients Indicating that the Best Time to Start Reading is During the First Year FY 07-08



*Evaluation Question: How often are parents/caregivers participating in services?
Benchmark: Parents/caregivers participating in services attend an average of 6 times.*

Programs met this benchmark, as staff encouraged parents/caregivers to attend programs regularly and frequently. Parents/caregivers had an average of 13.7 contacts with the programs (range = 1 – 94 contacts), and received 6.7 hours of service (range 0.5 – 190 hours). In addition, children experienced an average of 6.5 hours of early learning activities with their parents/caregivers (range 0.5 – 150 hours) over the course of 16.5 contacts (range 1 – 121 contacts).

*Evaluation Question: Do some providers perform better than others?
Benchmark: Providers meet 95% of targeted capacity levels.*

At the start of the fiscal year, each provider determined a minimum number of participants that they expect to serve. Seven of nine providers substantially exceeded 95% of their target number of participants in early learning and family literacy activities (Table 10). Two providers (Rio NfL and Santa Clara Valley NfL) served fewer participants than expected.

Table 10. Comparison of Target Number and Number of Children, Parents and Caregivers Who Received Early Learning Activities by NfL FY 07-08

Provider	Target Number	Number Served	Percent of Target
		Total	
Conejo NfL	402	485	120.6%
Hueneme/South Oxnard NfL	728	1,374	188.7%
Moorpark/Simi Valley NfL	900	1,400	155.6%
Ojai Valley NfL	174	220	126.4%
Oak Park NfL ¹⁷	12	--	N/A
Ocean View NfL ¹⁸	120	--	N/A
Oxnard NfL	231	564	244.2%
Pleasant Valley NfL	200	279	139.5%
Rio NfL	320	251	78.4%
Santa Clara Valley NfL	144	98	68.1%
Ventura NfL	130	632	486.2%

*Evaluation Question: What conditions/factors (e.g., program design or intensity, curriculum, population served) correlate with better performance?
Benchmark: Provider differences are explained by differences in program design or intensity, curriculum, populations served.*

For FY 07-08, there was no information systematically reported that addressed NfL-specific program design, intended intensity of service, or curriculum. It is expected that in future evaluations, these data will be available to further examine this evaluation question and benchmark.

Best Investment Area: Service Coordination and Case Management

Children living in poverty are at risk for poor health (e.g., increased infant mortality, elevated rates of acute and chronic diseases, greater exposure to neglect or abuse), problems in cognitive and social development, educational failure, and future unemployment. Thus, persistently poor parents and children may be inundated with multiple problems that require numerous services and interventions (Schorr 1999). Care coordination is a type of service where a service coordinator or case manager may assist a family in determining their most

¹⁷ Participant and service data were not entered into GEMS for this program.

¹⁸ Participant and service data were not entered into GEMS for this program.

pressing needs and how they might go about resolving those needs by linking families to community resources and services. The goals of care coordination include (1) developing a plan for appropriate services that integrates the recommendations of several professionals and service systems, (2) facilitating access to needed services while avoiding duplication of services or unnecessary costs, (3) aiding communication among multiple professionals, and (4) optimizing child health and family quality of life (2005).

The influence of care coordination on children and families has been studied to a limited degree. The evidence demonstrating effectiveness of care coordination is mixed, depending upon the primary problems of the children and families under study. One of the major challenges in understanding the effects of care coordination is that there are multiple models of coordination and varying levels of needs of service recipients; this variability reflects the reality of community-based work but makes it difficult to demonstrate effectiveness across all persons receiving care coordination services.

Despite these challenges, one recent research project showed that community-based case managers were substantially more effective in obtaining health insurance for uninsured Latino children than traditional outreach and enrollment. In addition, case managers helped children to obtain insurance coverage sooner and to have greater continuity of insurance coverage (Flores, Abreu et al. 2005). Such evidence supports the usefulness of such services in linking families to needed resources, and suggests how this linkage promotes healthier and more positive outcomes. F5VC service coordination and case management services seek to help families in various levels of hardship. Some services can be as brief as providing information and a referral for families who have limited needs, while for families in greater need, multiple office visits, phone calls, and possibly assisting families in directly accessing services may be required.

Evaluation Question: Are families accessing services?

Benchmark: 70% of referred parents report being able to access the service.

Eight providers provided service coordination and case management services to children and their families. These services extend beyond simple referrals: staff identify the needs of families and assist families in obtaining services to address their specific needs. A total of 1,851 parents/caregivers and 2,049 children received service coordination and case management services.

A small number of parents/caregivers (n=24) completed the outcome measure relevant to service coordination and case management. Of those, 16 completed the item on 'needed services' and reported that they received at least one referral for needed services. All 16 (100%) indicated that, as a result of coordination and management support, they were able to access the services that they needed. With such a small sample, these data may not be representative of all parents/caregivers who received services; nonetheless, available data suggest that providers are meeting the benchmark.

Evaluation Question: To what extent do parents feel their needs were addressed?

Benchmark: 50% of parents report having their needs addressed.

In FY 07-08, the outcome service coordination/case management outcome questionnaire did not include an item that directly addresses this criterion. Thus, the satisfaction item of the questionnaire is used as a proxy indicator. All 24 participants who completed the questionnaire

(100%) indicated that they were *very satisfied* or *satisfied* with the service coordination help they received. With such a small sample, these data may not be representative of all parents/caregivers who received services; nonetheless, available data suggest that providers are meeting the benchmark.

*Evaluation Question: Do some providers perform better than others?
Benchmark: Providers meet 95% of projected service levels.*

Based on data collected for all participants, four of seven providers met the benchmark (Table 11). Two providers appear to have served far fewer than targeted. The Mental Health/Social Work Professionals at NfLs – Human Services Agency (HSA) program was relocated after experiencing serious recruitment and service challenges. Barriers experienced limited the number of parents/caregivers served. Moorpark/Simi Valley NfL had problems with uploading data into the GEMS server, so limited data were available for this report. The remaining two providers (Rio NfL and Pleasant Valley NfL) were not able to provide services at expected rates.

Table 11. Comparison of Service Coordination and Case Management Providers’ Target Number and Number Served by NfL FY 07-08

Provider	Target Number	Number of Parents/Caregiver Served	Percent of Target
Conejo NfL	140	223	159.3%
Hueneme/South Oxnard NfL	120	127	105.8%
Mental Health/Social Work Professionals at NfLs – HSA	180	13	7.2%
Moorpark/Simi Valley NfL	96	33	34.4%
Oxnard NfL	375	903	240.8%
Pleasant Valley NfL	50	38	76.0%
Public Health Nurses/Health Educators at NfLs	300	463	154.3%
Rio NfL	75	51	68.0%

Best investment Area: Mental Health

Up to one-fifth of young children show significant levels of impulsivity, hyperactivity, oppositionality, and aggression at home or at preschool (Powell, Fixsen et al. 2007), with even higher rates when children are living in poverty (Qi and Kaiser 2003). Approximately half of preschoolers continue to display these behaviors over time (Keenan and Shaw 1994). For a subset of these children, their behaviors will escalate into disruptive behaviors resulting in an impairment in adaptive functioning, thus warranting a DSM-IV diagnosis of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and/or Conduct Disorder (Campbell, Shaw et al. 2000). Once established, disruptive behaviors become strikingly stable over time and are resistant to treatment (Hinshaw and Anderson 1996). Thus, successful prevention and intervention depend on early treatment when developmental trajectories are still malleable (Keenan, Shaw et al. 1998). One early treatment strategy utilizes a school-based mental health consultation model. This approach has been shown to decrease expulsion rates

(Gilliam 2008), as well as to improve classroom environment and increase teacher self-efficacy (Alkon, Ramler et al. 2003). Research on early childhood school-based mental health consultation has identified the characteristics of successful consultation: individualized focus on strengths as well as developmental needs; family-centered care; and, comprehensive, community-based, and coordinated services (Alkon, Ramler et al. 2003; Hemmeter, Ostrosky et al. 2006).

Evaluation Question: How many children/families are receiving mental health services as a result of F5VC funding?

Benchmark: 600 children receive mental health services.

F5VC funds two major programs that provide mental health services for children 0 - 5. F5VC partners with Ventura County Behavioral Health Department to provide early intervention and treatment by bilingual/bicultural professionals across the County. Staff conduct outreach, screening, assessment, intervention, and treatment. Services are provided at locations that are convenient for families, including NfL resource centers, homes, preschools, and elsewhere in the community.

Ventura NfL also provides mental health services in a school-based setting. Beginning in FY 06-07, Ventura NfL implemented a program that uses a credentialed teacher who is also a licensed school counselor to provide classroom-based services using behavioral principles. The intervention also includes consultation with involved teachers and parents to teach ways to help children succeed at school. The intention of the service is to intervene with behavior problems early so that children can maximize their potential to grow, develop, and learn in a classroom setting.

These two programs served 220 children in FY 07-08. The Ventura County Behavioral Health Department (VCBH) expected to serve 550 children this year. This was the first implementation year of a new program and partnership with VCBH, the Human Services Agency (HSA) and community-based mental health providers. Further, this was also a new approach for all these entities and NfLs. Delays in contracting, hiring, and an initial limited capacity to serve all referrals restricted the capacity of the program to meet targeted service goals. Once the program was fully operational, VCBH was able to serve 173 children. Ventura NfL served 47 children through their school-based partnership, almost meeting their projected goal of 50. It is expected that target numbers will be modified for FY 08-09 VCBH/HSA services, as other unanticipated challenges experienced after full implementation have resulted in a re-estimation of program goals and objectives.

Evaluation Question: To what extent is F5VC serving the people who need it the most?

Benchmark: 66% of children receiving mental health services are from at-risk families.

The intention of many F5VC programs is to provide services to children who are at-risk for educational and developmental problems. Typically, mental health services are employed when a child demonstrates emotional, social, and behavioral problems that interfere with important areas of functioning, such as interacting well with family and peers, and learning in school. As illustrated below, certain socio-demographic characteristics are associated with increased

likelihood of such problems and decreased capacity to access the services that can prevent problems.

Two-thirds of children who received F5VC-funded mental health services in FY 07-08 are between 3 and 4 years of age (Table 12). It is common for 3- and 4-year-olds to start interacting with same-age peers in childcare or preschool-based environments. Oftentimes, referrals for mental health services at this age are generated as result of the child’s inability to behave appropriately in these settings. Additionally, two-thirds of recipients are male (Table 12). This finding is consistent with research on early identification of behavioral problems: externalizing maladaptive behaviors that are disruptive to others are more common in males, whereas, especially in older children, internalizing problems are more common in females.

Low annual income places children and their families at greater risk for limited or no access to health care and family support services (i.e., childcare, early education), for contact with poor environmental conditions, and for exposure to violence. A vast majority of children served by F5VC reside in the cities of Oxnard or Ventura (Figure 9). According to the Ventura County Behavioral Health Youth and Family Division¹⁹, these two cities contain a larger number of at-risk neighborhoods than do other County areas. Also, participants largely live in families where the household income level is less than \$30,000 (82.6%; Figure 10).

Table 12. Demographics of Children Who Received Mental Health Services FY 07-08

		Ventura NfL and VCBH
Total children served		220
Gender	Males	66.7%
	Females	33.3%
Age	0 – 11 Months	7.3%
	12 – 23 Months	5.5%
	24 - 35 Months	8.7%
	36 - 47 Months	26.0%
	48 - 59 Months	41.6%
	60 - 71 Months	10.5%
	72+ Months	0.5%
Primary Language	Other language	55.0%
	Mostly/all English	30.9%
	Bilingual (English and other language)	10.0%
	Unknown	4.1%
	Most common language spoken other than English	Spanish (99.3%)

¹⁹ Ventura County Behavioral Health Department Youth & Family Division, Annual First 5 Report, FY 07-08.

Figure 9. City of Residence of Children Who Received Mental Health Services FY 07-08

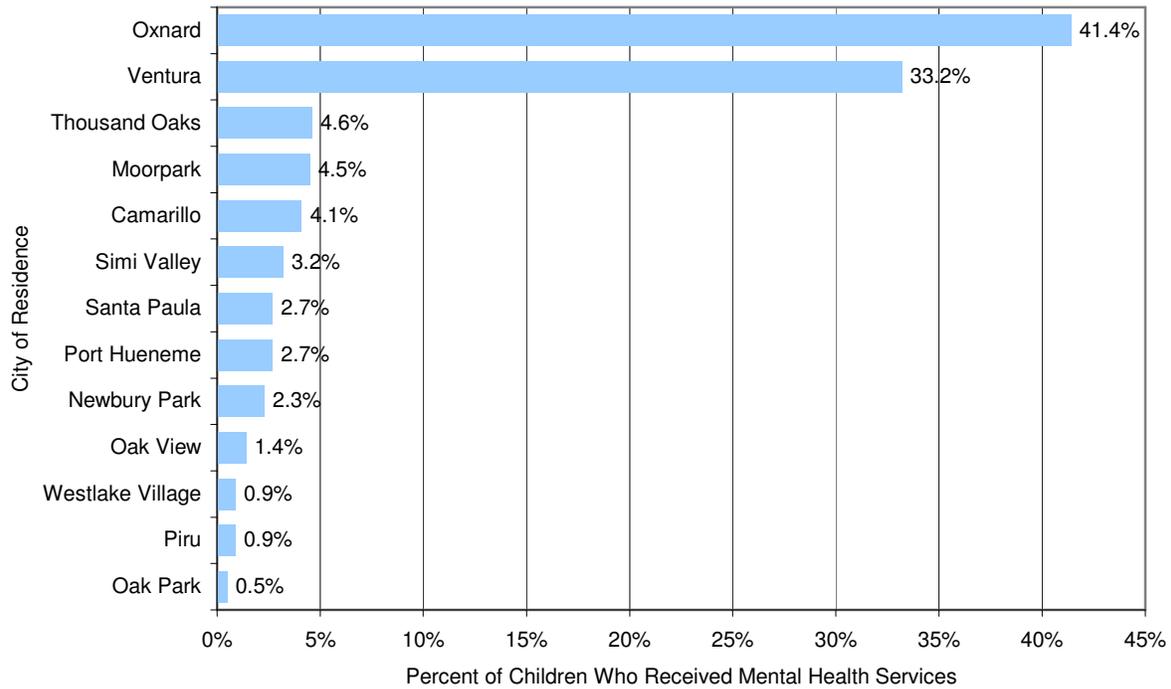
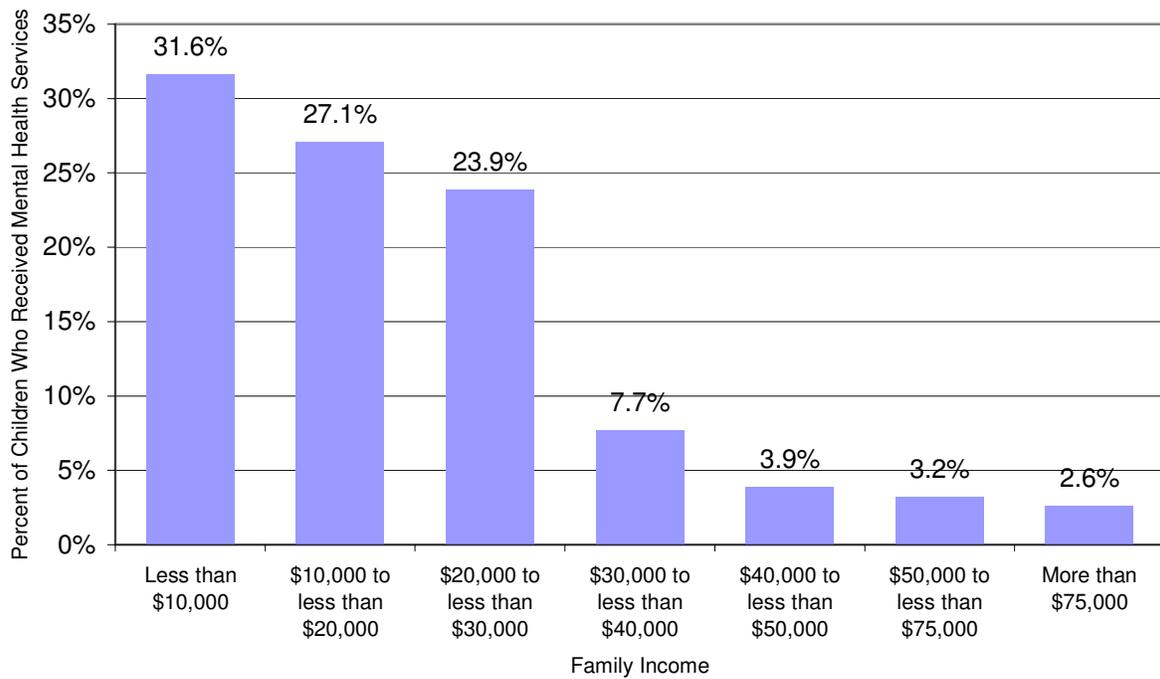


Figure 10. Family Income of Children Who Received Mental Health Services FY 07-08



Language may also pose a barrier to accessing services and employment for caregivers. In over half of homes, a language other than English is the primary language spoken (Table 12). This may indicate that there are serious impediments experienced by these families when trying to obtain educational services and health care for their young children.

In sum, these data suggest that this program has successfully targeted and reached children who have environmental conditions that may place them at higher risk for behavioral problems now and in the future. As mentioned earlier, early intervention can affect positively the long-term developmental, educational, and social outcomes of children with these risk factors.

*Evaluation Question: To what extent is support being provided in a preschool setting?
Benchmark: 35% of services are provided as early intervention in a preschool setting.*

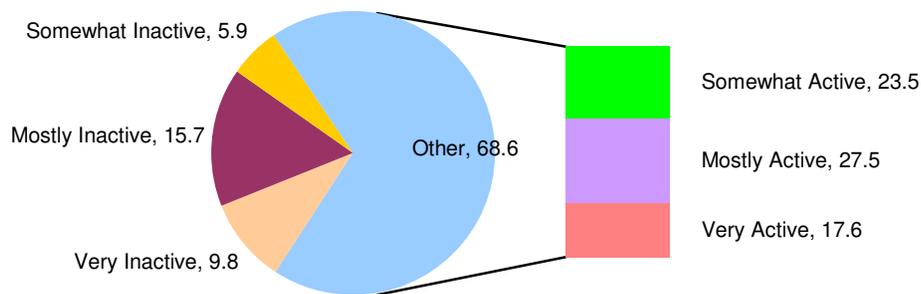
All mental health services provided by Ventura NfL are preschool classroom-based. Serving 47 children in FY 07-08, these preschool classroom-based interventions account for 21.4% of children who received mental health services. Ventura County Behavioral Health Department also provides mental health services in preschools; however, data regarding the extent of such services are not available for this report.

*Evaluation Question: Are families utilizing the mental health services provided by VCBH?
Benchmark: 40% of referred families utilize services.
Benchmark: 50% of participating families are rated by clinicians as “very active”, “mostly active”, or “somewhat active” for duration of treatment.*

VCBH reports that 309 families were referred for mental health services. Of those, 201 (65.0%) initiated treatment, exceeding the benchmark.

Active participation in mental health treatment can promote better outcomes. For children receiving VCBH services, two-thirds of children were assessed by their social worker as *most*, *very*, or *somewhat active* participants in service (68.6%) (Figure 11).

Figure 11. Level of Participation by Children in Mental Health Services as Rated by Social Workers FY 07-08 (n=51)



Evaluation Question: Are children better off as a result of receiving services?

Benchmark: Participants in Ventura NfL program show decrease in behavioral problems.

Benchmark: Participants in Ventura County Behavioral Health program show a decrease in symptoms and caregiver concerns.

Ventura NfL. To measure the impact of mental health services provided by the Ventura NfL, the Preschool Kindergarten Behavior Scales Second Edition (PKBS-2) was administered to children enrolled in this school-based service. The PKBS-2 is an instrument used by teachers and educational professionals to assess the behaviors of young children. The teachers of children receiving mental health services were asked to complete the measure within the first two months of the school year. If a child started mid-year, the PKBS-2 was collected as soon as possible thereafter. The second administration of the measure occurred at the end of the school year (in May 2008).

Items on the PKBS-2 are organized into two major areas: social skills and problem behaviors. For each area, a composite score is calculated based on item ratings. The composite score is translated into a standard score and corresponding percentile rank so that a child's performance can be compared to other children who have completed the measure.²⁰ On the PKBS-2, a higher social skills score suggests more adaptive and appropriate social behavior; in contrast, a higher problem behavior score suggests more maladaptive behavior.

In FY 07-08, there were 31 children who had pre- and post-intervention PKBS-2 ratings by their teachers. Paired t-test comparisons of pre-service and post-service PKBS-2 standard scores showed that children significantly ($p < .01$) improved social skills and decreased problem behaviors over time (Table 13). In fact, the average post-test PKBS-2 percentile ranks were 51st percentile for social skills and 54th percentile for problem behaviors. Both average percentile rank scores are close to the 50th percentile, which can be considered most representative of the "average" child. Similar results were seen in PKBS-2 pre-/post- comparisons last year, as improvements in social skills and decreased problem behaviors were demonstrated. Slightly greater change in percentile ranks for Social Skills from pre- to post- service was found this year compared to last year, where the average percentile rank before service was 17.4 and after service it was 38.4 after service (n= 46). A similar change in percentile ranks for Problem Behaviors was found last year (74.3 before service and 60.3 after service, n=46). Clearly, services are improving social skills and decreasing problem behaviors in each of the last two years of this service.

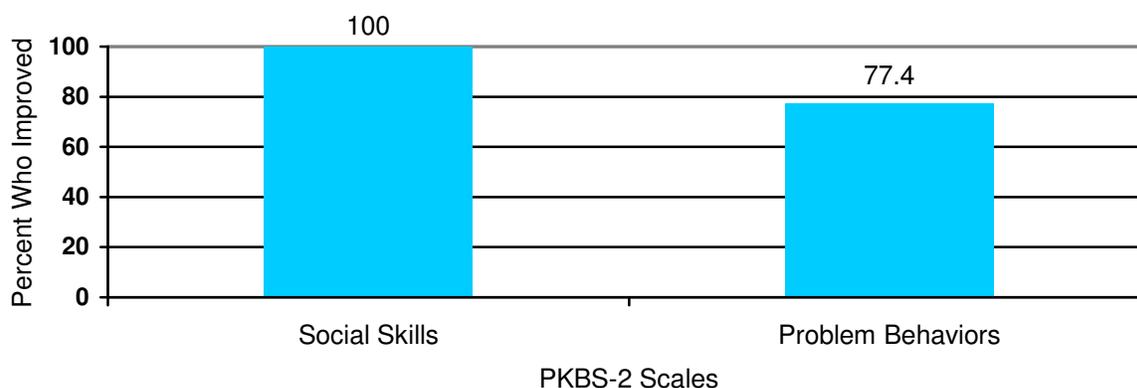
²⁰ Standard scores ranging from 85 to 115 are considered within normal range. In percentile ranks, normal range is 17 to 84. A child's percentile rank indicates what percentage of other children perform below that child. For example, if a child's percentile rank is 35, it suggests that 34% of children his/her age are performing below him/her, while 64% are performing above that child.

Table 13. Preschool Kindergarten Behavior Scales (PKBS-2) Scores FY 07-08 (n=31)

PKBS-2 Scales	Average Standard Score	Average Percentile Rank
Social Skills		
Pre-service	79.7	17.2
Post-service	101.3	50.9
Problem Behaviors		
Pre-service	113.3	75.9
Post-service	101.7	53.9

An examination of the percentages of children who had improved scores provides additional support for these findings. All 31 children experienced improvement in social skills as reported by their teachers. In over three-quarters of children, decreases in problem behaviors were reported (Figure 12).

Figure 12. Preschool Kindergarten Behavior Scales (PKBS-2) Ratings of Improvement FY 07-08 (n = 31)



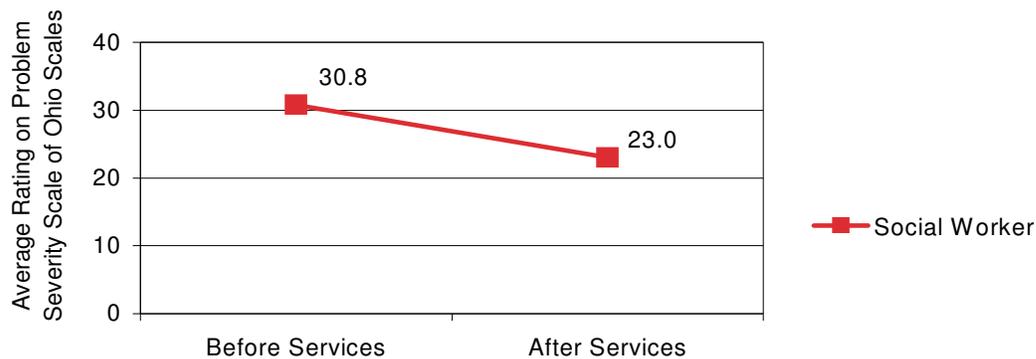
Regression models were used to evaluate the possible effects of child factors (age, initial problem severity), family factors (income, language), and treatment characteristics (intensity) on the degree of improvement as measured by the PKBS-2. When these five factors were considered concurrently, none was a strong predictor of change in Social Skills scores nor of change in Problem Behavior scores. However, any conclusions based on these regression analyses are severely constrained by the size of the sample (n=31) represented in the models.

Ventura County Behavioral Health Department. To assess the impact of mental health services on children and their families, Ventura County Behavioral Health Department uses the Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales). The instrument is completed before services and after services and is composed of four scales: Problem Severity, Functioning, Hopefulness, and Satisfaction. The Problem Severity Scale was chosen as the primary measure of child improvement. This scale includes a list of symptoms that a child may experience, and asks the respondent to rate how often the symptom occurs. For all scales, lower scores reflect more positive outcomes. Thus, a low score on the Problem Severity Scale suggests that the child experiences few or mild symptoms. There are multiple forms of the Ohio

Scales, which allow for different types of respondents. In this program, social workers and parents complete the form independently.

Overall, group average Ohio Problem Severity scale scores before and after treatment are consistent with decreasing symptoms; this decrease is apparent in social worker responses for 44 participants with matched, pre-/post- data (Figure 13)²¹. Comparisons reached statistical significance ($p < .05$)

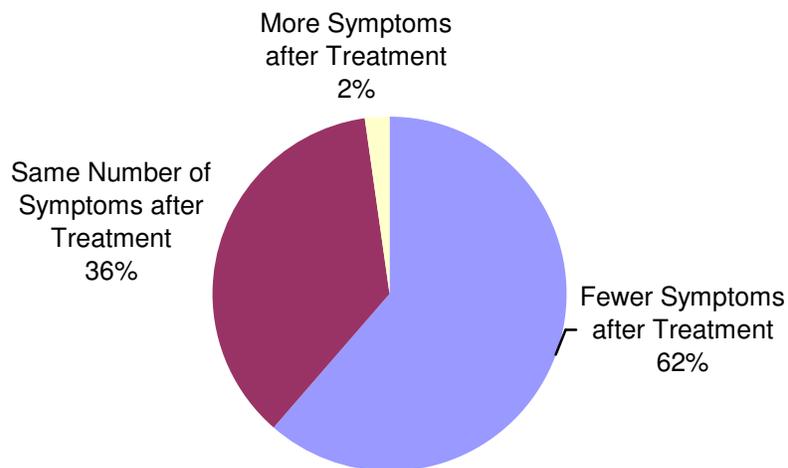
Figure 13. Average Ratings of Problem Severity by Social Workers Before and After Services FY 07-08 (n=44)



Few individual children have both pre- and post-service parent ratings. However, 44 children have completed pre- and post-service social worker ratings. Of those, a majority of children appear to have reduced symptoms after services (Figure 14). In combination, these results suggest that children are improving and have diminished problem severity after treatment services.

²¹ The availability of data for each time point and for each respondent type differs dramatically. Before services, there were 82 children with a Problem Severity Scale score as rated by parents, and 96 children with scale scores rated by social workers. For scores collected after services, only 9 parents completed the Problem Severity Scale while 82 social workers completed it. Due to the low number of parent responses after services, this analysis was not performed.

Figure 14. Change in Ohio Problem Severity Scale Scores, as Rated by Social Workers FY 07-08 (n = 44)



A regression model was used to evaluate the possible effects of child factors (age, initial problem severity), family factors (income, language), and treatment characteristics (intensity) on the degree of improvement as measured by social worker ratings on the Ohio Problem Severity Scale. When these five factors were considered concurrently, none was a strong predictor of change in Problem Severity. However, any conclusions based on this regression analysis are severely constrained by the size of the sample (n=44) represented in the model.

*Evaluation Question: Do some providers perform better than others?
Benchmark: 90% of referrals result in direct communication with families.
Benchmark: 40% of families complete an initial assessment.*

Based on data provided by VCBH, 65.0% of families that were referred to mental health services went on to use services; however, no information was available that provided evidence to evaluate whether direct communication occurred in all referrals or completion rates of the initial assessment. In the future, it is expected that such data will be made available for the annual evaluation report.

*Evaluation Question: Are families satisfied with services provided?
Benchmark: 90% of parents indicate high satisfaction levels.*

Satisfaction data were not available for the mental health service program located at Ventura NfL. Though the parent version of the Ohio Scales has a satisfaction scale, only nine parents completed the Ohio Scales after services. This is an insufficient number of surveys to perform any analyses. It is expected that next year, more surveys will be completed so that levels of satisfaction with the mental health services may be assessed. It is suggested that an additional measure be introduced for those families receiving mental health services through the Ventura NfL in order to capture their satisfaction with this classroom-based intervention. As mentioned previously, general satisfaction survey items indicated high levels of satisfaction with F5VC services (see pages 4-1 and 4-2).

Best Investment Area: Health Insurance Outreach, Enrollment, Utilization, and Retention and Oral Health

Compared to insured children, uninsured children are less likely to have a usual source of primary health care, that is, a place where the child regularly goes to receive health care. Among those with a usual source of care, uninsured children are more likely than are insured children to have no regular physician, to be without access to after-hours medical care, and to have families that are dissatisfied with their care (Forrest 2005).

Further, uninsured children have poorer access to essential specialty care, including preventive dental care, than do insured children. Substantial numbers of uninsured low-income children go without needed dental care, and are at increased risk of developing dental cavities with sequelae that can include persistent pain, missed school days, compromised nutrition, and diminished self-esteem (Liao, Ganz et al. 2008). Ongoing health insurance improves young children's access to physical and oral health services. Increased access to such services yields fewer child hospitalizations for unaddressed, chronic conditions (e.g., asthma) and more complete receipt of recommended immunizations (Eisert and Gabow 2002).

Evaluation Question: To what extent are children enrolling in health insurance/coverage as a result of F5VC funding?

Benchmark: 1,265 children are enrolled and/or re-enrolled in health insurance/coverage plans.

Benchmark: 1,500 children receive oral health treatment services.

Benchmark: 4,000 children receive fluoride varnish application.

In partnership with the Ventura County Public Health Department, a total of 1,123 children with their parents/caregivers received services to help them get enrolled in health insurance plans and ensure regular access to health care.

Two providers, Clinicas del Camino Real and Santa Barbara-Ventura Counties Dental Care Forum provided oral health treatment services to 1,240 children across Ventura County. Services included dental exams and fillings when necessary.

Fluoride varnish application can prevent and control dental cavities in children. The Ventura County Public Health Department, with F5VC funding, was able to apply fluoride varnish to 3,635 children in FY 07-08.

Evaluation Question: To what extent are we reaching children in all areas of Ventura County?

Benchmark: Health insurance enrollment assistance is provided countywide.

Benchmark: Oral health treatment services are accessible to children from all NfL service areas.

Children in families across the County received health insurance enrollment assistance through F5VC-funded providers. Using data from children more frequently served with health insurance enrollment assistance (n=550), child place of residence (16 cities/areas) demonstrates that services are reaching all parts of the County (Table 14).²²

Table 14. Ventura County Cities and Areas of Residence for Children Who Received Health Insurance Enrollment Assistance FY 07-08 (n=550)

City/Area	Number of More-intensely Served Children	Percent of All More-intensely Served Children
Camarillo	17	3.1%
El Rio	2	0.4%
Fillmore	27	4.9%
Moorpark	7	1.3%
Oak View	3	0.5%
Ojai	7	1.3%
Oxnard	217	39.5%
Port Hueneme	12	2.2%
Santa Paula	113	20.5%
Simi Valley	24	4.4%
Thousand Oaks	10	1.8%
Ventura	74	13.5%
Did not report city	37	6.7%
Total	550	100%

Similarly, children in families across the County used oral health treatment services supported by F5VC. Using data from children most-intensely served, child place of residence (14 cities/areas) demonstrates that services are accessible to children served by all F5VC NfLs (Table 15). Each city is associated with at least one of the 11 NfLs in the County.

²² Zip code of residence data are available for participants who completed an intake only. Though 1,123 children and their parents/caregivers received health insurance enrollment services, only 550 completed an intake or consented for their data to be included in the evaluation.

Table 15. Ventura County Cities and Areas of Residence for Children Who Received Oral Health Treatment Services FY 07-08

City/Area	Related NfLs	Number of More-intensely Served Children	Percent of All More-intensely Served Children
Camarillo	Pleasant Valley	7	1.1%
Fillmore	Santa Clara Valley	5	0.8%
Moorpark	Moorpark/Simi Valley	63	9.5%
Newbury Park	Conejo Valley	13	2.0%
Oak View	Ojai	2	0.3%
Ojai	Ojai	5	0.8%
Oxnard	Oxnard, Rio Ocean View	413	62.3%
Port Hueneme	Port Hueneme/South Oxnard	14	2.1%
Santa Paula	Santa Clara Valley	7	1.1%
Simi Valley	Moorpark/Simi Valley	43	6.5%
Somis	Pleasant Valley	3	0.5%
Thousand Oaks	Conejo Valley	46	6.9%
Ventura	Ventura	38	5.7%
Westlake Village	Conejo Valley	4	0.6%
	Total	663	100%

Best Investment Area: Access to Developmental Screenings

An estimated 5 to 10 percent of children zero to 18 years of age has a developmental disability (Rydz, Shevell et al. 2005). There are increasing efforts to identify those children with developmental delay during infancy and toddlerhood. This was prompted by several factors, including the understanding that brain plasticity varies with age, the awareness that early brain growth is dependent on environmental influences, and the premise that a favorable environment can enhance and optimize brain development (Joseph 1999).

Further, for children with developmental delay, intervention programs have been shown to be beneficial, maximizing developmental attainment. Early intervention programs are thought to activate the plasticity of the developing brain (Bonnier 2008). It is believed that gains will be greatest if the child participates in intervention services as early as possible, a concept iterated in public laws such as the Individuals With Disabilities Education Improvement Act of 2004, which mandates early identification and intervention for children with developmental disabilities.

Early diagnosis and intervention can also have a positive impact on child and family well being, as well as contributing to future savings related to social and educational costs of developmental disabilities. Because of these factors, professional organizations such as the American Academy of Pediatrics, as well as many state departments of education, are strongly endorsing the early identification of children with delays.

In FY 07-08, F5VC implemented developmental screenings across the County via NfL programs, with a goal of screening 900 children. VCPH nurses screen children using the Ages

and Stages Questionnaire (ASQ), which uses parent report to help identify areas of possible concern.

Evaluation Question: To what extent is F5VC implementing universal screening across populations (as defined by age, geography, income, race/ethnicity)?
Benchmark: 900 children receive a developmental screening through the NfLs.

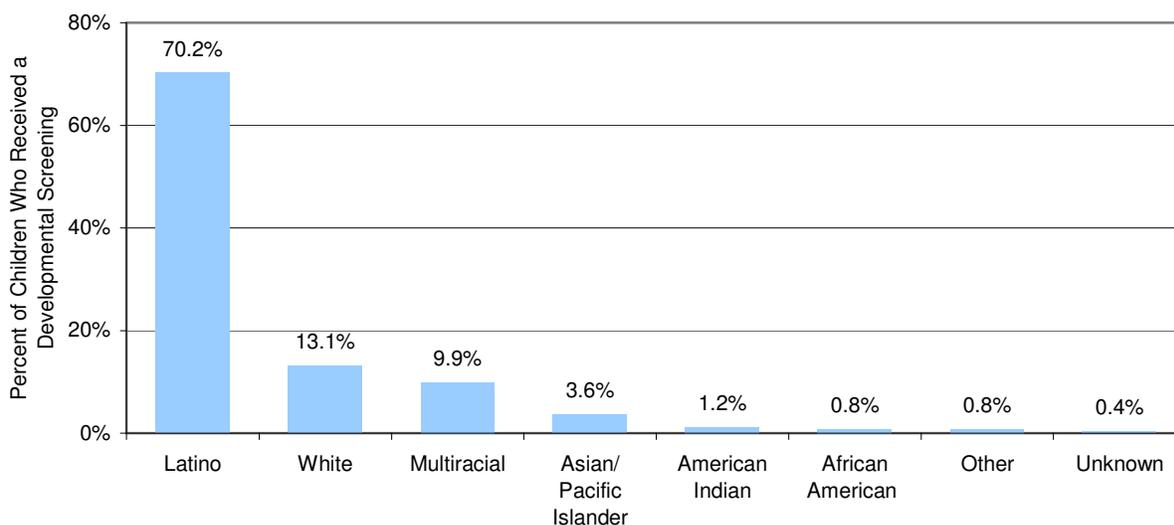
In partnership with the Ventura County Public Health Department (VCPH), the goal set by F5VC was achieved – 909 children in 11 NfLs received a developmental screen (Table 16).

Table 16. Children Who Received a Developmental Screening by NfL Program FY 07-08

Neighborhood for Learning	Percent of Children
Conejo Valley	4.8%
Moorpark/Simi Valley	22.6%
Oak Park	0.2%
Ocean View	12.5%
Ojai	0.4%
Oxnard	23.2%
Pleasant Valley	7.5%
Port Hueneme/South Oxnard	6.7%
Rio	5.8%
Santa Clara Valley	1.4%
Ventura	14.9%

Of those children who were screened, a vast majority of children are Latino (Figure 15). In addition, about half are between 0 and 3 years old (49.6%)

Figure 15. Distribution of Ethnicity of Children Who Received a Developmental Screening FY 07-08



Evaluation Question: To what extent is F5VC identifying children with developmental concerns?

Benchmark: The percent of children who screen positive is in line with national norms (i.e., 10-12% referral rate).

Of the 909 developmental screens for which we have outcome data, 243 were referred for further assessment. Thus, 26.7% of children screened had some developmental concern that required a referral to another provider for further assessment and/or intervention. This exceeds the benchmark, which references the national experience of 10-12% referral rate after developmental screening. This higher-than-expected occurrence of positive screens may be explained by the ways in which children were referred for screening. Educators or health professionals may notice child characteristics that suggest developmental concerns and then send a child to be assessed with a developmental screen; this type of recommendation increases the likelihood of a positive result on the screen. Similarly, parents may bring their children to be screened because they already have serious concerns about their children's behavior or development; this type of care-seeking also increases the likelihood of a positive screen.

Areas of developmental concern, as reported by parents, are identified using the Ages and Stages Questionnaire. Data from this measure were available for 171 children. The most common area of concern is communication (positive screen in 42.7% of children) (Table 17). The next most common areas of concerns were fine motor (positive screen in 10.1% of children) and socio-emotional (positive screen in 12.7% of children). Of note, an additional 22.0% indicated some other concern that did not fit these major categories of development.

Table 17. Areas of Parent Concerns Based on Developmental Screening FY 07-08 (n=171)

Areas of Parent Concerns	Percent of Parent Concerns
Communication	42.7%
Fine motor	10.1%
Social-Emotional	8.8%
Problem solving	7.1%
Gross motor	4.4%
Personal/Social	4.9%
Other	22.0%

After children receive a positive screen, they are referred to other agencies. Children are most often referred to their school district for early intervention (Table 18, 34.6%). Early Start, Public Health Nurses, and Behavioral Health are the next most common referrals provided. These referrals reflect the various needs of children for early intervention, which range from educational needs to mental health and physical health needs.

Table 18. Referrals for Children Who Screened Positive for a Developmental Problem FY 07-08

Total Referrals	
School District	34.6%
Early Start	19.6%
Ventura County Public Health Nurse	17.3%
Behavioral Health Service	12.6%
Other (e.g., WIC, NfL)	5.7%
Unknown	5.6%
Medical Provider	2.3%
Health Care For Kids	1.9%

CONCLUSIONS

In FY 07-08, First 5 Ventura County (F5VC) continued to fund a variety of program services that were provided to families to promote the healthy and appropriate emotional, social, and physical development of their young children. During this year, a new evaluation framework was developed to address limits to past evaluations. The new framework was a different model: it incorporated benchmarks and expected outcomes within evaluation questions, and was organized by selected areas of evaluation focus. The design of this framework concentrated evaluation efforts on more specific goals and services, rather than the broad perspective taken in the past. This model can be far more useful in a number of ways. It sets expectations for data collection and outcomes so that programs can plan their services with these demands in mind.

This Annual Evaluation report is structured by this framework and specifically addresses the interests and largest investments of F5VC, making it a tool that can be used in decision-making and planning. Additionally, the process of preparing the Annual Evaluation report highlights areas where data collection procedures need to be modified to better capture important and useful information. Lastly, the Annual Evaluation Report, reflecting this framework, is intended to help guide for program improvement efforts related to individual programs as well as cross-county efforts.

This is the first year using the new evaluation framework; thus, it was expected that programs would not have collected all of the data needed to address all benchmarks (the framework was implemented as the model for the Annual Evaluation after the end of FY 07-08). In essence, this Annual Report is a “demonstration project” reflecting the new evaluation framework. Nonetheless, despite the newness of this process, F5VC-funded partners and programs are demonstrating positive outcomes for the children and families served.

F5VC continues to serve children and families who face significant socioeconomic challenges. Most families report a family income far below the County’s median household income. The commitment to serving the youngest of children continues, as half of children served are between the ages of zero and three. Providing services to children as early as possible can both prevent developmental problems as well as provide the opportunity to intervene when a problem first is identified. Further, F5VC programs are identifying and helping those children in greatest need, as many children receiving more-intense services have a history of developmental problems.

Health care and childcare providers benefit from services intended to boost their abilities to address the unique needs of young children. New programs implemented in this fiscal year have resulted in the recruitment and training of a greater number of community pediatric health care providers (e.g., pediatricians). These efforts build the capacity of Ventura County providers and facilitate families’ access to fluoride varnish and other oral health services as well as developmental screening. Such efforts are preventive in nature, intended to preempt problems. However, with well-planned links to other services, families served by these F5VC programs are referred to providers who can provide intervention for any problems that are identified.

Best Investment Areas

The current Strategic Plan identifies major areas of F5VC investment; six of these are reflected in this report's evaluation foci. Within each area, offered services reflect local needs and environment. Generally, there is research evidence to support the use of such services to aid in the healthy development of young children, as outlined in this report. Evaluation questions and benchmarks, which are addressed through analysis of available data, substantiate the work of the F5VC-funded partners. In each area, most goals are achieved and positive outcomes are demonstrated.

Preschool

- Providers are exceeding target numbers of children served (1,062 vs. 1,002, actual vs. target).
- Preschool spaces have been expanded in the County (68 vs. 48 newly created preschool spaces, actual vs. target).
- Preschool children are showing improvements in development after receiving preschool services (78% vs. 75% at 'building' or 'integrating' developmental levels, actual vs. target).
- Most providers (82%) are meeting their targeted number of preschool spaces in their program.

Early Learning for Parents and Children Together

- Several thousand parents/caregivers and children are receiving early learning activities to promote early learning, literacy, and parent/caregiver attachment/bonding (5,303 vs. 3,361 parents/caregivers and children, actual vs. target).
- Programs are serving the youngest children, those aged 0 – 3 years (832 vs. 590 0-3-year-old children, actual vs. target).
- Family literacy outcomes are positive – parents who receive services read at rates higher than state estimates (94% vs. 76% of parents are book-sharing at least 3 days/week, actual vs. state).

Service Coordination and Case Management

- Through service coordination and case management activities, a large number of children (2,049) and parents/caregivers (1,851) are receiving assistance in obtaining needed health and social services.
- Outcomes appear promising, though respondent data are limited. All respondents (n=16) indicated that, as a result of coordination and management support, they were able to access the services that they needed.

Mental Health

- Children are benefitting from mental health services.
 - Increases in social skills (from 17th percentile to 51st percentile) and decreases in problem behaviors (from 76th percentile to 54th percentile) are seen in children receiving preschool-based intervention.
 - Clinicians of children receiving community-based mental health services report fewer symptoms in children after services (social workers report 62% of children with fewer symptoms after treatment).
- Partnerships with Ventura County Behavioral Health (VCBH) and the Human Services Agency result in the successful implementation of needed mental health services.

- 309 families were referred for mental health services through VCBH
- 201 referred families went on to use mental health services by VCBH (65% vs. 40% of referred families, actual vs. target).

Health Insurance Enrollment and Oral Health

- Families are receiving oral health treatment services for their young children.
- Many children are being given fluoride varnish, effectively preventing tooth decay and promoting dental hygiene in young children (3,635 vs. 4,000 children, actual vs. target).
- Countywide, F5VC families are obtaining health insurance, facilitating access and utilization of health services by their children (1,123 vs. 1,265 children, actual vs. target).

Developmental Screening

- Over 900 children had a developmental screening.
- Children whose developmental screening results suggest possible delay (243 out of 909, 27%) are being referred for further assessment.
- Of children with positive screens, the majority was referred to school districts (35%), Early Start (20%), Ventura County Public Health (17%), or Ventura County Behavioral Health (13%).

In sum, F5VC is meeting or exceeding most established benchmarks. Where benchmarks are missed, focused program improvement efforts that are informed by FY 07-08 evaluation results will help programs achieve their targets next year. There is evidence that some programs experienced challenges when implementing new services this year and this affected their ability to achieve service targets. It is expected that these barriers will not be experienced in the next fiscal year.

It may be useful to adjust targeted benchmarks in accordance with most recent service experiences. Further, the capacity to take full advantage of the evaluation framework is tied to having data available to address all evaluation questions and benchmarks. Thus, optimizing chances for complete data is important and may require revisions to data collection instruments, procedures, and the introduction of new data collection strategies. It may be useful to consider the implementation of a midyear report, to allow time to make any needed 'course corrections' in data collection and processing. In addition, it may be advantageous to have F5VC staff support data collection efforts, particularly outcomes data for those programs that are highly funded.

Appendix A

Data Collection and Analysis

Data Source

The purpose of GEMS is to capture program-level data including information specific to participants, services, and outcomes. These data are utilized for different purposes by funded programs and First 5 Ventura County. Programs use data in GEMS for quarterly reporting to First 5 Ventura County, grant writing, quality improvement, and program planning and evaluation activities. First 5 Ventura County uses data from GEMS for contract monitoring and evaluation purposes, including the capture of information required as part of ongoing statewide evaluation efforts. Additionally, data contained in GEMS can be useful for informing First 5 Ventura County cross-initiative evaluation efforts. The final data set that was cleaned, analyzed and summarized in this report represents data entered into GEMS from all funded programs.

Data Collection Instruments

Instruments were developed in conjunction with the original evaluation plan in order to collect information about participant demographics, services, and outcomes. Existing surveys and other instruments were used as often as possible. Data collection tools related to participants and services were drawn primarily from the data elements collected by the former First 5 California statewide evaluators, SRI International. Outcome measures were designed using items from state and national surveys. In cases where there were no appropriate pre-existing measures, new measures were designed. Some outcome measures were designed for data collection after receiving services (post-service), whereas other outcome measures included a pre-/post-service design so that changes in attitude and knowledge over time could be measured. Once finalized, all measures were built into GEMS.

Several standardized measures were used for specific services this year. For example, the Desired Results Developmental Profile, Revised (DRDP-R); the Ohio Scales; and the Preschool Kindergarten Behavior Scales, Second Edition (PKBS-2) were completed by programs that delivered educational and mental health services.

Participant Intake Form

The elements of the Participant Intake Form were taken directly from the initial First 5 California statewide evaluation requirements. This information was collected for participants who receive a more-intense level of service and can include children, family members, or providers. Common demographic data collected from these participants include: name, address, race/ethnicity, primary language used at home, and developmental status. Identifying information (e.g., name, address) is not forwarded to the central database. Instead, this information is located on computers at each local funded program to maintain the confidentiality of the children, family members, and providers served. In addition to common demographic data, there are unique items collected for each type of participant. For example, information about special needs is collected for child participants and family income data is collected for family member participants. No individual-level demographic data is collected for participants receiving less-intense services. Once all data are forwarded to the central database at the end of the fiscal year, data files are forwarded to the evaluator for analyses.

Service Transaction Form

Services data are collected differently for less-intense services and more-intense services. For a participant receiving more-intense services, the services transaction form records (for each

service) the day on which the service occurred and the length of the service (in hours or minutes). A single instance of a service is referred to as a service contact and is reported as “one occurrence”. The services transaction form allows program staff to report multiple service occurrences on a single form. For example, in one month a child may receive 10 occurrences of early education services. Program staff can enter “10” for the number of occurrences, rather than complete a form 10 times. When individual-level data are available, service occurrences can be aggregated for each participant receiving more-intense services and the data can be used to determine how often the service occurred.

For participants receiving less-intense services, program staff report data events of service contacts in the aggregate for the entire group served; that is, the form captures how many children, family members, and/or providers were served during a particular service event. The intention of less-intense services is to serve a large audience (e.g., distribution of Kit for New Parents). Collecting individual-level data would be burdensome for both programs and participants as the intake process requires time and additional staff beyond what is required to provide the less-intense service itself. As such, limited demographics (e.g., age, ethnicity, family member type) are reported on a group level for each less-intense service activity. This method can produce duplicated data: individuals who attend more than once, or who attend other less-intense services, are reported each time they attend an activity but in an aggregated way so that individuals cannot be tracked or counted. Therefore, analyses of participant demographics and service use data are restricted to individuals who received more-intense services.

Measures

Programs use outcome measures to collect information concerning the impact of services. Measures differ in scope; that is, some focus on perceptions regarding the extent to which a service affects participant well-being, while others address participant changes in knowledge relative to a particular topic. For instance, the outcome survey used for transportation-related services measures how easy it is to access needed transportation after receiving services. In contrast, the parent education outcome survey assesses change in knowledge that is assumed to be the result of the parent education service.

When a funded program defines its service by identifying strategy, method and activities, outcome measures are selected as well. Typically, the outcome measure is associated with the intended outcome of that service. The purpose of developing standardized measures for outcomes was to ensure that initiative-wide evaluation could occur across funded programs. By sharing a common approach to data collection through shared methods and measures, outcomes can be examined for all participants receiving services that are intended to produce similar results. In FY 07-08, training and support was provided to programs to help improve the quality of the data by providing more structure and consistency to the entry of data and use of outcome measures.

Data Entry Processes

GEMS software is installed at all funded programs, representing approximately 100 data entry users among the 39 First 5 Ventura County funded programs. Data entry staff entered data using GEMS intake and service transaction forms, and also entered information from the outcome measurement questionnaires that are collected at specified intervals. Quarterly reports were generated using the GEMS software system and sent to First 5 Ventura County staff.

Data Exports

Data are saved to each funded program site's local computer. At several points during the year, data are transferred or uploaded to the GEMS-Agent server, where data are stored for all funded programs. Data in the GEMS-Agent can be used by First 5 Ventura County staff and evaluators. When the data are transferred to the GEMS-Agent server, any identifying participant information (e.g., name, address, etc.) is removed from the electronic record. For participants receiving more-intense services, a unique alphanumeric code is attached to the record so that the individual participant can be identified across the three primary data components (i.e., intake, service transaction, and outcome).

For the current report, Mosaic Network, Inc. provided the data files in text format in October, 2008. These data were converted into a format used by the Statistical Package for Social Sciences (SPSS) Version 15.0. Data cleaning and analysis were then conducted by the evaluation team using SPSS software.

Data Cleaning

Data forwarded for analysis contained a number of errors that were identified and when possible, were "cleaned" or corrected. For example, in the child demographic files, several dates of birth were entered using a date in the future. In these cases, the date of birth was not used to calculate the age of the participant, rather, other information contained in the record was used.

For outcomes measures collected on different dates for the same individual, information from the most recent data collection timeframe within FY 07-08 was selected for analysis within each fiscal year. For instance, if a participant completed a case management post-service survey twice during the year, the measure with the most recent date was used to represent the fiscal year. This level of cleaning was only applied to participants receiving more-intense services outcome data, as they have unique identifiers. Other participants are given a generic client code each time an outcome measure is entered and this code is shared by multiple participants so that unique individuals could not be identified.

Once the data cleaning activities were complete, service transaction and outcome measure files were restructured. These files are organized such that an individual's data may be recorded on multiple rows, each row representing a separate service or an item on an outcome measure. In order to conduct analyses for the current evaluation period, the data were restructured so that each row corresponded to an individual. Once the data were restructured, the participant demographic data, as supplied by the intake forms, were linked to services transaction records. This merge was applied to participants in more-intense services only, as demographic information and individual-level services transaction data were not available for participants in less-intense services.

Data Analysis

Descriptive and inferential statistics were used to analyze data provided through GEMS. Descriptive statistics included reporting percentages by categories (e.g., race/ethnicity) and averages when data were appropriate¹ (e.g., average number of services provided to participants receiving more-intense services). Inferential statistics were used to detect statistical differences among data observed for different groups. For example, responses to pre-/post-service surveys were compared using a Chi-square or an Analysis of Variance (ANOVA), depending on the type of data collected. Chi-square analysis was used for categorical data, while ANOVA was used for interval-level data that were normally distributed. When a statistical

¹ To calculate averages, data must be numeric and reported on a continuous scale where the intervals between numeric values are equal.

difference was detected, the probability value (p) is reported. If a change from pre-service to post-service was recorded but no probability value is reported, this is because statistical tests did not demonstrate a statistically significant difference. This does not necessarily mean that the difference is not meaningful for program evaluation; rather it indicates that the difference was not great enough to be detected by statistical measures. This can be the consequence of a small sample size or large data variability (i.e., a range of item answers suggesting an inconsistent response pattern across individuals).

Appendix B

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Appendix C

Child, Family Member and Provider Participants: Fiscal Year Comparisons

The following tables were developed to detail findings from comparative analyses across fiscal years, which were conducted on a number of key variables concerning participants. This information is supplemental to the findings described in the body of the report.

Table C.1. Child Participant Demographic Data by Year (for Children who Received More-intensive Services)

		FY 05-06	FY 06-07	FY 07-08
Total children served		3,255	3,487	4,433
Gender	Males	54.7%	52.3%	51.7%
	Females	45.3%	47.7%	48.3%
Insurance Status	Uninsured	21.4%	18.3%	27.9%
Primary Language	Another language	53.1%	51.1%	47.1%
	Mostly/all English	26.2%	28.5%	31.0%
	Bilingual	19.3%	18.6%	21.5%
	Unknown	1.4%	1.9%	0.4%
	Most common language spoken other than English	Spanish (93.2%)	Spanish (93.9%)	Spanish (93.9%)
Race/Ethnicity	Latino	75.8%	73.9%	75.2%
	White	12.2%	13.6%	13.3%
	Multi-racial	6.1%	6.7%	5.6%
	Asian/Pacific Islander	2.8%	3.4%	3.6%
	Other	2.0%	1.3%	1.5%
	African American	0.7%	0.9%	0.6%
	Alaska Native/American Indian	0.3%	0.2%	0.2%
	(included in Latino - Mixteco)	(0.2%)	(0.2%)	(0.3%)

Table C.2. Child Participant Age Group Data by Year (for Children who Received More-intensive Services)

		FY 05-06	FY 06-07	FY 07-08
Total children served		3,255	3,487	4,433
Age Category	Less than 12 months	6.8%	7.0%	9.1%
	12 to 23 months	5.4%	6.4%	9.6%
	24 to 35 months	9.9%	9.1%	10.6%
	36 to 47 months	22.6%	20.9%	20.2%
	48 to 59 months	32.3%	36.2%	33.2%
	60 to 71 months	19.6%	18.3%	15.9%
	72 months and older	3.4%	2.0%	1.4%

Table C.3. Family Member Role by Year (for Family Members who Received More-intense Services)

		FY 05-06	FY 06-07	FY 07-08
Total family members served		3,128	3,812	3,263
Type	Parent/Guardian	90.8%	91.2%	93.3%
	Foster parent	3.1%	3.6%	2.0%
	Expecting parent	2.7%	1.5%	1.6%
	Grandparent	2.0%	2.2%	2.0%
	Other relative of child 0-5	1.4%	1.5%	1.0%
Gender	Male	10.3%	12.7%	13.6%
	Female	89.7%	87.3%	86.4%
Race/Ethnicity	Latino	77.1%	75.9%	72.0%
	White	14.6%	15.6%	17.5%
	Asian/Pacific Islander	3.5%	4.5%	5.3%
	Multi-racial	2.3%	2.1%	3.2%
	African American	1.2%	1.0%	0.7%
	Alaska Native/American Indian	0.1%	0.2%	0.1%
	Other	1.2%	0.7%	1.2%
	(included in Latino - Mixteco)	(0.7%)	(1.2%)	(1.8%)
Education Level	High school diploma/GED	46.9%	51.6%	56.1%
Employment	Unemployed	59.3%	57.7%	57.6%
	Part-time employment	12.0%	11.8%	11.8%
	Full-time employment	24.7%	24.8%	25.8%
	Seasonal worker	1.6%	3.4%	2.8%
	Temporary employment	2.3%	2.4%	2.0%

Table C.4. Provider Demographic Characteristics by Year

		FY 05-06	FY 06-07	FY 07-08
Total providers served		215	189	369
Gender	Females	97.2%	98.4%	84.3%
	Males	2.8%	1.6%	15.7%
Language	Mostly/all English	45.6%	36.4%	35.9%
	Bilingual	23.7%	44.9%	53.2%
	Another language	30.7%	18.7%	10.9%
	Most common other language	Spanish (94.8%)	Spanish (94.9%)	Spanish (97.2%)
Race/Ethnicity	Latino	59.2%	68.8%	38.0%
	White	29.1%	19.9%	49.6%
	Asian/Pacific Islander	3.9%	3.2%	6.5%
	Other	3.4%	1.1%	2.1%
	Multi-racial	2.4%	2.7%	0.9%
	African American	1.5%	3.8%	2.4%
	Alaska Native/American Indian	0.5%	0.5%	0.5%
	(included in Latino-Mixteco)		0.5%	(0.3%)

Table C.5. Provider Types by Year

		FY 05-06	FY 06-07	FY 07-08
Total providers served		215	189	369
Type	Center-based Child Care	34.9%	46.6%	32.5%
	Pediatric Health Care	--	--	29.5%
	Family-based Child Care (licensed)	52.6%	31.7%	12.2%
	Family-based Child Care (unlicensed)	6.5%	8.5%	6.2%
	Other	6.0%	13.2%	19.6%

Appendix D

Preschool for All Summary Report

Program Description

In 2003, First 5 Ventura County (F5VC) spearheaded a broad-based planning process involving over 500 stakeholders throughout the community. This group created a detailed work plan to improve children's readiness for school by recommending the expansion of access to high quality preschool programs. This Preschool for All (PfA) work plan describes rigorous preschool quality standards, provides a roadmap for gradual implementation of a pilot in the Hueneme School District area over a 5-year period, and proposes countywide system change strategies to address overall PfA goals. First 5 Ventura County, First 5 California, the U.S Department of Health and Human Services through its Early Learning Opportunities Act (ELOA) Grant, and the Packard Foundation have made significant financial commitments toward implementing Preschool for All (PfA) in the Hueneme School District area, investing nearly \$8 million over 5 years.

Upon submitting the PfA workplan to First 5 California, F5VC was selected as one of the nine Power of Preschool (PoP) Counties. Implementation of the PfA pilot in the Hueneme region ensued, including the creation of new preschool spaces and the improvement of the quality of existing center-based and family child care programs, with the goal of increasing the number of kindergarten children with quality preschool experiences to 70% by 2010. To reach this goal, F5VC builds on existing capacity and expertise by working with community partners and blends multiple funding streams, such as Head Start, State Preschool, Alternative Payment, and First 5 funds, to establish a diverse base of PfA-quality preschool programs that meet the needs of families.

The number of PfA spaces increased significantly from 92 in FY06-07 to 164 in FY07-08 by upgrading existing preschool spaces and creating 48 new spaces (which were operational by July 1, 2008, see Table 1). Upgrading the existing spaces includes providing increased compensation for teachers who increase their educational levels, technical assistance and training/coaching to teachers, and providing support to enhance the environmental quality of classrooms. To help teachers gain access to advanced education, F5VC links PfA teachers to the supports and benefits of the Comprehensive Approaches to Raising Educational Standards (CARES) program.

Table 1. Preschool for All Sites and Funding Sources

Preschool sites	Primary Funding Source				Pre-school for All spaces
	State Preschool	Head Start	PreK Family Literacy	First 5 Ventura County	
Williams	X				48
Haycox	X		X	X	63
Parkview	X	X			20
Larsen	X	X			20
Family Child Care				X	13
Total PfA spaces					164

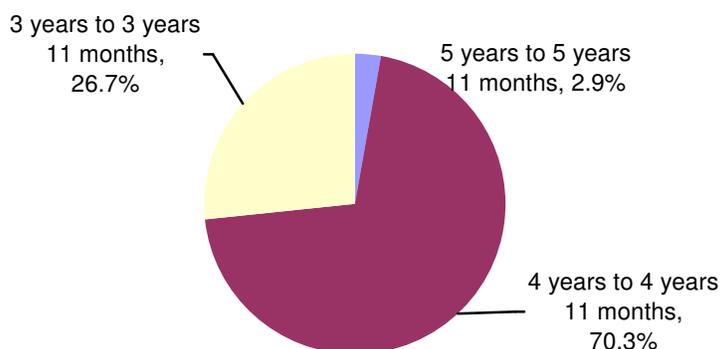
Population Served by Preschool for All

Almost 200 children (n=177) received PfA services. This number exceeds the number of spaces (164), primarily due to turnover of children in spaces. Compared to children receiving other F5VC more-intense services, children served by PfA are less likely to be uninsured and far more likely to be Latino (Table 2). Also, children in PfA are more likely to use a non-English language (usually Spanish) at home (Table 2). Ages of children enrolled range from 3 years to 5 years and 11 months, with the majority of children 4 years of age (Figure 1).

Table 2. Demographics of Children Who Received PfA Services Compared with Children Who Received More-intense F5VC Services FY 07-08

		F5VC (n=4,433)	PfA (n=177)
Gender	Males	51.7%	48.0%
	Females	48.3%	52.0%
Insurance Status	Uninsured	27.9%	16.8%
Race/Ethnicity	Latino	74.2%	90.3%
	White	13.2%	0.0%
	Multi-racial/Other	7.0%	7.9%
	Asian/Pacific Islander	3.5%	1.1%
	African American	0.6%	0.6%
	Alaska Native/American Indian (included in Latino - Mixteco)	0.2% (0.3%)	0.0% (1.1%)
	Other language	47.1%	78.5%
Primary Language	Mostly/all English	31.0%	10.2%
	Bilingual (English and other language)	21.5%	10.7%
	Unknown	0.4%	0.6%
	Most common language spoken other than English	Spanish (92.9%)	Spanish (94.9%)

Figure 1. Age of Child Participants in Preschool for All Services FY 07-08



PfA Results: Desired Results Developmental Profile-Revised (DRDP-R)

An analysis of DRDP-R performance of preschoolers four years of age and older is presented to assess the progress of children enrolled in PfA services. The DRDP-R is a teacher-rated scale that describes the developmental level of a student on 39 school readiness-related items (California Department of Education, 2007). The ratings of “building” and “integrating” are the two highest ratings on each item of the DRDP-R. The presence of this rating suggests that the child is using and mastering these skills. The change in the percent of items where building or integrating are used can demonstrate the growth in children’s skills. Younger children were excluded from these analyses, because a child three years of age is unlikely to be rated as building or integrating on these items.

Matched pre-/post-service data were available for 96 children ages four years or older. Across all items, 59.8% of responses after service were at the “building” or “integrating” levels, compared to only 18.7% before services (Table 3). This shows an improvement of 41.1%. These findings suggest that children are progressing with regard to school readiness.

Table 3. Comparison of Percent of DRDP-R Responses Before and After Preschool Services FY 07-08

	Number of Participants with Matched Pre-/Post DRDP-R	Percent of Responses Rated as Building or Integrating Before Service	Percent of Responses Rated as Building or Integrating After Service	Percent Change
Preschool for All	96	18.7%	59.8%	41.1%

PfA Results: Early Childhood Environment Rating Scale – Revised (ECERS-R)

The ECERS-R is an instrument designed to assess the quality of group programs for preschools through kindergarten (Harms, Clifford, Cryer, 1998). The ECERS-R is composed of 43 items that are organized into 7 subscales and also generating a global score. Sites are rated by a trained observer. Raters rate each item on a scale of 1 to 7, 1 represents lowest quality environments while 7 reflects highest quality environments. PfA classrooms were assessed using this system, and overall, sites received above-average ratings (mean of 5.6) on their global ECERS-R score (Table 4). Data suggest that there is room for improvement, as the highest possible score is 7, though certain infrastructure limitations (e.g., limited access to a safe playground or distance to a working sink) can affect ratings and may not be influenced by the support and resources that F5VC is able to offer.

Table 4. Average Global ECERS-R Scores by PfA Site Type FY 07-08

	All Sites	State Preschool	Head Start	Other
Average Global ECERS-R Score	5.58	5.49	5.69	5.54

PfA Results: Teacher Qualifications

PfA teachers meet or exceed the PfA education requirements as evidenced below (Table 5):

- 6 out of 7 master teachers (86%) hold BA degree
- 12 out of 13 assistant teachers (92%) hold either BA or AA degree
- 9 out of 20 master and assistant teachers (45%) have a Site Supervisor permit from the California Commission on Teacher Credentialing

¹ Harms, T., Clifford, R. M., & Cryer, D. (1998). *Early Childhood Environment Rating Scale-Revised*. New York, NY: Teachers College Press

Table 5. Power of Preschool Teacher Qualifications FY 07-08

	Master Teachers		Assistant Teachers	
	Number	Percent	Number	Percent
Teacher's Degree				
CDA	0	0.0%	0	0.0%
AA	1	14.3%	7	53.9%
BA	6	85.7%	5	38.5%
MA/Doc	0	0.0%	0	0.0%
Other	0	0.0%	0	0.0%
None	0	0.0%	1	7.7%
Total	7	100.0%	13	100.0%
Teacher's Permit				
Assistant	0	0.0%	0	0.0%
Associate	1	14.3%	3	23.1%
Teacher	2	28.6%	3	23.1%
Master	0	0.0%	0	0.0%
Site Supervisor	4	57.1%	5	38.5%
Program Director	0	0.0%	0	0.0%
None	0	0.0%	2	15.4%
Total	7	100.0%	13	100.0%

Summary

The F5VC PfA program has achieved positive outcomes this fiscal year. New and enhanced preschool spaces were created, and children served are demonstrating positive school readiness outcomes. Additionally, sites are rated as above-average in quality and teachers are meeting or exceeding educational requirements set forth in the PfA work plan. An area for program improvement may be to focus on increasing the quality of the environment in PfA sites, as ECERS-R scores suggest room for further advancement.

Appendix E

School Readiness Initiative

Background

First 5 Ventura County (F5VC) launched its local school readiness initiative “Neighborhoods for Learning” (NfL) in FY 2000-2001. Eleven geographically defined NfLs serve as programmatic platforms for most of the Commission’s early learning, health and family support activities as well as for State School Readiness (SR) Programs. NfLs are community-based collaboratives, implementing school readiness strategies based on the unique cultural, ethnic, linguistic, socio-economic and special needs of their communities.

The School Readiness (SR) Initiative is a centerpiece of First 5 California’s work with children. The purpose of the SR Initiative is to improve the ability of families, schools and communities to prepare children to enter schools ready to succeed. A primary function of SR Programs is to coordinate the effective delivery of quality services and supports for California’s youngest children (0-5) and their families. First 5 California has been providing matching funds for local school readiness programs since December 2001. State SR funds are matched at least dollar for dollar by local cash funds and these matched funds support locally tailored SR Programs linked to “high priority schools” (i.e., schools in deciles 1-3 of the Academic Performance Index, API).

First 5 Ventura County has participated in the State School Readiness matching funds program since its inception, utilizing the Neighborhood for Learning structure as a foundation upon which to build these additional programs. The Hueneme NfL, Oxnard NfL, Santa Clara Valley NfL and Rio NfL are the four F5VC NfL programs eligible to participate in the School Readiness Initiative targeted at high priority schools.

Building upon the extensive and comprehensive work done as part of the NfL planning and implementation process, the resources from the State SR Initiative have been used to expand and enhance school readiness activities in the areas of Early Care and Education, Parenting and Family Support, Health and Social Services, and School Capacity. The SR programs integrate previously isolated social and health services, expand opportunities for preschool experiences, create empowerment opportunities for parents, and facilitate fundamental systemic change by expanding the vision of local elementary school districts to include Pre-K.

In FY 2007-08, local and state First 5 school readiness investment totaled \$1,554,899. Funds were allocated to activities that include:

- Community resource and referral
- Family literacy programs
- Parenting education
- Preschool for 3 and 4 year olds
- Summer-intensive preschool (Kindergarten transition programs)
- Health insurance enrollment assistance

Participants

Services are diverse and may include children and their parents/caregivers together, or separately. A total of 800 children and 684 parents/caregivers received more-intense school readiness services (Tables 1 and 2). A majority of children and parents/caregivers identified themselves as Latino and 46.4% of parents/caregivers reported that another language was the primary language spoken at home (Table 2). Compared to children who received more-intense services across F5VC programs, children and their parents/caregivers in the School Readiness Initiative are somewhat more likely to be Latino (Tables 1 and 2).

A vast majority of parents/caregivers who received services were female, while children served were nearly equally male and female (Tables 1 and 2). Less than 3% of children were reported to have a special need by their parent/caregiver (2.7%) while 3.9% of parents/caregivers indicated that they had been told their child had a developmental delay. Nearly half of children in School Readiness programs were 4 years old (48.0%), just over one-quarter were 5 years old, and another quarter were 0 – 3 (Figure 1). This is different from the general population of children served by F5VC, where half are 0 – 3 (Table 1).

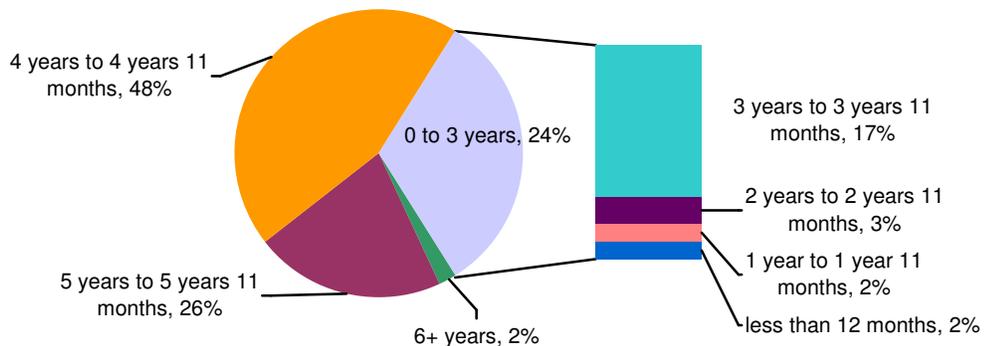
Table 1. Demographics of Children Who Received More-intense Services FY 07-08

		F5VC (n=4,433)	School Readiness (n=800)
Gender	Males	51.7%	49.8%
	Females	48.3%	50.3%
Insurance Status	Uninsured	27.9%	12.9%
Race/Ethnicity	Latino	74.2%	84.3%
	White	13.2%	7.0%
	Multi-racial/Other	7.0%	5.1%
	Asian/Pacific Islander	3.5%	2.1%
	African American	0.6%	0.4%
	Alaska Native/American Indian	0.2%	0.4%
	(included in Latino - Mixteco)	(0.3%)	(1.3%)
Primary Language	Other language	47.1%	46.4%
	Mostly/all English	31.0%	28.6%
	Bilingual (English and other language)	21.5%	24.6%
	Unknown	0.4%	0.4%
	Most common language spoken other than English	Spanish (92.9%)	Spanish (93.3%)
Age	Less than 12 months	9.1%	2.4%
	1 year old	9.6%	2.1%
	2 years old	10.6%	3.3%
	3 years old	20.2%	16.4%
	4 years old	33.2%	48.0%
	5 years old	15.9%	25.8%
	6 years old	1.4%	2.0%

Table 2. Demographics of Family Members Served by School Readiness Programs FY 07-08

		F5VC (n=3,263)	School Readiness (n=684)
Gender	Males	13.6%	10.0%
	Females	86.4%	90.0%
Education	High school diploma/ GED	56.1%	45.6%
Race/Ethnicity	Latino	72.0%	85.5%
	White	17.5%	8.0%
	Asian/Pacific Islander	5.1%	2.6%
	Multi-racial/Other	4.4%	2.7%
	African American	0.7%	0.7%
	Alaska Native/ American Indian	0.1%	0.1%
	(included in Latino - Mixteco)	(1.8%)	(5.6%)

Figure 1. Age of Child Participants in School Readiness Programs FY 07-08



School Readiness Results: Family Literacy

Using data from the outcomes measure related to family literacy, survey participants who received school readiness programs (n=211) indicated that by the end of service, 81.7% were reading at least 4 days a week with their child with 75.1% asserting that the best time to start reading with a child is during the child's first year of life. Also, the average number of days parents/caregivers were reading or showing picture books was 5 days (range = 0 – 7). These data are comparable to findings across all F5VC programs in FY 07-08 and suggest that services are helping to promote early learning environments in the home.

School Readiness Results: Preschool

Data from the Desired Results Developmental Profile – Revised (DRDP-R) were examined to assess the impact of school readiness services on preschool outcomes. Children are rated on a 4-point scale and it is expected that over the course of receiving services, the percent of children ratings in the higher categories of development (i.e., *building* or *integrating*) should be higher. The average percent of change across programs was calculated. Data were examined for children 4 years of age and older, as higher ratings on the DRDP-R are only expected from older, more developed children. Across programs, the average percent of change seen from before services to after services in FY 07-08 was 41.8%. This is similar to F5VC services, where the average percent of change was 43.2%.

Summary

The School Readiness Initiative has demonstrated positive family literacy behaviors by parents/caregivers and improved readiness for school for children served by these programs. Children and parents/caregivers in these programs tend to be Latino, and most children are 4 or 5 years old. A majority of parents/caregivers reported that they read or show picture books to their child at least 4 days a week, and the average number of days parents are doing this is 5 days a week. Preschool outcomes using the DRDP-R show that children's developmental readiness for school improves after school readiness services. In general, School Readiness programs are helping children and their families to be ready for school.