

CHOC-UCI Early Developmental Services
Evaluation Report
July 2013 through June 2014

Introduction

CHOC-UCI Early Developmental Services (EDS) provide a continuum of developmental services for children and families, from when a parent first has concerns about their child's development or behavior to full diagnosis and intervention for those children with developmental delays.

- Parents or professionals with a concern can contact **Help Me Grow (HMG)** at 1.866.GROW.025 or helpmegrowoc.org for connection to a variety of developmental and behavioral services. Help Me Grow also works with primary health care providers to promote and offer training in developmental surveillance and screening.
- **Child Behavior Pathways (CBP) (formerly CUIDAR)** provides a preventive and “intervention before diagnosis” approach for behavioral disorders through the use of 9-week COMMUNITY Parent Education (COPE) classes, 9-week COPEing with Toddler Behavior (CWTB) classes, social skills lessons for children, and teacher training services. CBP helps parents and teachers effectively manage challenging behaviors, improve family/classroom functioning, and encourage healthy relationships with infants, toddlers, and preschool age children.
- **The Early Developmental Assessment Center (EDAC)** provides comprehensive, multidisciplinary developmental and nutritional assessments, education, intervention strategies, care coordination and advocacy for high-risk infants and toddlers who have been referred from neonatal intensive care units (NICUs) and the community.
- When expert assessment and ongoing care are needed, **The Center for Autism and Neurodevelopmental Disorders (The Center) (formerly For OC Kids Neurodevelopmental Center)** provides comprehensive evaluations, diagnosis, treatment, and management of children of all ages who are suspected of having developmental, behavioral or learning problems. The Center also provides family support, education, and advocacy.

Help Me Grow, Child Behavior Pathways, EDAC, and The Center also provide training and education to health care professionals and educators to help them recognize developmental delays, signs of autism and ADHD, when to refer children for assessment and intervention, and how to manage difficult behaviors in typical child care settings.

Major funding for EDS is provided by the Children and Families Commission of Orange County (CFCOC), which began supporting developmental services at CHOC and UCI in 2001. EDS grew and evolved until 2005, when the last of the four programs, Help Me Grow, was established. The next organizational change occurred in 2012, when the CFCOC joined with the William and Nancy Thompson Family Foundation to make a catalytic funding award that is leading to an expansion of services and stronger connections among the four programs.

In 2013/14, HMG and CBP participated in the Child Signature Program (CSP), which is funded by First 5 California and invests in high quality preschool programs that enhance the quality of care and education that children receive. CSP targets children at greatest risk for school failure with the goal that they will enter school with the skills to be successful. The role of HMG is to oversee 20 Family Support Specialists who recruit families into the program, conduct home visits, provide case management, refer and link families to needed services, and collaborate with program staff and specialists to coordinate services for children and parents – all focused on achieving positive developmental outcomes for the children. With CSP funding, CBP was able to once again offer play-based social skills lessons to children whose parents are participating in COPE parenting classes. CBP also provides a team of Mental Health Specialists to work with community partners to support children in the home and classroom.

This evaluation report describes the accomplishments of EDS in the 2013/14 fiscal year. Its purpose is to show how EDS makes a difference in the lives of children and families in Orange County, tell its story to funders and families, and provide information for program improvement.

Data Sources

Unless otherwise noted, data for this report come from the data system of the CFCOC, or from the programs themselves. The Commission's data system is the source of data for process measures, such as how many people received services and how many services were provided. Data describing the children and families who received services and program outcomes come directly from the programs.

Process Measures

On a monthly basis, each program reports to the CFCOC how many new clients they served during the month and how many services they provided to all their clients. A count of only new clients provides an unduplicated count of the number of people served each year. For counting purposes, all clients are considered new at the beginning of each fiscal year. Each person may receive multiple services during a single encounter, so the number of services provided is typically much larger than the number of clients served. The tables on the next page show the data by program for each of the past three years. In the graphs that follow, the total number of people served and the total number of services provided by all four EDS programs are shown for the past six years.

As of April 1, 2013, The Center began reporting process measures for the catalytic funding separately from the continuing funding. In consultation with the CFCOC, The Center developed milestone targets and a protocol for reporting progress for both revenue streams. The Center only reported child-specific data on the continuing side because no catalytic funds were used to pay for physician time. Catalytic funds were used to provide parenting presentations, workshops, and trainings; support groups; consultations, and resource fairs, which were reported as services to parents and/or providers.

In this report, process data collected by HMG and CBP for the Child Signature Program are also included as separate entries.

Children

Program	Number of Children Served			Number of Services to Children		
	13/14	12/13	11/12	13/14	12/13	11/12
Help Me Grow	2345	2470	4395	11,677	12,899	16,013
CBP - original	108*	198*	0*	168*	198*	0*
CBP - CSP	130			690		
EDAC	1540	1864	2701	8429	10,298	11,642
The Center - continuing	1034	1083	1410	2989	2943	3654
The Center - catalytic	236	0		2094	0	
TOTALS	5393	5615	8506	26,047	26,338	31,309

* Child Behavior Pathways- original - does not provide direct services to children. In 2013/14 and 2012/13, CBP-original reported the number of children whose parents completed the Child Behavior Checklist (CBCL) as part of their participation in COPE or CWTB

Family Members

Program	Number of Family Members Served			Number of Services to Family Members		
	13/14	12/13	11/12	13/14	12/13	11/12
Help Me Grow	2345	2470	4395	11,677	12,899	16,013
CBP - original	262	271	695	2263	1719	4348
CBP-CSP	198			1010		
EDAC	1540	2022	2701	8429	10,298	11,642
The Center - continuing	2470	1570	2290	2529	2616	4285
The Center - catalytic	970	555		2023	1345	
TOTALS	7785	6888	10,081	27,931	28,877	36,288

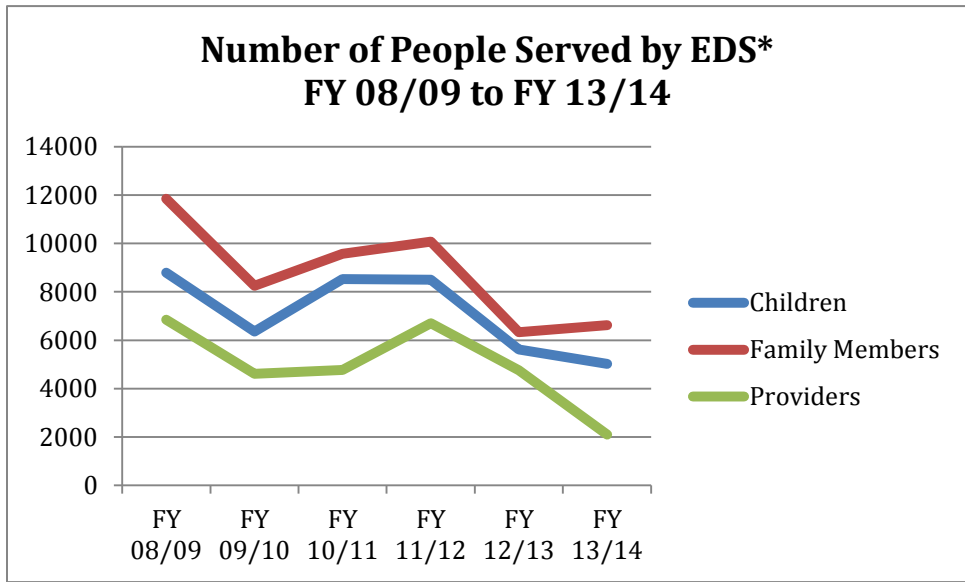
Service Providers

Program	Number of Providers Served			Number of Services to Providers		
	13/14	12/13	11/12	13/14	12/13	11/12
Help Me Grow	884	3209	4592	2750	3209	4592
CBP - original	138	162	341	397	172	409
CBP - CSP	210			751		
EDAC	79	327	494	904	1343	1819
The Center - continuing	989	1057	1273	989	1057	1273
The Center - catalytic	502	1318		701	1318	
TOTALS	2802	6073	6700	6492	7099	8093

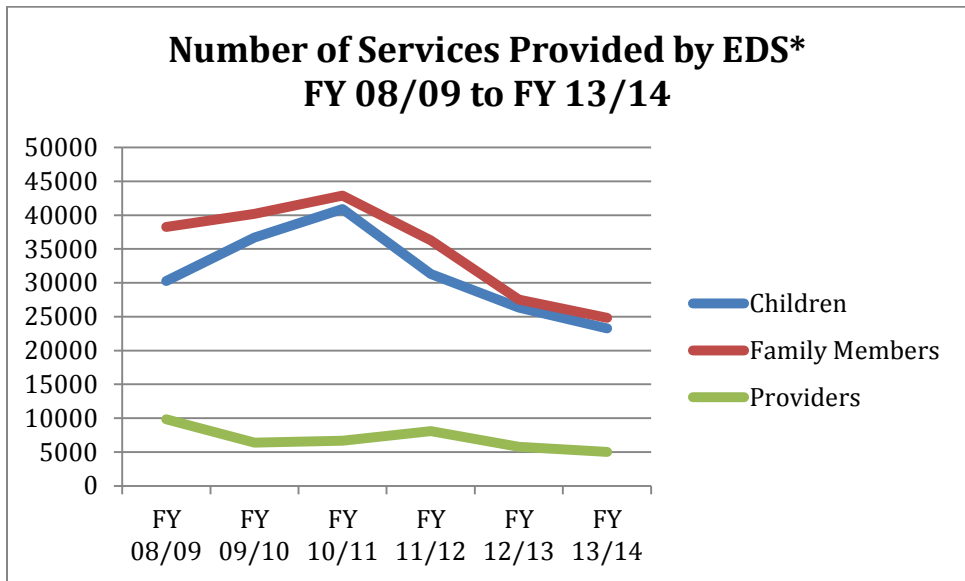
Data Source: Commission Data System

Note: The totals may include some duplication, because individuals served by more than one program are included in the counts of each program.

These two charts show the number of people served and the number of services provided over the past five years. The numbers have fluctuated along with the budget for EDS, as seen on the next page. The number of people served and services provided that are attributed to catalytic funds and CSP are not included in these charts to allow for comparison across all six years.

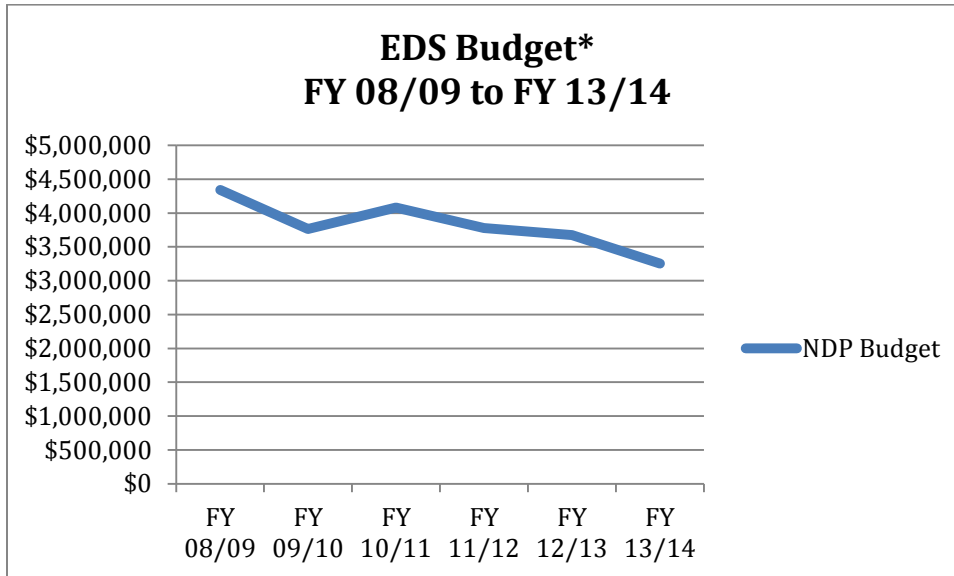


* excludes services associated with catalytic and CSP funds



* excludes services associated with catalytic and CSP funds

To understand at least some of the changes in the number of people served and the number of services provided, the annual budget for all four programs combined is presented below. Catalytic and CSP funding are excluded from this graph to allow for comparison across all six years.



*excludes catalytic and CSP funding to allow direct comparison across all six years

Progress toward milestones:

EDS reports their progress toward specific milestones selected by the CFCOC based on the services each program provides. These milestones are standardized across all of the CFCOC’s grantees. A one-year target quantity for each milestone is established in consultation with each program. The table below shows the target quantities for FY 13/14, the number of clients served during the year, and when comparable numbers are available, the number of people served during the previous two years.

For all but ten milestones, the programs surpassed their targets for FY 13/14. For those that fell short, it should be remembered that targets are an educated guess at the beginning of the year regarding what the program will be able to accomplish and there are many reasons programs may not have achieved the targets. In addition, there are some milestones over which the programs have little control, such as milestones that rely on referrals from other institutions or the condition of the children who are receiving services.

Milestone	Description	Program	12-Month Target for 13/14	# of Clients Served in 13/14	# of Clients Served in 12/13	# of Clients Served in 11/12
HC 2.1.1	Providers trained on how to screen, assess and /or identify child developmental milestones	HMG-original	60	136	136	125
HC 2.1.2	Providers educated on child development, recognizing key milestones and the importance of screening	HMG-original	122	98	202	142
		EDAC	100	79	307	452
		The Center - continuing	74	989	1083	1273
		The Center - catalytic	126	515	1318	
		The Center - TOTAL	200	1504	2401	1273
HC 2.2.1	Children receive developmental screening using AAP recommended tools.	HMG-original	50	481	689	2723
HC 2.2.7	Children receive behavior health screening using Commission-approved tool (including but not limited to ASQ:SE)	CBP - original	70	153 ¹	149	222
HC 2.2.9	Children receive assessment (e.g., vision, hearing, speech/language, psychosocial issues (cognitive, emotional, behavioral), motor skills, health, special needs, and/or parent-child functioning)	EDAC	700	431	489 ²	506 ²
		The Center - continuing	155	320	270	335
		The Center - catalytic	265	38	0	
		The Center - TOTAL	420	358	270	335
HC 2.2.10	Parents receive education, resources, referrals, and support regarding their child's development	HMG-CSP	300	345		
		EDAC	600	787	719	702
HC 4.4.1	Children receive specialty care clinic visits	The Center - continuing	629	1435 ³	1588 ³	2047 ³

Milestone	Description	Program	12-Month Target for 13/14	# of Clients Served in 13/14	# of Clients Served in 12/13	# of Clients Served in 11/12
		The Center - catalytic	1071	945 ³	0	
		The Center - TOTAL	1700	2380	1588	2047
HC 4.4.1a	Children receive specialty care follow-up clinic visits	The Center - catalytic	500	969 ³		
HC 4.4.3	Parents receive specialty care education, resources, referrals and support	EDAC	80	247	714	1093
		The Center - continuing	629	1331	1351	2000
		The Center - catalytic	1071	383	288	
		The Center - TOTAL	1700	1714	1639	2000
SF 2.2.1	Home visitors and/or program staff will assess and provide service plans to improve parent knowledge of healthy child development using a Commission-approved tool	HMG-CSP	500 service plans	465		
SF 2.2.4a	Parents participate in parenting education classes on healthy child development	The Center - continuing	179	1139	218	308
		The Center - catalytic	306	587	267	
		The Center - TOTAL	485	1726	485	308
SF 2.2.4b	Parents participate in a parenting education class series on healthy child development	CBP - original	200	262	271	695
		CBP - CSP	150	198		
		CBP - TOTAL	350	460	271	308
SF 2.2.6	Children receive group interventions to improve healthy child development	CBP - CSP	10 classes	10 classes		
		The Center	Unknown	118		

Milestone	Description	Program	12-Month Target for 13/14	# of Clients Served in 13/14	# of Clients Served in 12/13	# of Clients Served in 11/12
		- catalytic				
SF 2.2.7	Providers receive consultations to improve provider knowledge of healthy child development	CBP - CSP	70	101		
SF 3.1.2	Parents receive referrals to services	HMG-original	1800	2269	1826	1659
SF 3.1.3	Providers receive referrals to services	HMG-original	350	532	641	789
SF 3.1.4	Parents receive follow up on referrals and services are accessed	HMG-original	600	844	807	754
		HMG-CSP	400	307		
SF 3.1.6	Family support and child development teacher trainings	HMG-CSP	5	24		
		CBP - CSP	13	19		
SF 4.1.3	Providers receive training on behavioral health treatment services for children 0-5	CBP - original	120	208	162	341
		CBP - CSP	70	70		
		CBP - TOTAL	190	278	162	341
SF 4.1.4	Parents receive education, resources, referrals, and support regarding their child's behavioral health issues	CBP - CSP	750	258		
SF 4.2.3	Staff participate in case management team meetings to support the needs of the families served	HMG-CSP	10 meetings	6		
		CBP - CSP	40	58		
CB 2.2.1	Developing partnerships, coordinating and collaborating with other agencies to improve services	HMG-original	6	6	6	6
CB 2.3.4	Children with special needs	HMG-	250	453	563	531

Milestone	Description	Program	12-Month Target for 13/14	# of Clients Served in 13/14	# of Clients Served in 12/13	# of Clients Served in 11/12
	served	original				
		CBP - original	14	60	49	62
CB 2.3.8	Program staff will report the ongoing caseload for month reported	HMG-CSP	See note ³	558		

Source: Commission Data System

1: the total for 2013/14 includes 45 children served through CSP, although this milestone is not part of the CSP work plan

2: 82 were foster children in 2012/13; 132 were foster children in 2011/12

3: Children are counted each time they received a comprehensive assessment, so if they were assessed on three different occasions, they are counted three times.

Child Demographics

Each program collects data that describes the children and families they serve. The tables that follow provide the demographic picture of the children served in 2013/14. Charts are used to show trend data of key demographic measures over four years, from 2010/11 through 2013/14. Because of changes in how it has collected demographic data, comparison data for EDAC is not included in the charts.

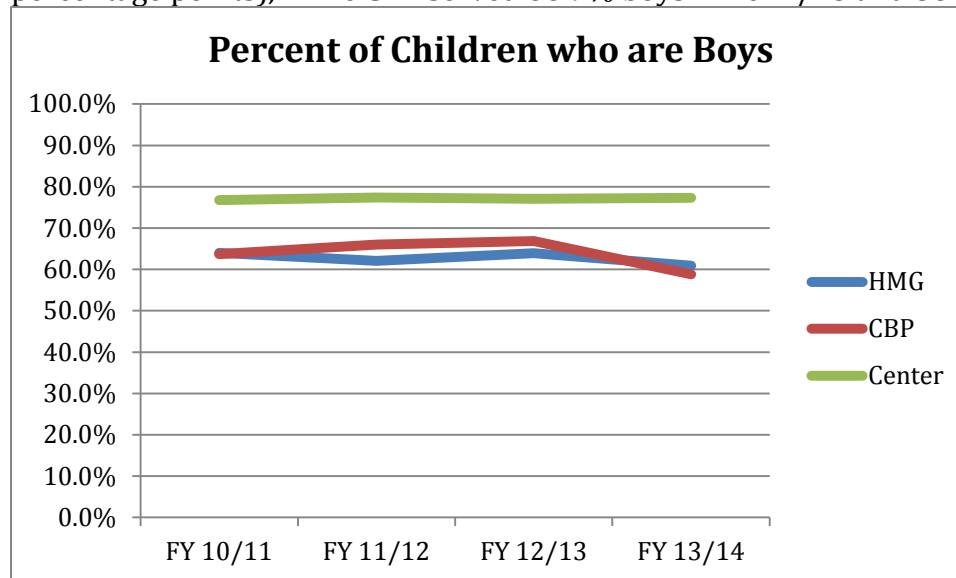
Overall, the programs served more boys than girls. EDAC serves primarily children who are infants through age 2; CBP serves children up to age 5. HMG and The Center serve children of all ages. Across all four programs, over 50% of the children served were Hispanic, but the rate varied from just over 25% at The Center to nearly 70% for HMG. The primary language of the families in three of the programs (HMG, EDAC, and The Center) was English (ranging from 60-84%), Spanish was the primary language for 56% of the families participating in CBP. The programs served a large percentage of children with public insurance. Of the three programs that collect insurance information, nearly three quarters of the children served by HMG and EDAC have public insurance; 41% of children served by The Center have public insurance.

Gender	HMG	Child Behavior Pathways	EDAC**	The Center
Boys	60.9%	58.8%	58.5%	77.3%
Girls	38.4%	41.2%	41.5%	22.7%
Unknown*	0.7%			
N=	3217	342	376	2086

* Unknown because the mother is pregnant

** EDAC data is of a cohort of children born in 2011 who qualified for service through CCS.

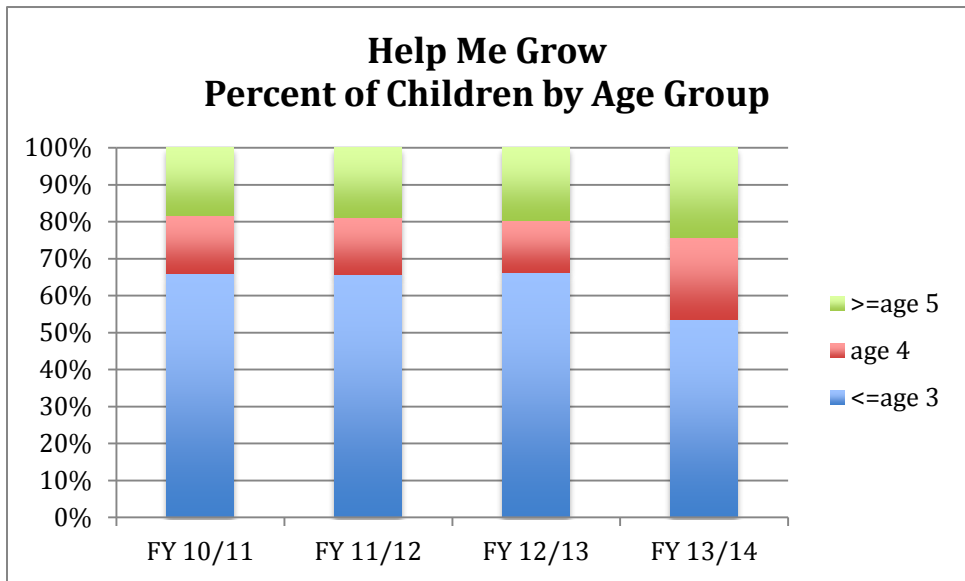
HMG had a slight decline in the percentage of children who are boys (down three percentage points), while CBP served 66.9% boys in 2012/13 and 58.8% in 2013/14.



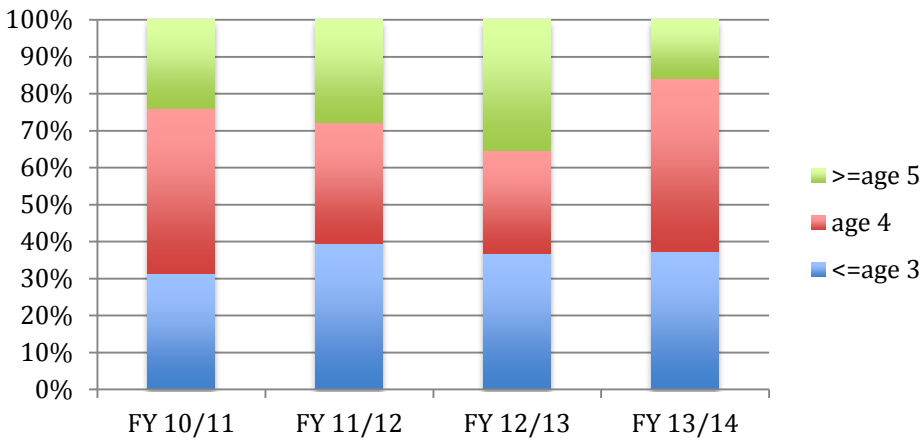
Child's Age	HMG	Child Behavior Pathways	EDAC*	The Center
<1 year	10.3%	6.4%	59.0%	0.2%
1 year	11.9%	5.3%	39.5%	1.0%
2 years	16.3%	7.0%	10.0%	5.7%
3 years	15.1%	18.7%	<0.5%	9.1%
4 years	22.2%	46.8%		9.3%
5 years	9.1%	15.2%		9.9%
>=6 years	15.1%	0.6%		64.9%
Unknown				
N=	3226	342		2086

*Age data for EDAC is from 2011/12; current data is unavailable but in the past these percentages were quite consistent from year to year.

Age trends are shown for each program with the exception of EDAC, which provides services only to children up to age 3. For the next three charts, the ages are combined into three groups, ages birth to three, age four, and ages five and older. Age four was separated out primarily to show the effect of the Child Signature Program (CSP), which focuses on preschool programs, on HMG and CBP. For HMG, the percentage of four-year-olds they served rose from 14.0% in 2012/13 to 22.2% in 2013/14. The percentage served by CBP also increased, from 27.9% in 2012/13 to 46.8% in 2013/14.

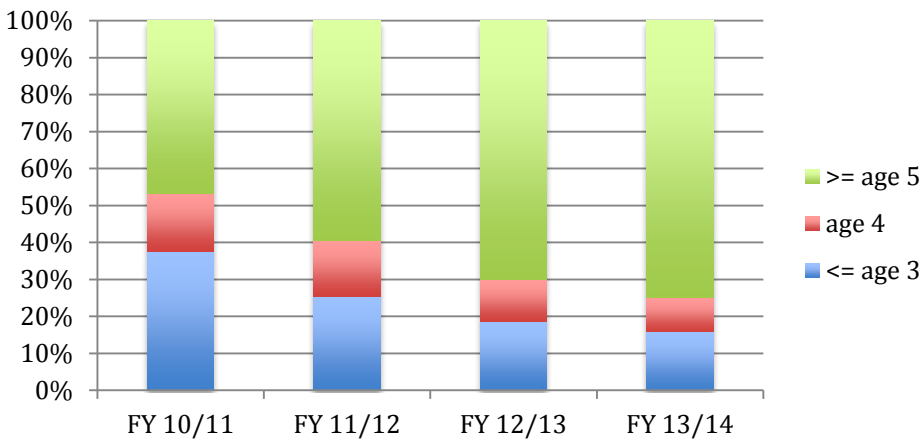


Child Behavior Pathways Percent of Children by Age Group



The Center has seen a steady increase in the percentage of children they serve ages 5 and older. The total number of children served by The Center, on which these percentages are calculated, has not increased over this time period, ranging from 2118 children in 2010/11 to 2086 in 2013/14.

The Center for Autism Percent of Children by Age Group



Race/Ethnicity	HMG	Child Behavior Pathways*	EDAC**	The Center***
American Indian	0.1%		3.1%	0.0%
Asian/Pacific Islander	7.7%	4.4%	9.8%	7.8%
Black	1.5%	0.3%	7.0%	1.0%
More than one	6.6%	8.3%	4.3%	
White	11.4%	19.3%	50.8%	51.1%
Other	1.7%	0.6%	29.2%	10.3%
Don't Know/ Decline to answer	1.5%	0.6%		4.2%
Hispanic	69.5%	66.5%	62.7%	25.7%
N=	2273	337	376	2086

* 5 missing responses were not included in the calculation of percents

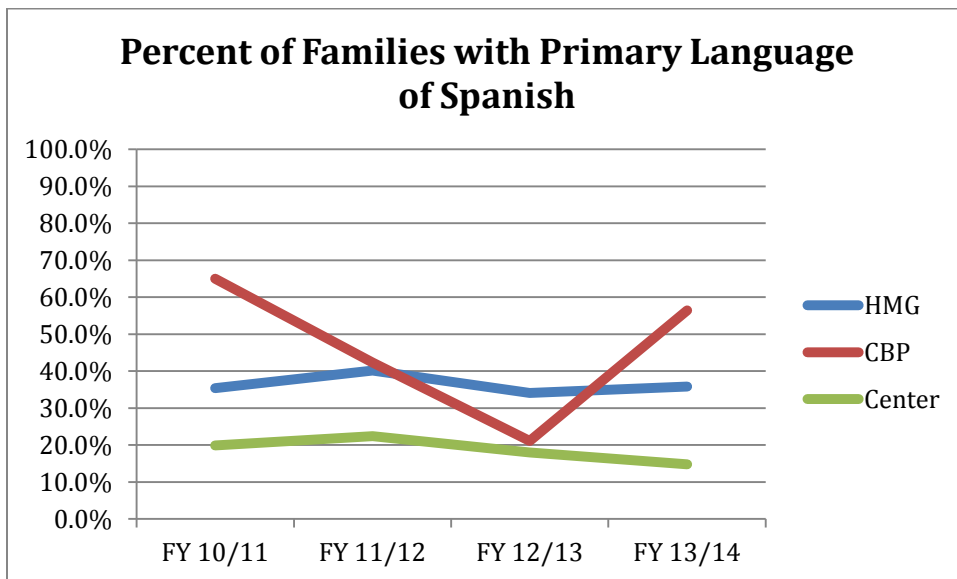
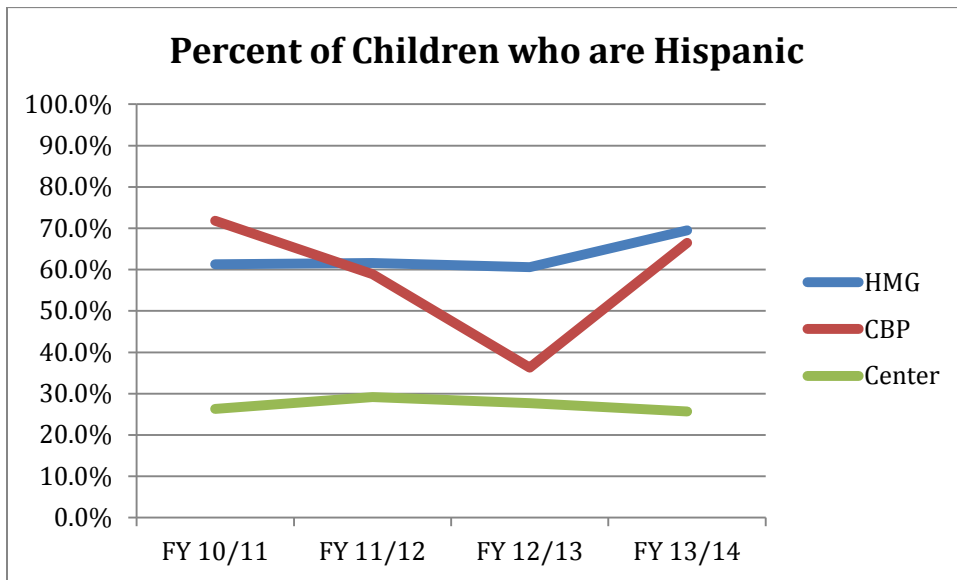
** EDAC data is of a cohort of children born in 2011 who qualified for service through CCS; percentages do not add up to 100% because there is a separate collection for "single race" vs. "multi-racial", so a single race may have been entered, and "multi-racial" also selected. The percent Hispanic cannot be separated out from the other race categories, so the other race categories include Hispanic and non-Hispanic.

Primary Language	HMG	Child Behavior Pathways	EDAC*	The Center
Arabic			0.3%	0.1%
Chinese	0.4%			
English	59.7%	39.2%	63.6%	83.9%
Farsi	0.1%			
Korean	0.1%		0.5%	0.1%
Cambodian/Khmer			0.8%	
Spanish	35.8%	56.4%	30.2%	14.8%
Tagalog	0.1%		0.3%	
Vietnamese	2.4%		0.5%	0.9%
Other	1.3%		2.1%	0.2%
Unknown		4.4%	1.6%	0.1%
N=	3203	342	374	2086

* EDAC data is of a cohort of children born in 2011 who qualified for service through CCS.

CBP saw dramatic shifts in the percentage of children they serve who are Hispanic and from families where Spanish is the primary language. In 2010/11, 72% were Hispanic and 65% lived in Spanish-speaking families. Two years later, the children they served were 36% Hispanic, with 21% living in Spanish-speaking households. The numbers rose to 66% and 56% respectively in 2013/14. The downward drop is mostly explained by budget cuts that led CBP to begin charging a \$150 fee for parents to take the COPE classes and to stop providing social skills classes for children, which meant the parents had to make alternate arrangements for their children while they attended the parenting class. Scholarships were offered to families who could not afford the fee.

While CBP continues to have a fee-based program, the classes offered through the Child Signature Program are free to parents, include social skills classes for the children, and are focused in communities with greater numbers of Hispanic families. As a result, the percent of children who are Hispanic and living in Spanish-speaking homes rose in 2013/14, the first year CBP participated in CSP. The increase in Hispanic children served by HMG is also connected to its participation in CSP.



CBP is the only program that collects data on household income. As a result of its participation in CSP, the percentage of children in homes with income below \$49,000 rose

from 60% in 2012/13 to 79% in 2013/14. While the percent of families with income between \$49,000 and \$106,000 stayed fairly constant, the percent with incomes above \$106,000 dropped from 23% in 2012/13 to 9% in 2013/14.

Household Income	Child Behavior Pathways*
Less than \$29,000	62.7%
\$29,001-\$49,000	16.0%
\$49,001-\$71,000	5.6%
\$71,001-\$106,000	6.9%
\$106,001 or more	9.0%
N=	233

* 109 Decline to Answer, Do Not Know and Missing responses are not included in the calculations of percents.

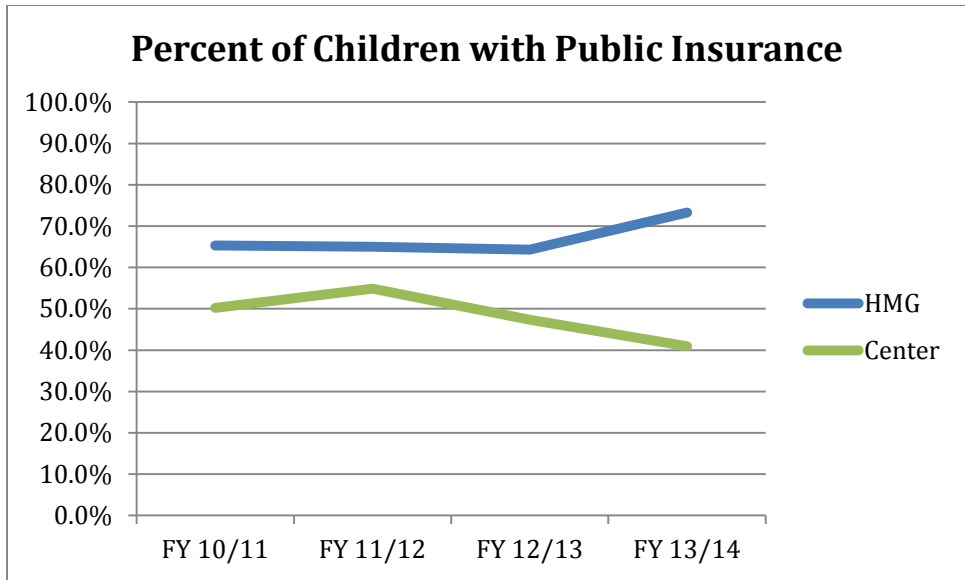
Health Insurance Status	HMG	EDAC	The Center
Caloptima (Medi-Cal assigned)	64.5%	63.8%	39.3%
California Children's Services		78.2%	
Healthy Families	0.8%	2.1%	0.1%
Healthy Kids			
Medi-Cal (Direct - unassigned)	8.0%		1.5%
None/Self-Pay	5.0%		2.8%
Private Insurance-HMO	9.5%	15.4%	10.4%
Private Insurance - POS/EPO	0.5%	5.6%	0.2%
Private Insurance-PPO	10.0%	16.5%	45.6%
TOTAL Private Insurance	20.0%	37.5%	56.2%
Tri-Care (Military Insurance)	0.3%		
Other	1.5%	0.5%	
Missing			0.1%
N=	2338	376	2086

* MediCal is secondary insurer

** Includes all MediCal direct and CalOptima

*** EDAC data is of a cohort of children born in 2011 who qualified for service through CCS; the percents add up to more than 100 because most of the children have more than one insurer.

CBP does not collect data on health insurance. After three years of steady rates of children with public insurance, HMG saw an increase from 64.3% in 2012/13 to 73% in 2013/14. The percent of children using public insurance at The Center declined over the past two years from 55% in 2011/12 to 41% in 2013/14.



Mother's Education	Child Behavior Pathways*	EDAC
Did not complete High School	20.5%	23.3%
High School Diploma or GED	29.2%	29.9%
Some college or vocational school	20.5%	20.4%
Bachelors Degree	17.1%	16.7%
Graduate or Professional Degree	12.7%	9.4%
Other		0.3%
N=	274	318

* 68 Missing responses were not included in the calculation of percents

** EDAC data is of a cohort of children born in 2011 who qualified for service through CCS. The percents were adjusted to exclude 9% who did not provide information about the mother's education.

The percentage of mothers participating in CBP services who did not complete high school rose from 6% in 2012/13 to 20% in 2013/14. Similarly, the percentage who had a Bachelors degree or higher dropped from 51% in 2012/13 to 30% in 2013/14. This is most likely the result of adding CSP services.

Why Families Use Early Developmental Services

The reasons families use EDS varies by program. Some families are referred from a neonatal intensive care unit or by their child’s pediatrician; others are referred by a childcare provider or a family friend. Children present with a wide variety of concerns, which are shown in the data below.

Help Me Grow – Families contact HMG for a variety of reasons; the most common are shown in the table below:

Percent of All Concerns*			Reason for Call
13/14	12/13	11/12	
16.1	15.6	14.8	Behavioral
12.5	19.5	20.4	Communication
10.5	10.8	13.9	General Development
8.7	3.6	3.5	Family Issues
7.8	9.5	8.8	Parental Support
7.0	3.0	0.5	General Information
5.6	11.8	5.8	Developmental concerns
4.7	4.4	2.6	Basic Need
4.3	2.1	1.7	Health/Medical
3.8	4.2	4.7	Childcare
3.6	3.8	5.0	Hearing
2.6	1.1	3.4	Mental Health
2.5	0.7	2.8	Education
2.2	2.9	4.6	Diagnosis
1.6	1.3	1.5	Health Insurance
1.6	0.9	1.7	Social/Emotional
1.3	1.3	1.3	Adaptive
1.2	0.4	0.2	Cognitive (Learning)
1.1	1.7	1.3	Gross Motor
0.6	0.1	0.1	Vision
0.3	0.7	0.6	Fine Motor
0.1	0.1	0.0	Living Condition
0.5	0.5	0.7	Other
4232	2834	2420	N = total number of concerns

* Callers may have more than one concern per child, so the totals are greater than the number of children served by HMG.

Child Behavior Pathways – serves families who are concerned that their child may have attention or behavior difficulties and are looking for parenting strategies to help them cope with these challenging behaviors. In FY 2011/12, Child Behavior Pathways took over the COPEing with Toddler Behavior classes for parents of high-risk infants and toddlers who

wish to learn more about encouraging and nurturing a healthy and positive relationship with their infant/toddler, including infant bonding and attachment, as well as development.

Families receive referrals to CBP from a variety of sources. In 2013/14, more families had been referred by Help Me Grow than any other single source. The other most common sources of referrals to CBP were family support specialists and preschool teachers and childcare providers.

Percent of all Referrals	Referral Source
2013/14	
17.1%	Help Me Grow
14.8%	Family support specialist
13.8%	Preschool teacher/childcare provider
8.6%	Brochure/flyer
5.6%	Social Services/social worker
5.3%	Presentation/school meeting
5.0%	Physician
3.5%	Friend/word of mouth
1.8%	Psychologist/specialist
1.5%	The Center for Autism & Neurodevelopmental Disorders
0.9%	Family Resource Center
0.6%	Library
0.6%	Website
20.9%	Other
339	Total number of referrals for the year

The COPE parenting classes help families recognize when their child has special needs. When families enroll, they are asked if their child currently receives services related to his/her behavioral and/or physical needs. About 13% respond yes and those children are considered “special needs.” About midway through the COPE Group, the parents rate their child using the Child Behavior Check List (CBCL). Any child who scores about the 92nd percentile on any of the subscales is considered special needs. Based on the CBCL, 39% of the children were identified as having special needs.

Special Needs	Before COPE Group (reported by parents)	During COPE Group (Scores on Child Behavior Check List)
Yes	12.8%	39.0%
No	87.2%	61.0%
	N= 264 children	N=122 children (153 total CBCLs)

EDAC

One way families qualify for services from EDAC is to meet the eligibility requirements for California Children's Services (CCS). Children eligible for CCS typically receive three comprehensive assessments from EDAC in the first 24 months of their lives; Visit 1 occurs when children are 6-8 months old, Visit 2 at 14-16 months of age, and Visit 3 when they are 24 months or older. By looking at the children born in 2011, who should have completed 3 visits to EDAC by the end of June 2014, it is possible to develop a picture of the children's needs and their progress over time. The 2011 cohort started with 376 children, served either at CHOC EDAC (287 children) or UCI EDAC (89 children).

In addition to the demographic information provided in a previous section of this report, 78% of these children were Low Birth Weight, meaning they weighed less than 2500 grams at birth. 77% of the children were premature (born before 36 weeks gestation) and 62% were considered Very Preterm, born at less than 32 weeks gestation. Most of the infants were singletons (83%); 17% were a twin or triplet, etc.

Listed below are the percent of children who met the various criteria to qualify for CCS. Because children could meet more than one criteria, the percentages add up to more than 100%.

2011 Babies	2010 Babies	CCS Medical Eligibility Criteria
62.5%	63.6%	Gestational age at birth was less than 32 weeks
54.8%	53.9%	Birth weight was less than or equal to 1500 grams (considered Very Low Birth Weight)
11.4%	16.3%	Used oxygen for more than 28 days and have chronic lung disease (CLD)
9.0%	6.6%	Received iNO (nitric oxide) for more than 4 hours for Persistent Pulmonary Hypertension (PPHN)
6.6%	3.2%	Documented seizure activity
4.0%	5.2%	Persistent apnea
1.6%	0.3%	Extracorporeal Membrane Oxygenation (ECMO)
376	349	N=number of babies

The Center for Autism and Neurodevelopmental Disorders (The Center)

The Center is dedicated to the earliest diagnosis and treatment of autism, ADHD and other developmental disorders. They see children who have any type of developmental, behavioral or learning problem.

Children referred to The Center have many issues requiring evaluation and diagnosis including language delays, communication deficits, global developmental delays, motor delays, learning issues, and behavior problems of all types (including ADHD, oppositionality and defiance, hyperactivity/impulsivity, anxiety, OCD, disruptive,

aggressive, noncompliant, destructive and self injurious components). For many children, the major presenting concern is possible autism. Some children already have other known diagnoses, but need to be assessed for co-morbid autism or other issues needing clarification or treatment recommendations (eg., Down Syndrome, Rett, Fragile X, etc.). The Center also sees children with possible delays or who are at-risk for delays, such as infants of substance abusing mothers and children in foster care or being adopted.

Outcome Measures

Each program collects outcome measures to demonstrate that their program is meeting the needs of the community and the clients they serve. Outcome measures often demonstrate a short or intermediate-term effect of the program because the long-term effects are difficult to measure and may not be as attributable to the program as shorter-term effects are. The program data used for outcome measures includes data about children and families in the Child Signature Program (HMG and CBP) and catalytic funding (The Center). Outcomes are not reported separately for these funding sources.

Help Me Grow

Help Me Grow provides a free service that is available to all Orange County residents regardless of income. Residents from every city in Orange County, and a number of cities outside Orange County, have contacted Help Me Grow seeking referrals because they have concerns about a child’s development. The table below shows the Orange County cities that accounted for at least two percent of HMG clients, and compares the percent of HMG clients to the percent of all Orange County births represented by each of those cities. In FY 13/14, these eleven cities accounted for 80% of HMG’s clients and 69.2% of all Orange County births. HMG also received calls about 81 children who lived outside Orange County.

Where HMG’s Clients Live

City	Percent of HMG clients by city			Percent of Orange County births by city
	2013/14*	2012/13	2011/12	2012**
Santa Ana	27.6	27.2	28.6	15.6
Anaheim	15.2	13.1	17.8	14.1
Irvine	5.2	5.4	4.7	7.1
Tustin	5.2	2.7	3.0	3.3
Orange	5.1	4.2	3.9	4.9
Fullerton	4.8	3.6	3.7	4.1
Huntington Beach	4.6	3.3	5.2	4.9
Garden Grove	4.4	4.6	5.6	6.2
Costa Mesa	3.5	4.0	4.7	3.9
Buena Park	2.3	1.7	2.8	2.8
Mission Viejo	2.1	2.4	1.9	2.3
Cumulative percent	80.0	72.2	81.9	69.2
N=	3103	2834	1777	38,186

* percentages are calculated among only Orange County cities; in 2013/14, HMG received calls about another 81 children who lived outside Orange County
 Birth data is for 2012 as reported in the 20th Annual Report on the Conditions of Children in Orange County.

How callers heard about HMG

The next table shows how callers learned about HMG in FY 13/14, FY 12/13, and FY 11/12. In all three years, more callers heard about HMG through their health care provider than any other source (25.1% in FY 13/14). In 2013/14, for the first time, the second most common way for callers to have learned about HMG was through a school (20.5%), up from 3.5% in 2012/13. This is a result of the CSP. Community agencies, such as The Center, WIC, MOMS, or the Social Services Agency (collectively, 19.2%) are the third most common way people said they had heard about HMG. Early Care and Education Providers (childcare providers, Early Head Start, and school readiness programs) referred 13.1% of the callers. The percentage who heard about HMG from friends or family, 2-1-1 Orange County, HMG outreach, or the Regional Center, or were a previous caller, has been fairly consistent over the three years. Fewer callers came to HMG from a screening program in 2013/14 than in the previous years. Hospitals, the media (television, newspaper, online media, etc.), and other sources (CalOptima, Children and Families Commission, and mental health providers) accounted for very few of the calls to HMG in 2013/14.

Source	Percent of Callers by Source		
	FY 13/14	FY 12/13	FY 11/12
Health Care Provider	25.1	29.3	29.4
School	20.5	3.5	4.6
Community Agency	19.2	18.3	19.9
Early Care and Education Provider	13.1	14.8	13.1
Friend or Family	5.3	6.2	4.5
2-1-1 Orange County	4.7	4.6	6.4
Previous Caller	4.2	6.8	5.6
HMG Outreach	3.9	5.9	3.8
Regional Center of Orange County	2.3	2.3	3.1
Developmental Screening	0.5	6.2	8.0
Hospital	0.5	1.2	1.2
Media	0.2	0.1	0.3
Other	0.5	0.6	0.2
N=	2852	2772	1862

The types of referrals families receive from HMG

Families can receive a wide variety of referrals from HMG, depending on their concerns about the child and their needs. The most frequent types of referrals (each accounting for at least 1% of referrals in one of the three years) made by HMG are shown in the next table. Services with the least referrals (less than 1.0% of all referrals) included legal assistance, psychiatry, psycho-educational testing, feeding, and physical therapy. Only 0.7% of referrals in 2013/14 were for services outside of Orange County.

Percent of all Referrals			Type of Referral
2013/14	2012/13	2011/12	
16.7	18.3	14.9	Parenting/Education
7.4	7.0	1.9	Health/Primary Care
7.4	3.1	6.0	Mental Health/Counseling
6.9	6.3	8.3	Educational/Enrichment
5.7	10.0	6.2	Developmental Screening
5.7	9.8	11.5	Communication/Speech & Language
5.3	4.7	4.0	Behavioral Services
5.1	2.0	4.7	Parent/Child Participation
5.0	4.9	2.4	Basic Needs
4.5	3.9	4.6	Recreation/Sports/After School/Camps
4.1	1.9	3.3	Family Support
4.0	4.9	5.3	Childcare
3.5	5.2	4.5	Regional Center of Orange County
2.8	3.7	3.9	School District
1.9	2.0	1.8	Early Literacy
1.8	0.5	1.3	Advocacy
1.8	3.4	3.8	Health/Neurodevelopmental Subspecialists
1.5	1.5	1.7	Allied Health Professionals
1.2	0.5	1.2	Social Skills
1.1	0.4	0.7	Health/Medical Specialists
1.0	0.9	1.2	Access to Health Insurance
0.8	0.8	1.0	Occupational Therapy
9367	6774	7091	Total Number of Referrals for the Year

Follow-up to ensure families are connected to care

If callers agree to receive a follow-up phone call, HMG can check to make sure the child is connected to the referrals provided. The table below shows the number of callers who agreed to receive a follow-up call in FY 13/14, FY 12/13, and FY 11/12, followed by the number and percent of those who were reached when the follow-up attempts were made.

	2013/14	2012/13	2011/12
Total number of callers who agreed to a follow-up call	1737	1568	1315
Total number of callers who were reached on a follow-up call and received care coordination	1161	987	928
Percent of callers who agreed to a follow-up call who were actually reached	67%	63%	71%

Children are connected to care

Callers to HMG may call about more than one child and may receive multiple referrals regardless of the number of children about which they are calling. The multiple referrals offer families a choice and it is not expected that families would connect with every referral they receive. When HMG follows up with families, they track the status of the referrals for each child and the family as a whole (the case). When a family or child has completed an appointment for at least one referral, the case or child is considered “connected.” If a family or child has not yet completed an appointment, but has an appointment scheduled, they are considered “pending.” The next table shows the number of cases and children that had connected with a referral or had an appointment pending at the time of follow-up.

The rate at which cases and children were connected rose in FY 2013/14 from the previous two years. The total connected or pending stayed about the same for cases but declined slightly for children. Similarly, the rate at which cases were not connected was constant across all three years while the rate for children not connected rose slightly.

	2013/14	2012/13	2011/12
CASE (Entire Family)			
Connected	70.7%	63.0%	65.4%
Pending	8.9%	15.6%	14.1%
TOTAL Connected or Pending	79.6%	78.6%	79.5%
Not Connected	20.4%	21.4%	20.5%
Number of Cases	1137	987	929
CHILD			
Connected	67.2%	61.9%	65.2%
Pending	9.1%	15.8%	14.0%
TOTAL Connected or Pending	76.4%	77.7%	79.2%
Not Connected	23.6%	22.3%	20.8%
Number of Children	1337	1110	1009

There were a number of reasons children were not connected to any referrals in a particular referral category. By far, the top reason was that the caregiver did not follow through (this explained 55.4% of the times a child was not connected to at least one referral in a referral category). Eleven percent of the time, it was because the child was connected to an alternate service in another referral category. Other reasons that occurred in at least 2% of the cases were: scheduling conflicts (7.7%), the child did not meet the program’s eligibility criteria for age, income, diagnosis, etc. (4.3%), prohibitive costs (3.1%), lack of childcare (2.2%) and lack of transportation (2.1%). Reasons that each explained less than 2% included waitlists; language barriers; difficult applications; location was difficult to access, caregiver depression or cognitive impairment; and lack of insurance.

Child Behavior Pathways

Outreach Efforts

In 2013/2014, Child Behavior Pathways was able to resume social skills classes for children participating in the Child Signature Program (CSP). With this new service, CBP now offers English and Spanish speaking social skills groups in conjunction with the parenting groups for CSP participants. Non-CSP groups are still offered to parents without the social skills component for a \$150 fee. The fee changes were undertaken in response to budget cuts and recommendations from the Commission. Because of the impact of these changes on enrollment, greater outreach efforts were made to increase awareness of Child Behavior Pathways and its value in the community and to serve as many families in Orange County as possible. The outreach efforts included more contact with families at community workshops, presentations, resource fairs, and school events. CBP staff also attended workshops and made presentations for the professional community to emphasize that CBP is still the “go to” program for parents seeking social, emotional, and strategic behavior support services. The table below lists the types of outreach efforts undertaken in FY 2013/14, the number of events attended, the number of attendees for each type, and the number of hours spent attending the outreach events. Compared to 2012/13, Child Behavior Pathways participated in 8 more events in 2013/14, a 9% increase, but encountered 44% fewer attendees than it had the year before.

	Example of Type of Event	# of Events	# of Attendees	# of Hours
Community Collaboration / Consultation	Cal Optima Community Alliance Committee	3	143	7.5
Community Event	Connection Cafés, Community Alliance meeting	8	744	18.5
Promotion of Project	SCAN monthly meeting, health fairs	81	1,517	135.0
Training/Education Seminar	Pediatric medical student training, parent stress management workshops	5	113	9.5
TOTALS		97	2,517	170.5

Serving low-performing school districts

One goal of the Child Behavior Pathways program is to serve families who live in school districts with low Academic Performance Index (API) scores. In FY 2013/14, 21 out of 30 (70.0%) COPE groups were in school districts with low API scores. This is a higher percent than reported in 2012/13, when 8 out of 19 (42.1%) COPE groups were in school districts with low API scores.

Outcomes for children and families

Data collected from parents who attended COPE classes demonstrate that parents use and value the strategies they are taught and see improvements in their child's behavior as a result of the classes. Parents also indicated they found CBP's parent support services to be extremely useful.

The **Parenting Strategies Assessment (PSA)** allows parents to rate the frequency and utility of suggested parenting strategies at the first and last COPE session. Each year, parents with both a pre and post rating have consistently shown significant increases in the use of positive strategies and a decrease in the use of physical punishment after participation in the COPE classes, indicating a significant increase in the overall frequency of parents' use of the recommended strategies ($p < 0.001$). Parent ratings have consistently demonstrated a significant increase in the overall helpfulness of the COPE strategies they learned in class ($p < 0.001$).

The **SWAN Rating Scale (SWAN)** is a parent report form used to measure changes in child behavior upon completion of the COPE program. It illustrates that although Child Behavior Pathways is a parent-based service, there is a significant direct impact on the child's functional behavior. The SWAN Rating Scale is collected at the first and last sessions. Analyses have consistently demonstrated significant reductions (improvements) in both the Inattentive ($p < 0.001$) and Hyperactivity domains ($p < 0.001$).

The **Parenting Scale (PS)** is a self-report measure of dysfunctional discipline practices by parents. The PS assesses three discipline styles: laxness (permissive, inconsistent discipline), over-reactivity (harsh, emotional, authoritarian discipline and irritability), and hostility (use of verbal or physical force). Parents completed the PS at the first and last sessions. Results show that following participation in the COPE parenting class, parents were significantly less likely to endorse using each of the three dysfunctional discipline styles (laxness, $p < .001$; over-reactivity, $p < .01$; hostility, $p < .05$).

The **Eyberg Child Behavior Inventory (ECBI)** is a parent report measure that assesses child behavior problems. It evaluates both the frequency of problem behaviors (Intensity Scale) and the degree to which parents are distressed by these behaviors (Problem Scale). The ECBI is collected at the first and last sessions. Analyses demonstrate significant reductions (improvements) in both the frequency of child behavior problems ($p < 0.001$) and the amount of parental distress caused by behavior problems ($p < 0.01$). This provides evidence that concurrent participation in the COPE parenting class and the children's social skills class improves children's functional behavior and reduces parenting stress.

Parents felt strongly that Child Behavior Pathways was beneficial to them in a number of ways. Rating a series of statements on a six-point scale, with 1 being strongly disagree and 6 being strongly agree, each of the five statements scored a mean rating of 5.2 or better in 2013/14. The ratings were similar to those reported in FY 2012/13 and FY 2011/12.

Statement	Mean Rating (highest rating possible is 6)		
	2013/14	2012/13	2011/12
I have been able to apply many of the parenting strategies.	5.5	5.7	5.5
I feel more confident in my parenting skills.	5.3	5.5	5.3
I have noticed improvements in my child's behavior.	5.2	5.3	5.2
I feel that the relationship with my child has improved.	5.3	5.4	5.3
I feel that I am a better parent as a result of this course.	5.4	5.4	5.4
N=	225	133	273

Parents who participated in COPEing with Toddler Behavior indicated that as a result of the class, they had a better understanding of their child's behavior and were better able to deal with their child. The chart below presents the average rating for the 2013/14 fiscal year, which was similar to the average ratings across the previous five-year period.

COPEing with Toddler Behavior Statement	Mean Rating 2013-2014	Mean Rating 2008-2013
	Highest rating possible is 5.0	
This workshop has increased my understanding of my child's behavior.	4.9	4.6
I can come up with solutions to challenges better because of this course.	4.7	4.7
I am more confident in dealing with my child because of this workshop.	4.6	4.6
N=	29	496

Teachers are better able to manage challenging behaviors

Child Behavior Pathways teacher training surveys during FY 2013/14 indicated an increase in their understanding of the sources that may trigger behaviors and that they felt better prepared and more confident in their ability to address the behavior in the classroom.

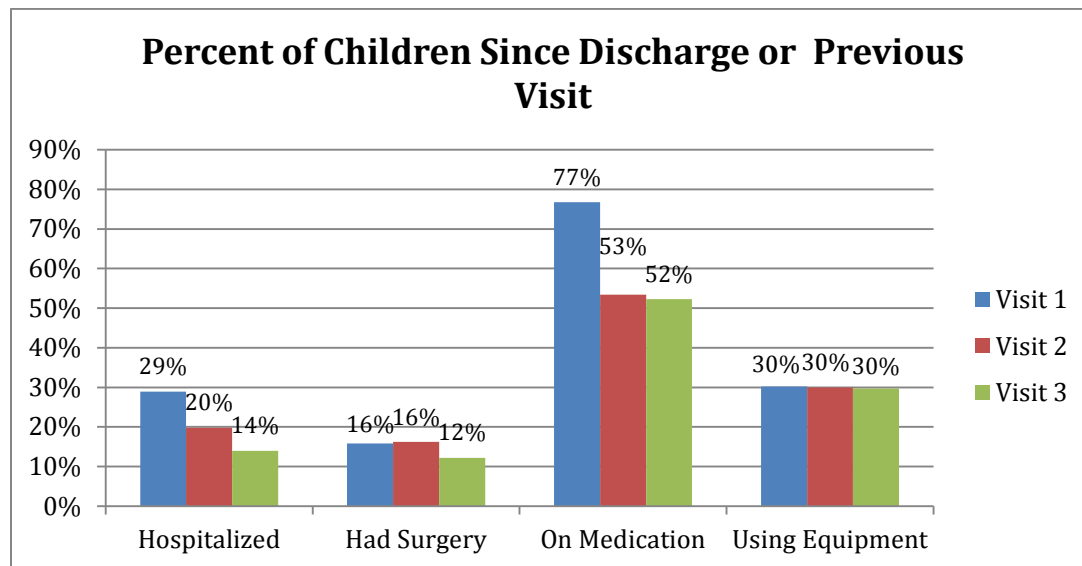
Since completing the program:	Mean Rating 2013-2014 (highest rating possible is 7)
How well do you understand the potential sources or causes that trigger behaviors in the classroom?	5.0
How knowledgeable are you about various intervention strategies intended to improve behavior in a classroom environment?	5.0
The concepts/strategies were presented in a way that can easily be applied to my work with children.	5.7
N=	17

EDAC

Data collected on all children born in 2011 across their three visits to EDAC provide some insights to how these high-risk infants and their need for services change over time. It is important to keep in mind that this is not a true cohort because more children are seen for the first visit than for either of the subsequent visits. There are a number of reasons children do not receive all three visits. For some disorders, children may qualify for the first visit, but subsequent visits are up to the discretion of the program. Children who are well connected to therapies and resources may be discharged from the program. Sometimes parents opt to not return because they feel their child is receiving the services he/she needs and the EDAC visit is duplicative. Some children are in protective custody and move out of the area after they are adopted. Other reasons a child may not receive all three visits include inability to pay insurance co-payments; the child is making good developmental progress; and the families are too busy or lack transportation.

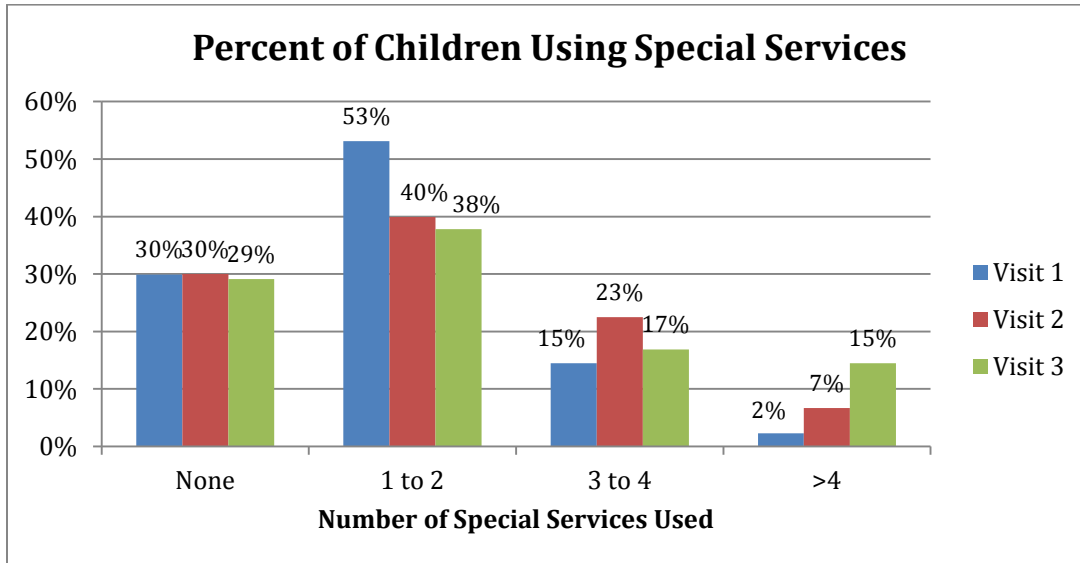
The number of children who attended Visit 1 was 311, by Visit 2 it was 253, and 172 children returned for Visit 3. During this period eleven children died, and 175 cases were closed.

At each visit, the child's medical history is recorded to show what happened between the previous visit and the current visit. The percent of children hospitalized, having surgery, or on medication declined from Visit 1 to Visit 3. The percent using equipment, such as a nebulizer, stayed constant across the three visits.

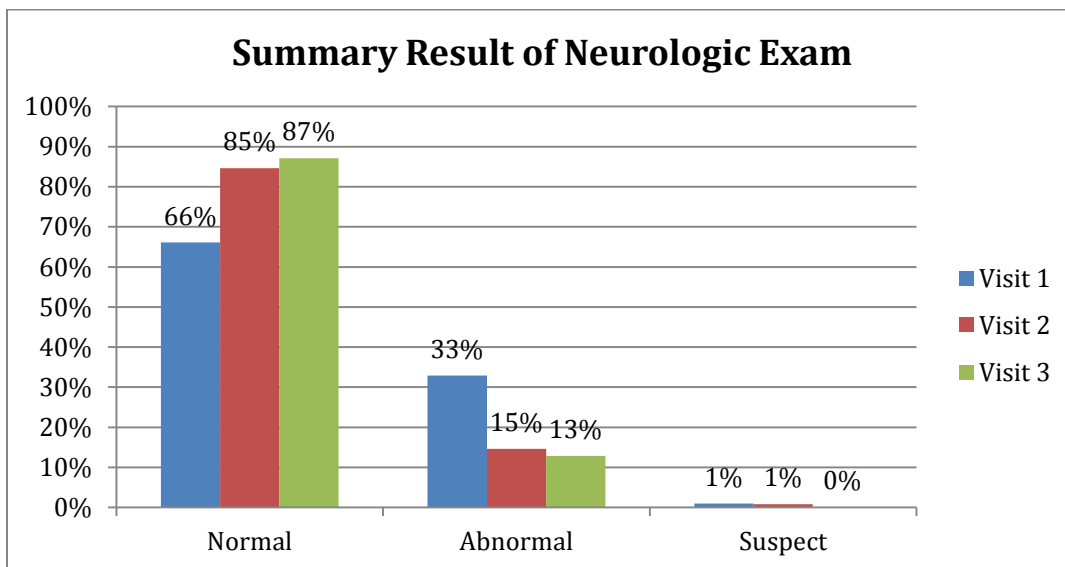


The percent of children using special services, such as physical therapy, occupational therapy, speech/language communication, behavior intervention, feeding therapy, etc., stayed fairly constant across all three visits, but a greater percentage of children were using

3 or more special services by the second and third visits. This could indicate that the children who returned for subsequent visits had more complex problems, or just reflect that children are ready for additional services (such as speech/language and behavior intervention) as they get older.

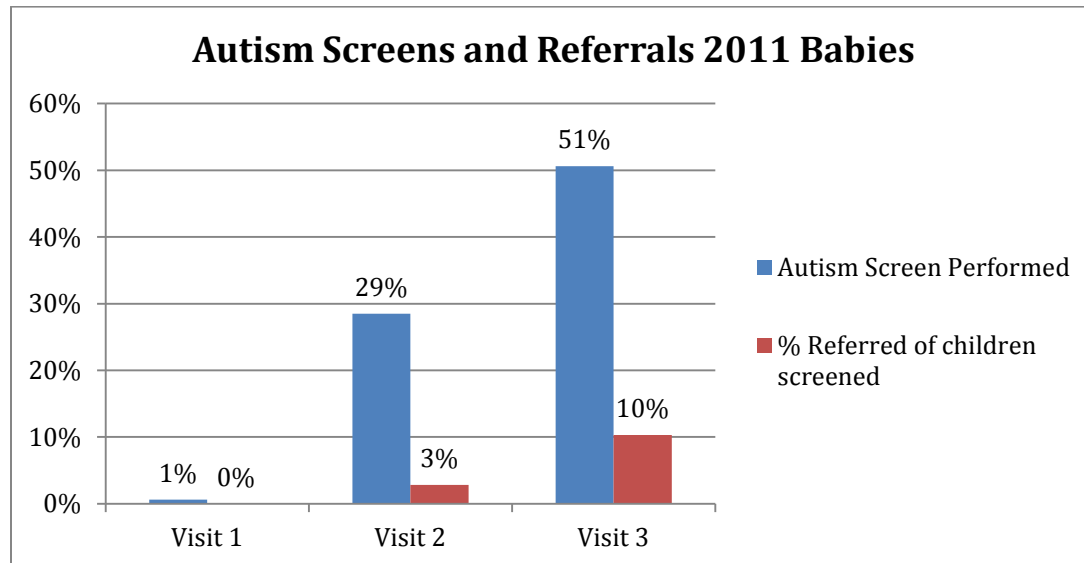


Nearly all children received a neurologic exam at each visit, and the percent of children with a normal exam rose across the three visits.



EDAC uses the M-CHAT to screen for autism in toddlers between the ages of 16-30 months. The only children screened at the first visit are children who didn't make it to the first visit until they were 16 months old. By the third visit, just over half of the children were

screened; children with significant developmental delays are not screened because their developmental delays have already been identified and are being addressed. Of those screened, 3% were referred for further autism spectrum assessment at the 2nd visit and 10% were referred for further assessment at the 3rd visit.



The next table shows the number and percent of infants who were screened and referred for both the 2011 and 2010 babies. Fewer of the 2010 babies were screened at Visit 2 than the 2011 babies, but more received referrals. For Visit 3, more of the 2010 babies were screened and more were referred.

	2011 Babies		2010 Babies	
	Number	Percent*	Number	Percent*
Visit 2 Screened	72	28.5%	39	17.2%
Visit 2 Referred	2	2.8%	9	23.1%
Visit 3 Screened	87	50.6%	121	76.6%
Visit 3 Referred	9	10.3%	16	13.2%

*For “screened,” the percentage is of all babies who attended the visit; for “referred,” the percentage is of all the babies who were screened at that visit.

Families whose infants or toddlers have a developmental delay or disability or an established risk condition that has a high probability of resulting in a delay may be eligible for the Regional Center’s Early Start program. The program provides early intervention and family support services for young children from birth to three years of age who meet eligibility requirements. The next table shows the percent of children who are receiving Early Start services by visit, along with the percent referred to Early Start, determined to be ineligible, and for whom the parent had declined this service. Compared to the 2010 babies,

a greater percentage of babies were receiving or referred to Early Start at Visit 1 and fewer babies were receiving or referred at Visits 2 and 3. In 2010, 6% had been determined to be ineligible for Early Start at Visit 2.

2011 Babies	Visit 1	Visit 2	Visit 3
Receiving Early Start services	22.8%	34.0%	37.2%
Referred to Early Start services	27.0%	18.2%	15.1%
Determined ineligible for Early Start	1.3%	3.2%	1.2%
Parent refused referral to Early Start	1.6%	0.4%	0.0%
N=	311	253	172

Patient satisfaction

CHOC Children’s Hospital uses the NRC (National Research Corporation) Picker Patient Satisfaction Survey to learn how patients feel about the services they receive. In the fourth quarter of FY 2013/14, the responses for EDAC were:

- 100% of respondents said their provider listened carefully to them
- 90% said the provider spent enough time with them
- 92% thought the provider was as thorough as their child needed
- 89% said they got as much information as they wanted from the provider
- 97% said the provider explained things about their child’s health in a way that was easy to understand

The Center for Autism and Neurodevelopmental Disorders

In FY 2010/11, The Center developed three parent surveys based on input from staff about what outcomes they thought would tell the story of The Center and show that it makes a difference for children and families. All three surveys were administered in FY 2010/11, FY 2011/12 and FY 2013/14; only Survey One was administered in FY 2012/13. In 2013/14, the questionnaires were translated into Spanish, allowing Spanish-speaking parents the opportunity to provide their responses for the first time.

Each survey is described below with the results from all the years in which it was administered. The surveys were given to parents who were returning to The Center for at least a second visit. The sample sizes are small, initially because the surveys were being pilot tested to see if any changes would be necessary before expanded implementation. In 2013/14, the number of respondents was small because The Center moved to a new location during the year.

Parent Survey 1 asked about parents' confidence with the diagnosis they received from The Center, whether they had sought a second opinion, and the results of that. It also asked whether their child was able to obtain the services recommended by The Center, and if not, why not. In 2013/14, 6 of the surveys were completed in Spanish.

FY 13/14	FY 12/13	FY 11/12	FY 10/11	Parent Survey One
81%	86%	81%	86%	Parents were very confident that their child had received a correct diagnosis from The Center
4	13	4	6	Number of parents who had sought a second opinion
4	12**	3	4	Number of parents who said the second opinion was completely or mostly the same as the diagnosis they received from The Center
80%	79%	83%	87%	Parents said their child had received all or most of the therapies or treatments recommended by The Center
Number of respondents who claimed the following reasons to explain why their child did not receive a recommended therapy or treatment:				
5	22	8	5	Insurance did not cover the cost
5	13	2	3	There was a long wait list
4	6	2	5	The service was not available at convenient hours
2	13	2	2	It was too expensive
2	7	2	1	There was no provider close to us
2	3	0	1	I could not get childcare for my other children
1	4	0	1	I didn't know how to access the therapy
1	1	3	2	I didn't think the therapy would be helpful
0	1	0	1	I did not have transportation to the provider
0	0	2	2	I didn't think the therapy was necessary
0	0	1	1	The therapy was not available in our language
0	1	0	1	I didn't know who to call for an appointment
N=22*	N=94*	N=38*	N=47*	

* Missing or not applicable responses were not included when calculating percentages

** One respondent who had sought a second opinion did not answer the question about whether the second opinion was the same

In each year, over 80% of the parents said they were very confident that their child had received a correct diagnosis from the Center. About 80% also said their child had received all or most of the therapies recommended by the Center. Each year, lack of insurance coverage was the primary reason given to explain why their child had not received a recommended therapy or treatment. Other common reasons were long wait lists and that the service was not available at convenient hours.

In FY 2013/14, the therapies families were most likely to have difficulty obtaining were occupational therapy (3 respondents), applied behavior analysis (ABA) (2), and CTPP, speech therapy, group social skills, respite care, and in-home support services (1 each). In FY 2012/13, the therapies families had the most difficulty obtaining were ABA (13 respondents), occupational therapy (8), speech therapy (7), and social skills groups (5).

Parent Survey 2 is a set of Likert-style questions that asks parents whether they agree or disagree with a series of statements about the care they received from The Center. This survey was not administered in FY 2012/13.

In 2013/14, the survey was completed by only 14 parents (4 Spanish language), who all generally had favorable responses about the services their child had received from The Center. The only statements that received a “disagree” response (one each) were the statement about whether the diagnosis helped their child obtain services from the school district and/or Regional Center and the statement about whether the Center had met their expectations. The average rating score ranged from 4.3 to 4.6, with the highest possible score equal to 5.0 if all parents Strongly Agreed with a statement.

% Who Agree or Strongly Agree			Statement – Parent Survey Two
FY 13/14	FY 11/12	FY 10/11	
90%	87%	82%	The diagnosis we received from The Center helped my child obtain services from the school district and/or Regional Center*
100%	80%	74%	The diagnosis we received from The Center led to changes in the services my child receives from the school district and/or Regional Center*
93%	84%	78%	My child’s condition has improved since we’ve been coming to The Center
93%	86%	73%	The Center has contributed to the changes I see in my child
93%	95%	81%	The services we received from The Center have been effective
86%	95%	82%	The services we received from The Center met my expectations
86%	95%	82%	The services we received from The Center were what I needed
93%	98%	89%	A team approach is important for serving families like mine
100%	89%	72%	The Center uses a team approach to care for children and families
100%	98%	87%	A family-oriented approach is valuable for families like mine
100%	97%	82%	The Center is family-oriented
100%	91%	91%	I am satisfied with the care we received at The Center
N=9-14	N=57	N=58	

* the percentages are calculated based on the number of respondents who disagreed or agreed, and excludes those who did not respond or for whom the question did not apply.

Parent Survey 3 is another set of Likert-style questions that asks parents to think about how things were when they first came to The Center and how things are now. Parents respond to a series of statements and indicate their level of knowledge or ability before and now. On the rating scale, 1 = very low/poor, 3 = average, and 5 = very high/good. The average rating was calculated for each item. In FY 13/14, although relatively few surveys were completed, for the first time, 3 surveys were completed in Spanish. This survey was not administered in FY 2012/13.

The table below presents the average ratings for how parents felt at the time they took the survey (after more than one visit to The Center) and the change in average rating from how they felt before going to The Center. Although not presented in the table, in 2013/14, the average ratings before their first visit were below 2.0 for all but three of the statements. The only three that had an initial average score about 2.0 were the parents attitude about their child’s condition (2.2); acceptance of their child’s condition (2.3); and willingness to CHOC-UCI Early Developmental Services

take their child to a restaurant (2.8). This differs from FY 2011/12, when the initial scores ranged from a low of 2.0 (Ability to control child's behavior) to a high of 3.3 (Feelings of hope for child's future). These same two items were the lowest and highest rated items in FY 2010/11.

In FY 2013/14, the average improvement was 2.0 from before to now. In the two previous years the questionnaire was administered, the average improvement was 1.5 points. The areas with the greatest improvement varied across the three years. In FY 2010/11 the biggest improvements were seen in knowledge of the child's condition, knowledge of how to advocate for services for the child, and acceptance of the child's condition (each with a 1.7 point improvement). In FY 2011/12, the greatest improvements came in the areas of knowledge of how to work with the child, knowledge of how to locate services, and knowledge of how to advocate for services (each with a 1.8 point improvement). In FY 2013/14, the greatest improvement was in the parents' sense of empowerment to help their child (up 2.5 points).

In FY 2010/11, the area with the least improvement was knowledge of community services for the child (improved by 0.6 point). In FY 2011/12, the least improvement was seen in the knowledge about the child's condition, acceptance of the child's condition, and willingness to take the child to restaurants (all up by 1.1 points). In FY 2013/14, the area with the least improvement was willingness to take the child to restaurants (up 1.3), the area with the highest before rating, which means it had less room for improvement.

Parent Survey Three How would you rate your:	Average Rating Now			Change in rating		
	13/14	11/12	10/11	13/14	11/12	10/11
Knowledge about your child's condition	4.2	3.5	4.5	+2.3	+1.1	+1.7
Attitude about your child's condition	4.4	4.1	4.3	+2.3	+1.4	+1.4
Knowledge of how to work with your child	4.1	4.2	3.9	+2.3	+1.8	+1.3
Effectiveness in working with your child	3.9	3.8	4.2	+2.2	+1.2	+1.6
Ability to control your child's behavior	3.4	3.6	3.9	+1.5	+1.5	+1.5
Sense of empowerment to help your child	4.0	4.0	4.3	+2.5	+1.6	+1.5
Knowledge of how to locate services for your child	3.7	4.1	4.1	+2.0	+1.8	+1.6
Knowledge of how to obtain services for your child	3.8	3.8	4.0	+2.1	+1.6	+1.6
Knowledge of how to advocate for services for your child	3.5	4.0	4.1	+1.8	+1.8	+1.7
Effectiveness in advocating for services	3.6	3.8	4.0	+1.8	+1.5	+1.5
Acceptance of your child's condition	4.4	4.4	4.5	+2.1	+1.1	+1.7
Knowledge of community services for your child	3.2	3.7	2.9	+1.5	+1.6	+0.6
Willingness to take your child to restaurants	4.1	4.1	4.2	+1.3	+1.1	+1.2
Feelings of hope for your child's future	4.3	4.5	4.5	+2.3	+1.2	+1.5
N=	11-12	31-33	38-41			

Success Stories and Parent Appreciation

Sometimes, the best way to communicate what a program does is to share the stories of individual children and families who have received the services of that program. Below are stories of a few of the children and families who have been helped by Early Developmental Services and testimonials from parents. The complexity of the families and the services they need comes through in a way that the data cannot fully show.

All names are fictitious.

Help Me Grow

Story 1

Robert was referred into the HMG screening program by the Social Services' First Response Team at 16 months of age. On the Ages and Stages Questionnaire (ASQ), Robert scored at risk in communication, fine motor and problem solving. His mother, Annie, was very concerned with his communication, behaviors and social skills. At the time of the screening, Robert could say dad, daddy, drink and this, but he was not pointing or understanding simple commands. Annie stated that he was very aggressive and would hit, bite, and pull hair. She also noted that his eye contact was sporadic. Robert would engage socially a little bit, but then would get over excited and just throw things. Annie said she talked with the pediatrician who was concerned about possible autism and referred Annie to HMG for resources.

Annie told the pediatrician that she had just completed a developmental screening through HMG. After going over the results with Annie, HMG explained that the next step would be a developmental evaluation and described the different ways she could access one. Annie agreed for HMG to send a direct referral to the Regional Center of Orange County (RCOC) for Robert. HMG also referred Annie back to the pediatrician for a referral to a pediatric neurologist to assess for autism. At follow up, Annie reported the RCOC evaluation found him eligible for speech therapy and physical therapy. Annie said they were starting services next week. Annie also stated that both the pediatrician and the RCOC therapist had recommended that Robert be assessed by a pediatric neurologist. Mom was thankful for all the help connecting her to services.

Story 2

A teacher sent a referral to HMG due to a child's poor attendance and to help the family with transportation. When the HMG Care Coordinator met with the mother, Jane, to discuss the attendance issue, Jane reported she was recently fired from her job and requested help with counseling because she was feeling depressed and was having difficulty getting through the day. Jane recently found out she was pregnant with her second child. The pregnancy was unplanned and she was feeling extremely worried that she wouldn't be able

to manage two children and complete courses to get her high school diploma by May 2014. Jane described having no emotional support from her aunt, with whom she lived, and minimal emotional support from her biological parents. Jane also indicated that she had attempted suicide when she was 15 years old, was hospitalized, and received treatment during that time.

The Care Coordinator discussed several options for counseling and provided her with three referrals for crisis counseling and long-term counseling services. The first option was for a direct referral to the Early Head Start (EHS) Mental Health Consultant due to Jane's past history of suicidal ideation and lack of family support. Jane gave consent for the direct referral. The second option was to contact Kaiser Behavioral Health Services to get referred to long-term counseling or therapy. The third option was to contact the Santa Ana College Continuing Education Department for Personal Counseling.

The Care Coordinator prepared a Family Partnership Agreement with Jane to meet with the EHS Mental Health Consultant for short-term counseling and to follow up with long term therapy via Kaiser Health Insurance to address her depression. The Care Coordinator suggested Jane enroll in the MOMS Orange County home visitation program due to the pregnancy, but she declined because she was receiving prenatal care through Kaiser.

The Care Coordinator received a follow-up contact from the EHS Mental Health Consultant indicating receipt of the direct referral and that a meeting was scheduled to meet with Jane. On a follow-up contact, Jane reported she had met with the EHS Mental Health Consultant regularly and completed the sessions. On a later follow-up contact with Jane, she reported she had an appointment to meet with a psychiatrist through Kaiser Behavioral Health for long-term therapy. Jane also reported her child's father was supportive and drove her daughter to the Early Head Start program daily. He also drove Jane to her therapy sessions and prenatal appointments at Kaiser. Mother was very grateful for the help she received from Help Me Grow.

Story 3

Eduardo contacted HMG requesting help finding a job. He had gone to a temp agency and the Santa Ana Work Center, but hadn't found permanent full-time employment. His certificate as a food handler was going to expire in 2015. When asked why he had worked at several jobs for short periods of time, he replied that he was diagnosed with epilepsy in 2009 at the age of 19 and when he had seizures on the job, employers usually terminated him on the spot.

The Care Coordinator asked Eduardo if he had registered with the California Department of Rehabilitation, which can provide help with employment and other services for adults with a medical diagnosis and disability. However, he did not know anything about the agency and was not registered with any type of program. The Care Coordinator asked Eduardo to obtain his medical records to show proof of the diagnosis. Then the Care Coordinator called

the CA Department of Rehabilitation and, along with Eduardo, spoke to the intake counselor about his situation before scheduling an orientation meeting. The Care Coordinator also referred Eduardo to the Epilepsy Support Network Foundation and Goodwill Industries.

Eduardo resides with his girlfriend, with whom he has twins (a boy and girl). Both children are enrolled in the Early Head Start Preschool. The Care Coordinator discussed safety concerns with Eduardo because of the potential danger of him having a seizure when walking the children to school. The parents decided the grandmother would bring the twins to preschool.

At a follow-up meeting, Eduardo reported he is now registered with the CA Department of Rehabilitation, has met with his counselor, and submitted his medical records. The counselor was helping him get 2 suits for job interviews and a monthly bus pass registered as a disabled person. Eduardo will receive a placard for his girlfriend's car because she drives him to medical appointments, and a disability dog to alert him of impending seizures. He will be assigned a new primary care physician and a new neurologist. Eduardo completed the SSI application and Goodwill Industries let him know they would contact him when a job becomes available; he will have to wear a safety helmet on the job. The Care Coordinator also encouraged Eduardo to contact the Epilepsy Support Network so he and his family could learn what to do in an emergency.

The family was grateful to Help Me Grow for connecting Eduardo to a counselor who coordinated continued services for him.

Story 4 – Child Signature Program

Roci was a teen parent and high school dropout. She is in a long-term relationship with the father of her three children and the family of five lives with her parents in a 2-bedroom apartment and four other family members. The father is unemployed.

Roci was one of the first parents to schedule a home visit through the CSP program and the only parent to set two goals in her Family Partnership Agreement (FPA). Through home visits, phone calls, consultations, and screenings using the Ages and Stages Questionnaire and the Parental Stress Indicator, the HMG Family Support Specialist (FSS) learned that Roci was trying to obtain her GED while experiencing emotional abuse from her partner, and dealing with her toddler's potty training challenges and her preschool-age daughter's low social skills.

The FSS connected Roci to COPE parenting classes, helped her fill out a scholarship application to Orange County Children's Therapeutic Arts Center (OCCTAC) for their arts program, and provided her with information about the GED program through Santa Ana College. Roci also was connected with the Santa Ana Public Library story time, given an introductory session and tips from Triple P (Positive Parenting Program), and provided

support during the potty training process. The FSS also encouraged Roci to make an appointment with Latino Health Access to connect with a promotora for help with her marital issues.

By the time of her final FPA update, Roci had successfully completed both of her goals. She had completed the 9-week COPE class, potty trained her toddler, and enrolled her older child in preschool, which allowed her to take the GED placement test and enroll in her first set of GED classes. Roci also was actively working with a MADRE at Latino Health Access. Roci had taken her preschool-age child to 4 weeks of ballet classes and planned on enrolling her in cheerleading classes to continue building her self-esteem. She also was participating in weekly family story time at the library and volunteering more in her child's classroom.

Story 5 – Child Signature Program

Yolanda has a 2-year-old daughter who has an Individualized Family Service Plan (IFSP) for speech and language. When Yolanda began receiving services, she was living with her daughter's father, Marcos, who was working two jobs, and his father in a studio apartment.

Through a series of home visits, phone calls, on-site consultations and family assessments, the Family Support Specialist (FSS) learned that Yolanda felt depressed and had no hope for getting out of her living situation. Marcos' father was constantly meddling in the family's affairs and Marcos was verbally and emotionally abusive to her. Yolanda was having difficulty with her daughter's speech and language providers and was continually receiving inappropriate and negative statements regarding her daughter's behavior. Yolanda wanted to move out on her own, but needed a job and housing.

The FSS offered Yolanda Triple P sessions to help her learn to manage her daughter's behavior. Yolanda also used referrals to Women Helping Women, the Rancho Santiago Community College District's (RSCCD) Empowering Parent Series, and the Illumination Foundation to help jump start her independence. Within a week, she landed a job and felt empowered enough to tell Marcos that she would be leaving with the child once she had the financial ability to do so. The FSS also made a referral to have the daughter observed by the CSP mental health specialist.

By the end of the program, Yolanda had moved out but still had an amicable relationship with Marcos. She had completed 5 sessions of Triple P and the RSCCD parenting series workshop. The mental health specialist and Regional Center resources provided additional support for her child in the classroom and helped work out the behavior management conflict with the speech therapy provider. Yolanda continues to work and hopes to be self-sufficient in just a few more months.

Story 6 – Child Signature Program

Ana has three children, one over the age of 5, one preschool age, and a newborn. At the time she started in CSP, Ana and her children were living with the father of the newborn in a 3-bedroom apartment. She was maintaining a positive co-parenting relationship with the father of the two eldest children.

At the first home visit with the Family Support Specialist (FSS), Ana disclosed feelings of hopelessness, having little energy, and lacking drive. She was crying a lot and having difficulty remembering, but was not suicidal. The FSS told Ana about the CSP's mental health specialist (MHS) and the Orange County Post-Partum Wellness program (OCPPW). She also provided Ana with contact information for the OC Crisis Hotline and County Emergency Services.

Within 36 hours of the first home visit, the FSS, along with the MHS, conducted a second home visit. The MHS spoke with Ana about her concerns and symptoms and provided informational pamphlets. The FSS supported Ana in connecting with OCPPW by completing the referral form with Ana, faxing the form to OCPPW and coordinating communication between OCPPW and Ana.

At a third home visit, the FSS learned that Ana was connected to OCPPW and had a plan to transition to Connect to Tots. Ana was grateful for being connected to OCPPW and the continuous support she receives from the program.

Child Behavior Pathways

Comments on COPE

- “Rosa Santoyo is an amazing instructor! She gives a lot of information, yet manages to keep it fun!”
- “Every single technique was very helpful. The instructor did a great job explaining every technique.”
- “I loved everything I learned so much. I am not a parent but a Preschool teacher. This class will benefit me to work with families in the future.”
- “Everything! It put everything into perspective and made us evaluate how our parenting influences our child's behavior.”
- “I really enjoyed the class. It's the best parenting class I have taken and I'm thankful for the techniques.”

Coping with Toddler Behavior-What did you enjoy most about the class?

- “Great instructor, great parents attending the class.”
- “The instructor Nicole is great, knowledgeable and taught me a lot.”
- “Practical skills; learning what to expect and deal with potential future behaviors from other parents/instructors.”

EDAC – Early Developmental Assessment Center

This story captures how coordinating efforts nurture and protect the patient's well-being as well as the family.

Michael was a term baby who experienced perinatal depression at birth. His condition was managed in the NICU at a referring hospital, but due to respiratory deterioration, he was transferred to CHOC Children's NICU for a higher level of care. Michael developed serious cardiopulmonary conditions that required intensive treatment. He also had G-tube placement due to poor feeding and weight gain and developed lung disease that required multiple medications, home oxygen, and respiratory treatment. Home health nursing care was arranged and he was supposed to receive follow-up with multiple specialties and therapy services.

During Michael's first visit in the High Risk Infant Follow-up (HRIF) clinic in EDAC, an assessment of his post-NICU medical care, therapy services, nursing services and psychosocial evaluation was performed. It was noted that his parents had to reside with extended family and stress was felt in the family dynamic due to his constant care and follow-up visits. Michael's mother experienced difficulty navigating through the Medi-Cal system and was unable to get authorizations in time for his necessary treatment, diagnostics tests/scans and specialty follow-up visits as well as for his therapy services. She had difficulty understanding the difference between Medi-Cal and CCS (California Children's Services), and which conditions qualify for benefits from each entity. She had to coordinate multiple therapy appointments with medical follow-ups and at times she missed therapy visits due to competing medical follow-ups. Ongoing stress impacted her and her family's daily lives and eventually she separated from his father.

It was also noted that Michael had received consistent medical follow-ups despite some delayed diagnostic tests and scans, and his medical condition had improved so he no longer required oxygen. Mother had declined public health nursing (PHN), because she felt that frequent PHN visits would be intrusive to other family members. Michael was a client of the Regional Center's prevention program. He was receiving infrequent physical therapy through Medi-Cal and was on a waiting list for feeding therapy. His developmental assessment revealed the need for immediate feeding therapy, occupational therapy and physical therapy.

Mother expressed exhaustion managing his medical and developmental follow-ups and psychosocial issues so the EDAC team went into action. The HRIF provider contacted his pediatrician and conferenced; the social worker spent a long time listening to her and provided social service resources, support group information, made referrals to community agencies, and continued to be available for the mother; the dietitian conferenced with the GI clinic provider and dietitian and discussed a plan of care for feeding regimen; the EDAC HRIF coordinator contacted Medi-Cal to discuss issues that had resulted in delayed services, requested to have a case manager assigned to this patient, and contacted CCS for

therapy services that could be covered. The HRIF coordinator also spoke to the case coordinator at the Regional Center prevention program and discussed ways to provide early intervention for his developmental delays in coordination with Medi-Cal.

The HRIF coordinator remained the focal contact to manage his care in communication with multiple entities as aforementioned as well as in contact with the mother. Physical therapy sessions were increased to appropriate frequency and mother committed to attend these sessions. Occupational therapy was authorized. Despite our efforts, he was still on the waiting list for feeding therapy for another 2-3 months at the center where he was originally authorized so Regional Center made a decision to initiate therapy. Of note, OT was providing feeding sessions (sessions paid by Medi-Cal), but Michael required individualized feeding therapy sessions, which Regional Center decided to provide. Having community partners and medical providers united for the patient, mother and the family, mother expressed gratitude and empowerment to overcome the difficult challenges she faced. Michael was thriving by the second EDAC visit and in ongoing therapy with progressive improvement in development. We're looking forward to seeing his progress at his third visit.

This story captures how EDAC meets the cultural and language needs of the patient and family and helps coordinate a transition to another high risk infant follow-up service.

David was born with low birth weight, which qualified him for the High Risk Infant Follow-up (HRIF) program. EDAC received a call from the referring hospital's HRIF coordinator that due to changes in insurance, the patient would be referred to EDAC for HRIF services. Once the EDAC HRIF coordinator processed intake, it was noted that the family spoke Vietnamese. An effort to secure a translator was initiated prior to the first visit and CHOC Interpretation Services was also notified. The medical plan agreed to provide a translator and the first visit went smoothly, providing education, home programs and answering all of the parents' questions.

The EDAC HRIF coordinator had to follow-up with David's pediatrician and public health nurse for ongoing medical and developmental therapy service needs. CHOC Interpretation Services provided translation service communicating to the parents regarding necessary follow-ups well after the first visit. The insurance changed again requiring a transfer to the original referring hospital's HRIF program. The EDAC coordinator transferred the case and explained the effort required for translation services and to meet the cultural needs of the family, close follow-ups with the parents, and David's ongoing medical and developmental needs. The receiving HRIF coordinator was able to coordinate her efforts to meet the cultural and language needs of the patient and family working with her team.

The Center

Mark and Brad

Mark and Brad are brothers who were both diagnosed with autism and global developmental delays. The brothers were first seen at The Center when Mark was 3 years old and Brad was 4 years old. The brothers were originally diagnosed and treated in Riverside County and then moved to Orange County where they established care at The Center.

We will first present Mark's story. Mark's parents requested an urgent appointment because they had just moved to Orange County and had run out of Mark's medications. Additionally, they could not control his aggressive behavior and hyperactivity. Because of the move, they had not yet been approved for services through the Regional Center (RCOC). The parents were desperate for help. The provider determined there should be an adjustment in Mark medication, the adjustment was made and the family was told to return in a month. At the next visit his behavior was worse and the parents still did not have approval for Applied Behavioral Analysis (ABA) services; in addition, the patient had excessive weight gain. The provider then decided to change the medication completely. The Center worked at securing at-home ABA for Mark. At the next appointment, Mark was calmer and was actually able to watch TV for a while and his weight dropped slightly. Additionally, the provider worked with educating the parents regarding setting limits and not reinforcing negative behavior. Mark is now 8 years old. Although there are still challenges, he has improved immensely. He is better focused and he pays more attention in trying to learn.

Mark's brother Brad was first seen at The Center when he was 5 years old. Brad had a history of head banging, sleep problems and speech and language delays. Upon initial evaluation the provider felt Brad was over-medicated and decided to taper down his medication. At the next visit, his behavior was much better at school and he was making excellent progress; his teacher stated "He demonstrates very good social skills at school and he is a pleasure to have in class." His mother felt the medication change "woke up" Brad and she was relieved his behavior issue at school had improved. However, he continued to have aggressive behavior towards his mother. The provider worked with and supported the mother to learn how to work with her child to improve his behavior. Brad is now 9 and he is better focused, learning multiplication tables, and plays soccer with his school friends. He also is less aggressive with his mother and his sleeping habits have improved. Mark and Brad's parents are so thankful for their provider and the services provided to them by The Center.

Tim

Tim was diagnosed with autism and global developmental delay when he was 3 years old and was seen at The Center at age 5. The family had just moved to Orange County from Nebraska and they were awaiting benefits from the Regional Center.

Tim's mother is a monolingual Vietnamese speaker. She has four children, two with autism, and her husband lives and works in Bakersfield most of the time. Essentially, Tim's mother is a single parent. At the first visit, the mother was crying and felt her children's autism was her fault. Also, she felt imprisoned in her home because she could not control her children's behavior and would never leave the house. The provider and social work counseled the mother and expressed to her that it was not her fault, and we would do everything we can to help her and her family. She was given information to attend our SEEPAC class, which was offered in Vietnamese. At the end of the initial visit, the mother felt relieved and Tim would be seen again in two months.

Tim's ABA was approved and the mother was attending SEEPAC class. Both were improving. However, Tim was having behavior issues in school and the teacher was concerned regarding his inattention and hyperactivity. The provider adjusted his medication and counseled the mother on how to administer a reward system for Tim. With the help of the ABA provider and The Center, the mother excelled in learning how to work with her children with autism; and her morale improved greatly. Tim is now 9 years old, his hyperactivity has improved, he has no problems at school, and his sleep has improved. At the last visit Tim's mother shared that she took all four of her children on a vacation (which they had never done before) to Las Vegas and the Grand Canyon. The provider expressed how proud she was of the mother's achievements with her kids.

Ray

Ray was first seen at The Center when he was 4 years old. He is diagnosed with Autism, ADHD, disruptive behavior disorder, hearing loss, and visual acuity deficit. At the age of 6 he was placed in foster care and currently has a very caring foster parent. He had extreme behavior concerns for both violence and inappropriateness. He was doing well academically at school, but his behavior was "out of control." At his first appointment, after he was placed in foster care, his ADHD medication was adjusted, he was referred to counseling and the foster mother was counseled on how to work with and care for Ray. Ray had his ups and downs, however, his foster mother was consistent and stable with him. He continued to be treated at The Center and both he and his foster mother were provided with positive reinforcement of Ray's improvements. Ray is now 8 years old and is doing great at school and has demonstrated an improved ability to self regulate even when he is sad or disappointed. Ray was recognized as Student of the Month and the criteria was "personal responsibility and exemplary behavior." According to his foster mom, he was beaming with joy. We will continue to work with Ray and address challenges as they arise. As long as we all work together, he will continue to succeed. In a letter his foster mother sent to the provider she said, "It certainly takes a Village" and we are glad to be a part of Ray's village.