Help Me Grow
2007- 2008 Annual Evaluation Report

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Help Me Grow: 2008 Annual Evaluation Report

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Introduction

Help Me Grow Program

Help Me Grow is a comprehensive, statewide, coordinated system of early identification and referral for children at risk for developmental or behavioral problems. Parents, pediatricians and other providers are given information and training in how to recognize the early signs of developmental problems and to contact *Help Me Grow* when they have a concern or need help. Children who are facing difficulties are then connected to community resources and local programs.

Connecticut Children's Trust Fund administers *Help Me Grow*, working in collaboration with The United Way of Connecticut/211 (the state's telephone information and referral service), the Connecticut Department of Developmental Services' Birth to Three System, the State Department of Education Preschool Special Education Program, and the Department of Public Health's Children and Youth with Special Health Care Needs (CYSHCN) program. The programs work in partnership to facilitate coordinated services. It is through this collaboration that *Help Me Grow* contributes to a statewide network for providing triage and referral for those concerned about children's development.

The components of the program include: on-site training for Pediatricians and Family Health Care Providers in early detection of child developmental and behavioral concerns; a statewide toll free telephone number for accessing Child Development Infoline (CDI), part of The United Way of Connecticut/211 system; telephone Care Coordinators (CCs) who triage calls, provide referrals and follow up with families; and partnerships with community-based service and advocacy agencies facilitated by the *Help Me Grow* Community Development Liaisons (CDLs).

A chief strategy of *Help Me Grow* is to reach out to community child health providers and provide training in practical methods of conducting developmental surveillance and screening. The training, coupled with *Help Me Grow's* centralized referral system, is designed to eliminate frequently cited barriers to developmental surveillance and to change provider practice so that a child's developmental needs are met at the earliest possible age. Through follow up after referrals are made, *Help Me Grow* ensures that health providers are informed about evaluations and recommended services. This communication enhances the role of the health care provider.

When a provider or family calls *Help Me Grow*, they are asked a series of questions that help the care coordinator make an assessment and appropriate referrals. If, after initial assessment, the child does not meet the criteria for Birth to Three, Pre-School Special Education services, or Children & Youth with Special Health Care Needs, the family becomes part of the Help Me Grow system. The care coordinator researches existing resources or services for the family. If the care coordinator experiences difficulty finding an appropriate resource, they call the community development liaisons for technical assistance. The community development liaisons are the researchers in the community. Moreover, they facilitate networking and partnerships with community-based agencies through outreach and advocacy to maximize use of existing services. They serve as a conduit between the community-based services and the telephone access point.

Children are connected to such existing resources as primary and specialty medical care, early childhood education, developmental disability services, mental health services, family and social support, and child advocacy providers. The Care Coordinators provide families with program information that includes a specific name of a contact person and details about services. If necessary, the care coordinator will call the resource and arrange a telephone conference call with the family. The Care Coordinators also contact the family approximately two weeks after the referral is made to see if they were able to access services, and send a letter to the child health provider to let them know when a family has been connected with a community-based resource. The letters are designed to be included in the medical record in order to prompt discussion with parents regarding development, concerns, and needed services at their next office visit.

Other *Help Me Grow* services and programs

Ages & Stages (ASQ) Child Monitoring Program

Effective since July 2002, *Help Me Grow*, through the Child Development Infoline, offers families the *Ages & Stages (ASQ) Child Monitoring Program* designed to screen children for developmental delays. The ASQ is a screening tool completed by parents and used to identify children from four months to five years of age. Families learn about the ASQ from several sources, including child health care providers, the Birth to Three program, and Help Me Grow contacts. Parents fill out an enrollment/consent form and are mailed the ASQ at specified intervals; once they complete the questionnaire, they mail them back for scoring. If no developmental delays are identified, the parent is sent an activity sheet that outlines the next stage of development and what to expect until the next questionnaire is mailed. The consent form includes permission to send the ASQ results to the child's health provider. The provider can then add the results to the child's chart and have a record of development to guide surveillance at subsequent health supervision visits. Community development liaisons also provide information and training for pediatricians and other health care providers on how to encourage parent use of the ASQ developmental screening. Specifically, during the past year the *Help Me Grow* program distributed Ages & Stages Child Development Kits for the four month well-child visit to pediatric practices in an effort to promote *universal* monitoring of development by parents that begins at the earliest age possible.

Tracking gaps and barriers in services

A systematic process for identifying and tracking gaps and barriers was established during the past year and these data are now being collected. For example, barriers to connecting families to services include such things as long waiting lists and language/cultural barriers. In addition, agencies that are either unresponsive or do not return phone calls, or do not meet client needs, or otherwise have exhausted their resources are also considered barriers. Gaps, more system-based, are specific services that are not available to families. Gaps in services include programs such as parent education, respite, and home-based services.

Reaching "hard to reach" families

With support from the Kellogg Foundation, *Help Me Grow* also conducted a pilot project during the past program year in Hartford, CT (North End neighborhoods) designed to connect hard to reach families to services. Hard to reach families, as identified through Child Development

Infoline, include families that: are difficult or unable to contact by phone; have multiple/complex needs; have unpredictable living circumstances; experience difficulty "navigating" service system due to a language or cultural barrier; and/or experience difficulty navigating service system due to issues related to literacy/education. The Maternity and Infant Outreach Program (MIOP), a division of the Hartford Health and Human Services Department, contracted with *Help Me Grow* to work in partnership in developing this new outreach model and provided the services. In addition, the majority of hard-to-reach families were identified and recruited through the MIOP program. Face-to-face care coordination (versus by phone or mail) was more immediate and effective when working with hard-to-reach families. In addition, the initial presenting issues were often not the most important. It was through observations in the home that a more comprehensive assessment of needs was possible.

Overview of report

The report is divided into five sections. The first section, by far the largest section, reports on *Help Me Grow*'s *statewide system of early detection and care coordination*. This includes data on the utilization of the program, referrals, outreach efforts (to both pediatricians and community support programs), and outcomes. The second section reports on utilization of *Help Me Grow's Ages & Stages Child Monitoring Program*. The third section describes the new system for tracking gaps and barriers in services. The fourth section is on the process and outcomes of *Help Me Grow's* pilot project, reaching "hard to reach" families. The fifth section provides a brief summary and recommendations.

Connecticut General Assembly and Results-Based Accountability. In accordance with Connecticut's General Assembly Appropriation Committee, results-based accountability (RBA, Freidman, 2005) provides a framework for Sections I and II of this report; that is, data – or indicators of performance and results - are presented to show where the program's been, and a forecast of where the program is going. Specifically, "baselines" are created that show trends over time. Other measures are used to tell the story behind the baselines and other parts of the program process. In addition, performance measures are organized according to the following:

- "How much did *Help Me Grow* do?" (i.e., utilization of the program and related data)
- "How well is *Help Me Grow* doing?" (i.e., family referrals for services and community outreach efforts)
- "Is anyone better off as a result of utilizing *Help Me Grow?*" (i.e., outcomes and final disposition of cases)

Analysis of data by the "Five Connecticuts." While Connecticut is a prosperous state with the highest per capita income in the country, it also has areas throughout the state with very high concentrations of low-income populations. In the larger cities such as Hartford, over forty percent of the children live below poverty level. Since children living in poverty are at *increased* risk for developmental and behavioral problems that affect future learning and function, it is important to get a better understanding of family needs and services in the different communities of Connecticut. We compare utilization and outcomes of the program between five distinct Connecticut town groups: Wealthy, Suburban, Rural, Urban Periphery, and Urban Core (see *The Changing Demographics of Connecticut-1990-2000*, Center for Population Research, University of Connecticut, 2004).

SECTION I. *Help Me Grow's* state-wide system of early detection and care coordination

A. How much is the program doing?

- **Utilization of *Help Me Grow*:** Number of calls made to *Help Me Grow* by parents, pediatricians, and others with concerns about a child's learning, development or behavior during the past three years (Figure 1 and Table 1).

Figure 1. Who Calls *Help Me Grow*?

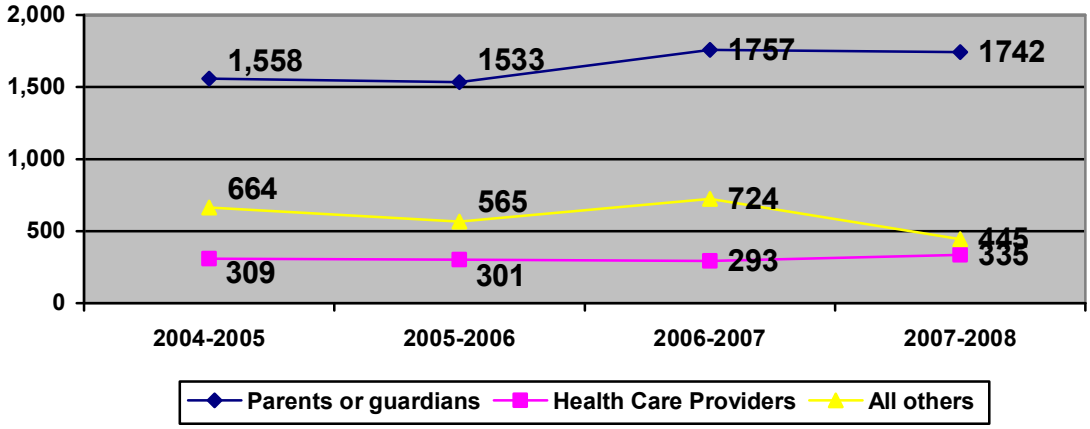


Table 1. Total Number of Callers

2004-2005	2005-2006	2006-2007	2007-2008
2,531	2,399	2,774	2,522

Figure 1: Summary analysis

- During the 2007-2008 program year, a total of 2,522 calls were made to *Help Me Grow* by parents, pediatricians and other providers, and families and friends who were concerned about a child's behavior, learning or development. This is a 9% decrease from last year's total and can be explained by the decrease in needed interim services for families who initially requested Birth to Three services (i.e., in previous year, there was a waiting list for Birth to Three services which has since been addressed).
- As with previous years, the majority of callers are parents or guardians (69%). Pediatricians make up the second largest group of callers (19%) and there has been an increase in calls from pediatricians for the first time in the past 4 years (14% increase from last year). This is likely due to the increase in pediatrician outreach (phone calls, emails, mailings) and training during the past year (almost double the amount of trainings than the previous year). See below section on outreach activities.
- The remaining twelve percent of the calls are evenly distributed among social service agencies, child care providers, relatives and friends, and the Department of Children and Families. Unlike the previous year, there has been a 38% decrease in calls from this group since June 30, 2007. This decrease coincides with a decrease in funding within United Way for outreach and informational services to these groups.

- **Story behind the baseline:** How families learn about the program (Figure 2) and the nature of service requests and presenting issues (Figure 3).

Figure 2: How Do Parents Learn About *Help Me Grow*?

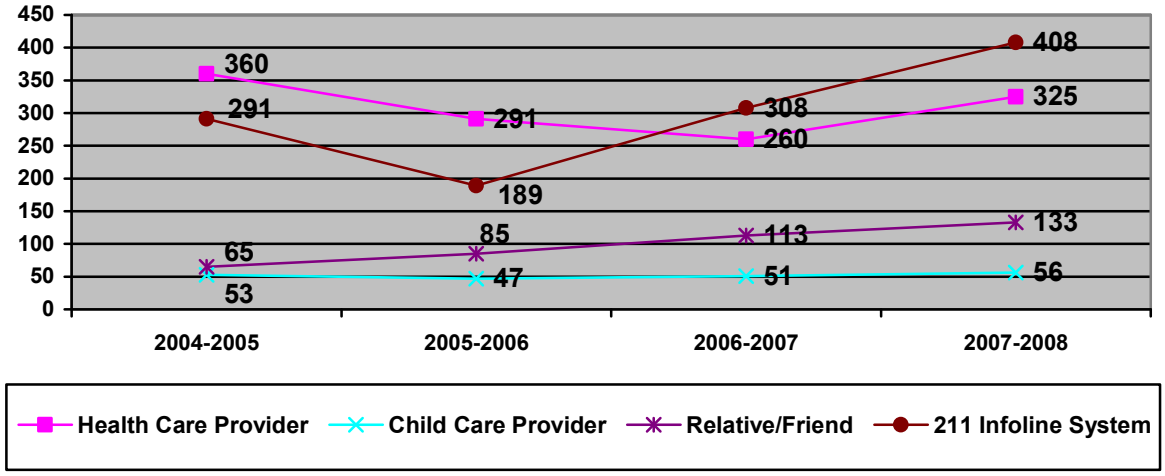


Figure 2: Summary analysis

- Many families that call *Help Me Grow* report that they already know about the program (48% of the callers in the past year; not noted in above graph). Families also learn about *Help Me Grow* from their pediatricians, from a relative or friend or from their child care provider.
- Due to improvement in documentation by the care coordinators on this item during the 2007-2008 year (i.e., documentation on how callers learn about *Help Me Grow* services is more systematically collected), there is an increase in the number for each of the ways in which families have learned about the program.
- There was a significant increase in the *percentage* of calls that are transferred to Help Me Grow when families call the State's 211 Infoline System at the United Way, from 25% of all calls in the previous year to 32% of all calls in this past year ($\chi^2 = 13.5$, p=.000). This can be explained by an improvement in internal coordination and communication within United Way between the 211 system and the Child Development Infoline.

- **Why families call *Help Me Grow*: Nature of service requests and presenting issues**
  Families call *Help Me Grow* for a variety of reasons; when a call comes in, there are typically two or more service requests or presenting issues. The following are reasons why families call *Help Me Grow*:
  - inquiries about specific child development programs,
  - questions related to general development concerns,
  - seeking an evaluation for child,
  - concern about child's social or emotional behavior,
  - concern about child's health or disability,

- need for special health services,
- education needs, in particular special education services,
- basic needs such as medical care, mainly due to financial difficulties,
- family issues and functioning (e.g., domestic violence),
- social and recreational programs for their child (camps, playgroups),
- adaptive needs (e.g., related sensory issues), and
- mental health condition and/or treatment for child.

As figure 3 shows, the percentages of reasons for calling have mostly stayed the same among the different categories over the past three years with a couple of important exceptions during the past year (as noted below). Also, over the past two years there has been an overall increase in the number of reasons for calling; that is, the number of service requests or presenting issues per family has increased. This is explained by improvement in care coordination and assessment of family needs at time of intake.

Figure 3: Nature of Service Requests and Presenting Issues

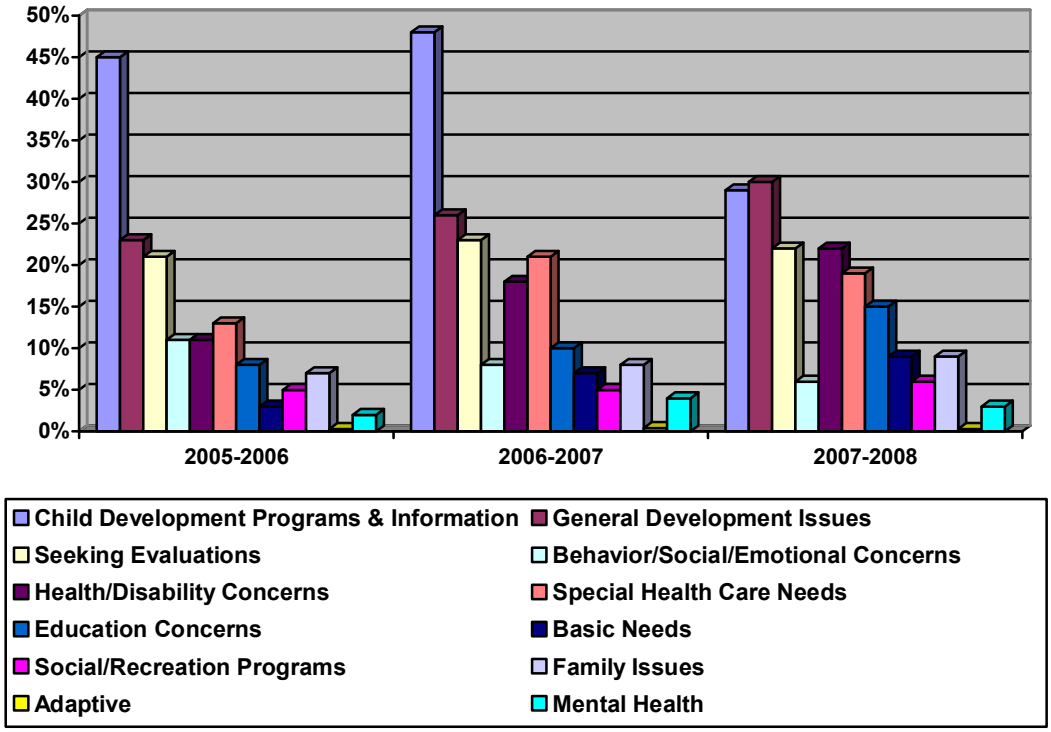


Figure 3: Summary Analysis

- For each of the past three years, the majority of calls have been inquiries about specific child development programs, questions related to general development concerns, or families seeking evaluations for their children.
- However, there has been a relatively dramatic decrease in the percentage of calls inquiring about child development programs during the past year (from 48% to 29%). Interestingly, this can be explained by changes in the Birth to Three program. In the former two years, many families who were referred for a Birth to Three evaluation for

their child were placed on a waiting list; information on child development programs was often requested (or suggested by the care coordinators) during the interim. During this past year, the Birth to Three program increased its capacity and parents are rarely placed on a waiting list thereby decreasing the requests for program information.

- Families also call with questions or concerns regarding their children's social or emotional behavior, their child's health, or their child's disability and for special health care needs. The percentage of calls from families regarding their children's behavior has steadily decreased over the past three years (11% in 2005-2006 to 8% in the 2007-2008 to 6% during the past year). This may be due to issues related to documentation (i.e., change in coding of these issues) rather than an actual change in presenting issues.
- However, the percentage of calls related to disabilities have doubled over the past three (from 11% in 2005-2006 to 22% during the past year) and the percentage of calls for special health care needs have also increased by approximately 50% since three years ago (from 13% to 19%). These increases are likely due to the partnership agreement between *Help Me Grow* and CYSHCN beginning in 2006 (as noted in the introduction) and relatedly, an increased awareness of these issues and the availability of programs for these families.
- There has been a steady increase in the percentage of families calling with concerns regarding education or basic needs. This is explained by improvement in the assessment process by care coordinators at time of intake. Calls regarding educational concerns (30% of which are families inquiring about special education services, 29% are families concerned that the educational program is not meeting child's needs, and 13% are because the family's childcare or day program is reporting difficulty managing child) have nearly doubled since three years ago (from 8% to 15%). Calls from families inquiring about basic needs have tripled, from 3% in 2005-2006 to 9% in 2007-2008 (in the past year 34% are families who report financial issues; financial concerns include such things as being unable to afford medical care, diapers, child care, food, shelter, and clothing).

- **Follow up services for Birth-to-Three program:** Starting in January of 2007, *Help Me Grow* has been providing follow up services for families who were being screened for Birth to Three services (see Figure 4).

Figure 4: Number of Birth To Three Follow Up Cases

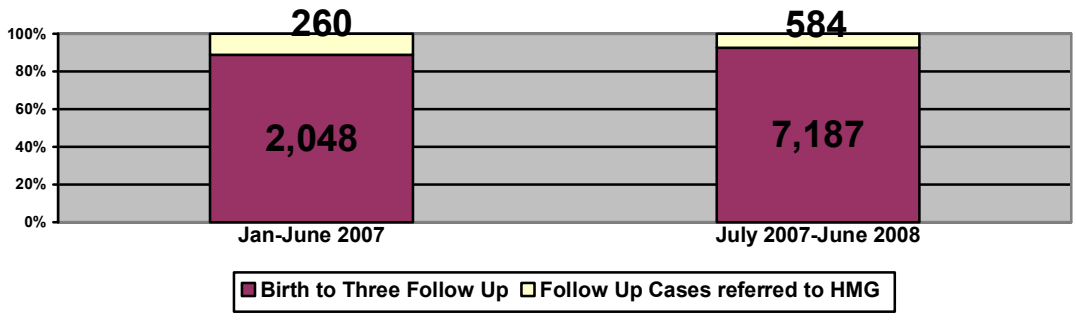


Figure 4: Summary Analysis

- Of the total number of families who received a follow up phone call in the *past year* (7,771), 8% (584) requested services through Help Me Grow. This is comparable to 10% from the previous *6 months* (services began in January of 2007).
- During the 2007-2008 year, there were 306 referrals for program services made on behalf of 257 families. Below are the numbers of referrals by type of inquiries or services requested by families, and the types of services or programs where families were referred.

HMG Presenting Issues (N=584):

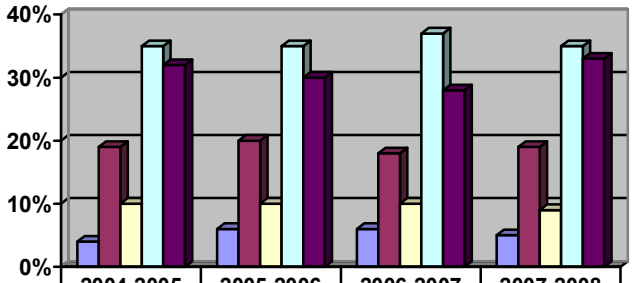
- Child Development Program Info – 363
- General Development – 273
- Health/Disability - 38
- Evaluation requests – 36
- Socialization - 29
- Special Health Care Needs - 25
- Family Issues - 18
- Basic Needs – 12
- Education – 12
- Social- Emotional – 9
- Mental Health – 4; Adaptive – 3

HMG Referrals for services (N=257):

- ASQ - 155
- Infoline - 44
- Disability Related - 40
- Educational services - 38
- Parenting – 29

- **Analysis of data by the "Five Connecticuts."** Similar to last year, we examined "caller" data further to determine if there were meaningful patterns between different socioeconomic town groups related to where *Help Me Grow* families live (see Figures 5 and 6), rates of phone contacts (see Figure 7) and reasons for calling *Help Me Grow* (see Figures 8 and 9). In order to do this we used an analysis conducted by the Center for Population Research, University of Connecticut (2004) that categorized individual towns into five "distinct, enduring, and separate groups" in terms of income, poverty and population density (http://popcenter.uconn.edu).

Figure 5: Where the Families Live
Wealthy, Suburban, Rural, Urban Periphery, Urban Core



	2004-2005	2005-2006	2006-2007	2007-2008
Wealthy	4%	6%	6%	5%
Suburban	19%	20%	18%	19%
Rural	10%	10%	10%	9%
Urban Periphery	35%	35%	37%	35%
Urban Core	32%	30%	28%	33%

Figure 5: Summary analysis

- As figure 5 shows, the percentages of where *Help Me Grow* callers reside within the different town groups has been remarkably similar across the past four years.
- Similar to the previous years, the majority of families who contact *Help Me Grow* in 2007-2008 resided in the Urban Periphery (35%) and the Urban Core (33%) of Connecticut. Altogether, these towns have the lowest income, the highest poverty rates, and the highest population density. The Urban Periphery (36% of the State's population) consists of 30 "transitional" towns (i.e., located between the urban cores and the suburbs) with below average income, average poverty rates, and a high population density. The town of Manchester is most representative of this group. The Urban Core (19% of the State's population) consists of the 6 Connecticut cities that have the lowest income, the highest poverty rates, and the highest population density. Bridgeport is the most representative of this group.
- The next largest group of callers resides in Suburban Connecticut (19%), consisting of 61 towns and 26% of the State's population, with above average income, low poverty rates, and moderate population density. The town of Cheshire is most representative of this group.
- A small percentage of callers (9%) reside in Rural Connecticut, consisting of 63 towns and 13% of the State's population, with average income, below average poverty rates, and the lowest population density. North Stonington is most representative of this group.
- The fewest number of callers reside in Wealthy Connecticut (5%) consisting of 8 towns and 5% of the State's population, and has exceptionally high income, low poverty, and moderate population density. The town of Westport is most representative of this group.

Figure 6: Percentages of Families Residing in the Five Town Groups- *Help Me Grow* Compared with State Population 2007- 2008

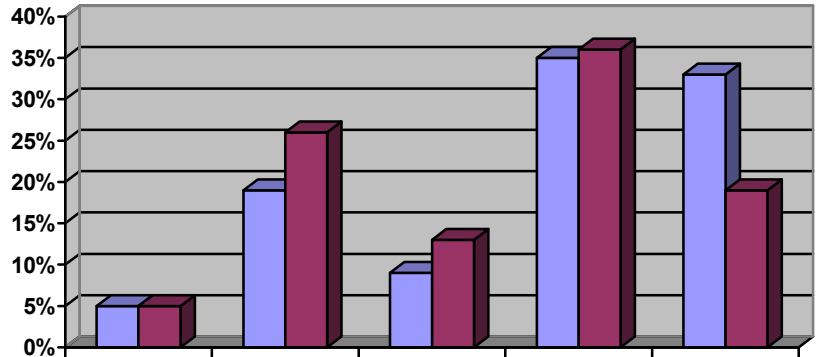


Figure 6: Summary analysis

- Figure 6 shows that the percentages of *Help Me Grow* families that reside in the Wealthy (5%), Rural (9%), and Urban Periphery (35%) town groups are *proportionate* to the

percentages of these town groups' overall population in the State (i.e., 5%, 13%, and 36%, respectively).

- The percentage of *Help Me Grow* families that reside in Suburban CT (19%) is *disproportionately* lower than the percentage of this group's overall population in the State (26%), and the percentage of callers from Urban Core CT (33%), unlike all the other groups, is disproportionately *higher* than the percentage of this group's overall population in the State (19%).

Figure 7: Average Number of Calls per Case between Town Groups

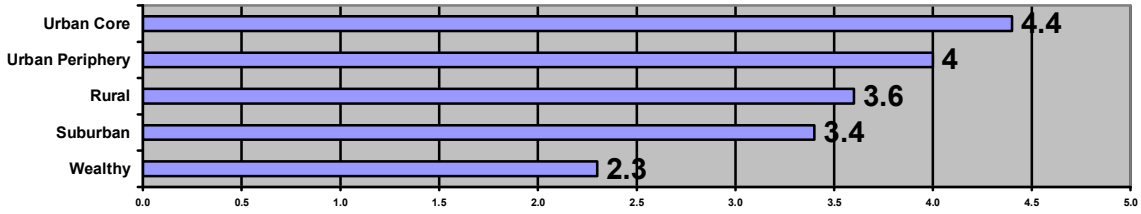
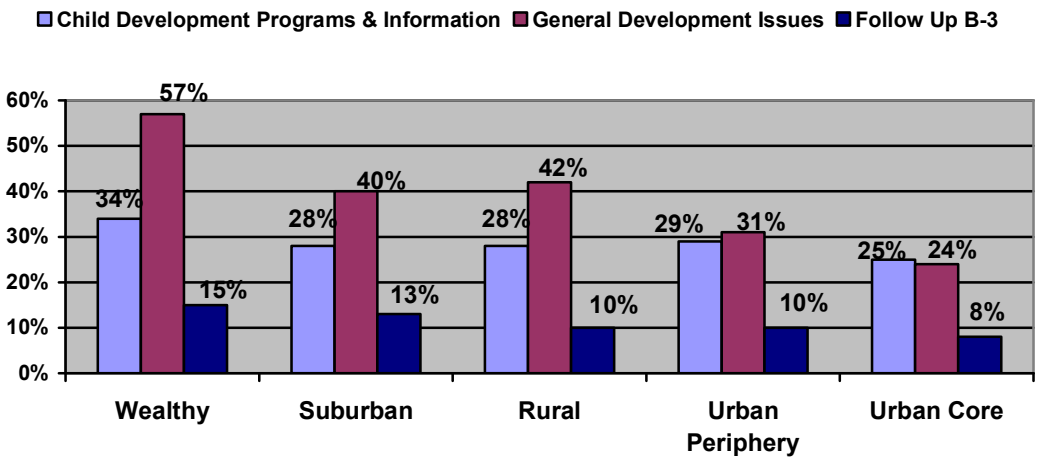


Figure 7: Summary analysis

- Analysis comparing average number of phone contacts per family (incoming and outgoing) across town groups (Fig. 7) showed a significant difference (F=17.8, p<.00). The greatest number of phone contacts per case occurs in the poorer communities, specifically, the Urban Core and the Urban Periphery, and the least number of calls per case occurs in Rural, Suburban, and Wealthy CT.

- **Figures 8 and 9, together, make up the majority of service requests and presenting issues by the different town groups.** In order to better understand family needs and services in the different communities, we compared issues that represented prevention (Figure 8) and those that represented intervention (Figure 9) across the five town groups.

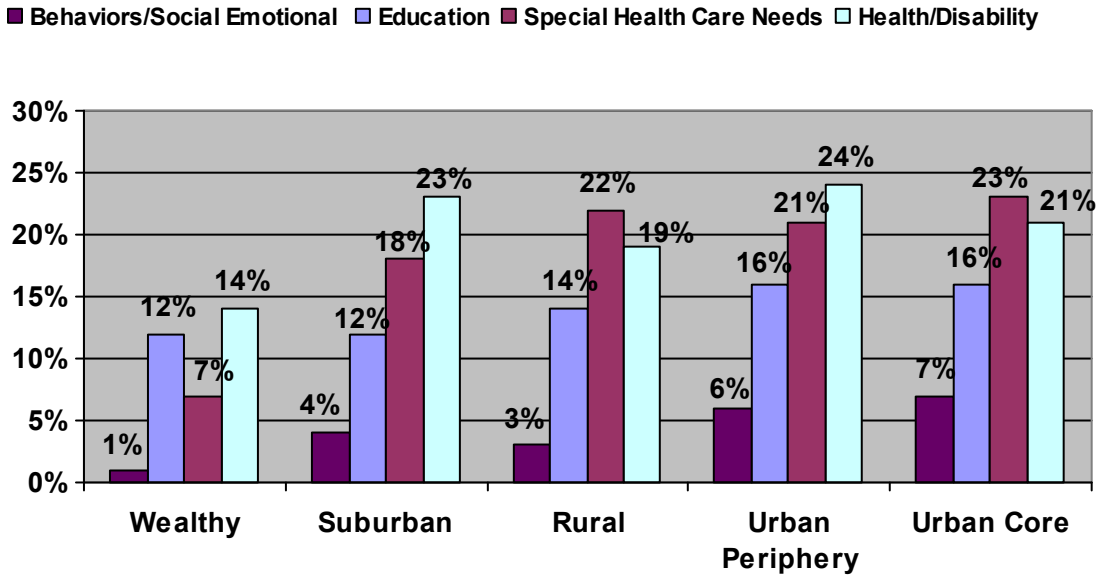
Figure 8: Why People Call Help Me Grow: Prevention



Figures 8 & 9: Summary analysis

- The data in Figure 8 are all the calls made to *Help Me Grow* that are *preventive* in nature: families seeking information regarding development programs and/or inquiring about their child's development, as well as families who continued to seek support when they learned their child was not eligible for Birth to Three services (e.g., developmental monitoring through ASQ program). Overall there is a *higher* percentage of calls related to prevention from families that reside in the wealthier communities and a *lower* percentage of calls related to prevention from families that reside in poorer communities.
- The data in Figure 9 are calls made to *Help Me Grow* that represent *intervention* efforts: inquiries about social/behavioral concerns, educational concerns, special health care and disability-related needs. Overall there is a *lower* percentage of calls that represent intervention efforts for families that reside in wealthy communities and a *higher* percentage of calls that represent intervention efforts for families that reside in poorer communities. Calls from families seeking evaluations (not included in the graph) are the one exception to this pattern; percentages of these calls are similarly represented among the different town groups: Wealthy-22%, Suburban-21%, Rural-19%, Urban Periphery-25%, and Urban Core-25%.

Figure 9: Why People Call Help Me Grow: Intervention



B. How well is *Help Me Grow* doing? This subsection has two distinct sets of measures: (1) family referrals for services, and (2) community outreach and training (i.e., for pediatric and family health practices and for community-based service providers).

1) Family referral for services

- **Number and type of referrals for program services on behalf of families**

When a provider or family calls the Child Development Infoline number they are asked a series of questions that help the care coordinator make an appropriate referral. The care coordinators' ongoing training addresses how to interview and build a relationship with callers, ask for appropriate clarification, use active listening skills, educate callers on how the system works, summarize what has happened during the call, and clarify follow-up program and referral needs. For example, care coordinators will determine if it is appropriate to refer a family for a Birth to Three assessment or to a preschool special needs program. Figure 10 shows the five service programs that receive the most referrals (note that this does not include referrals to Birth to Three program as this is immediately referred over without being documented).

Figure 10: Five Highest Number of Referrals to Service Programs

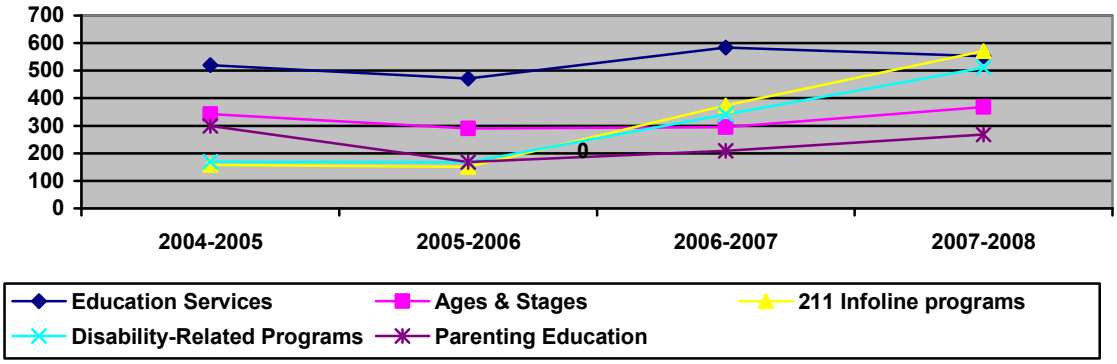


Table 2. Total Number of Referrals

2004-2005	2005-2006	2006-2007	2007-2008
2,237	1,954	3,122	3,950

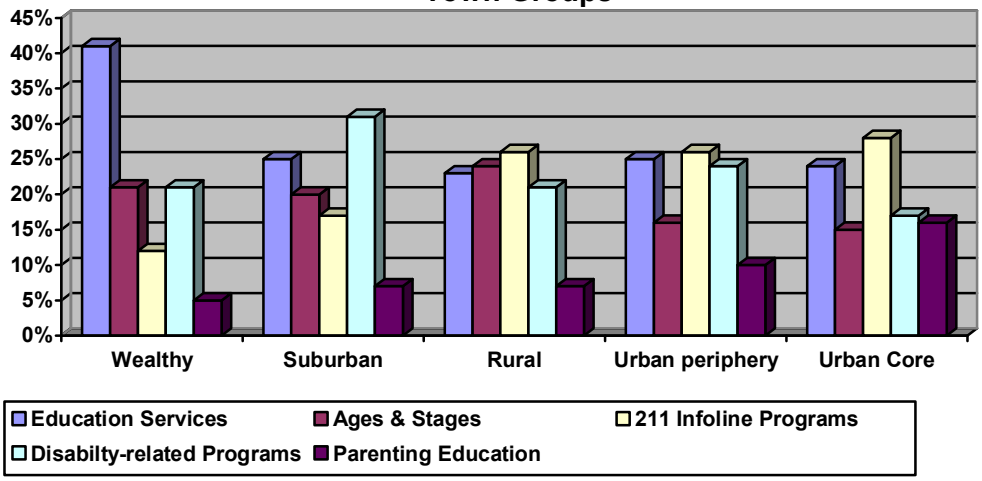
Summary analysis:

- The total number of *Help Me Grow* referrals to service programs for Connecticut families during the 2007-2008 program year was 3,950, a 26% increase from the previous year and more than a 100% increase from three years ago. Given that the number of callers did not increase during the past year, the overall increase in the number of referrals can be explained by (1) an increase in the number of service requests or presenting issues (see Figure 3), and (2) improved "resourcing" by the care coordinators, many of whom have been employed in their position for at least 1 to 2 years, and several for at least 3 years.
- The top 5 program referrals for the past four years have consistently included referrals for: (1) education-related services, most of which are for preschool special education, (2) the Ages & Stages Child Monitoring Program, (3) Infoline (e.g., basic needs, Husky Health Insurance), (4) disability related services, and (5) parent education.
- In the past year, there has been a relatively large increase in the number of referrals to Infoline and disability-related programs, and an increase (to a lesser degree) in referrals

for the Ages & Stages program and parenting education, while referrals for educational-related services have remained the same.

- **Story behind the baseline:** Comparison of the referrals among the five Connecticut town groups (see Figure 11).

Figure 11. Comparison of the Five Highest Referrals between Town Groups



Summary analysis

- Unlike the other town groups, the percentage of referrals for education services is the highest in Wealthy Connecticut (i.e., majority for Special Ed. Service), communities where parents are often well connected to each other and share information on services such as *Help Me Grow.*
- In comparison with other town groups, the percentage of referrals for Ages & Stages Child Monitoring Program and disability-related programs are lowest in Urban Periphery and Urban Core Connecticut.
- In comparison with the wealthier town groups (including suburban communities), the percentage of referrals for Infoline programs (e.g., basic needs) is high in the relatively poorer communities (Urban Periphery and Rural) and highest in Urban Core.
- Referrals for parenting education programs are comparatively much higher in poorer communities (especially the Urban Core town group).

2) Community outreach and training

- **Outreach activities to community-based family and child service organizations**

Help Me Grow's Community Development Liaisons (CDLs) serve as the conduit between Connecticut's community-based services and the telephone access point. In the past year, there was an expansion in these services, and table 3 shows that, overall, the number of outreach and networking activities has increased accordingly in the past year.

Table 3. Outreach Activities: July 1, 2007 through June 30, 2008

Outreach and Networking Activity	# of activities 2006-2007	# of activities 2007-2008
Presentations on *Help Me Grow,* Shaken Baby Syndrome, and ASQ	48	52
Pediatric Trainings in how to use *Help Me Grow*	16	30
*Pediatric Outreach	--	71
Regional Networking Breakfasts	38	49
Collaborative meetings (public/private) at the regional & town levels	55	43
On-site, face-to-face outreach/individualized meetings	30	33
*Mailings (distribution of brochures and other materials)	--	8

* Process for tracking of pediatric outreach and mailings during 2006-2007 was different between the two years and is not comparable from year 2006/2007 to year 2007/2008.

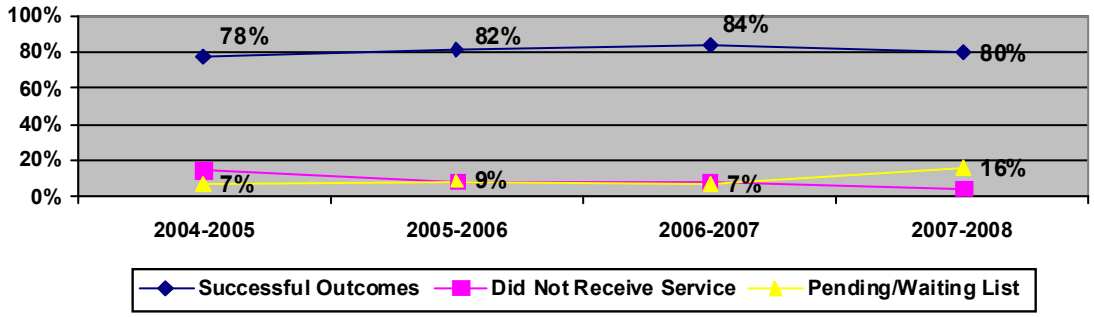
Summary analysis

- CDLs conduct formal presentations on *Help Me Grow*, the ASQ Developmental Monitoring Program and Shaken Baby Syndrome to child health care providers, other professionals in child care, domestic violence shelters, homeless shelters and social service agencies. During the past year there were 52 of these presentations.
- During the past year CDLs also provided training in how to use *Help Me Grow* for 30 pediatric offices, almost double the number of the former year. *Help Me Grow* health provider education in developmental surveillance highlights the use of the ASQ Monitoring System and the Parents' Evaluation of Development Status (PEDS) - a three to five minute validated screening instrument for detecting developmental delay that is filled out by the parent, often while in the waiting room. *Help Me Grow* also uses a "tool box" that allows practices to store all developmental surveillance materials in one place in the office, and is easily integrated with other health supervision materials (e.g., immunization consent forms, safety handouts, and growth charts).
- During this past year there were approximately 1,000 Ages & Stages Four Month Development Kits disseminated at pediatric offices to encourage as many families as possible to sign up for the ASQ as early as possible (i.e., encouraging universal monitoring of development by parents).
- CDLs also provide information on *Help Me Grow* to a range of programs serving children in the State, and facilitate networking partnerships among community-based agencies. Specifically, they conduct regional Networking Breakfasts that bring together community-based agencies to widen their connections to a broader group of service providers, support each other's organizations, share information and to develop solutions to challenging cases. During the past year, there was an increase in Networking Breakfasts during the past year for a total of 49.

C. Is anyone better off as a result of utilizing *Help Me Grow*?

- **Rates of successful or positive outcomes:** Outcomes of family referrals for service and information requests (Figure 12).

Figure 12. *Help Me Grow* Outcomes

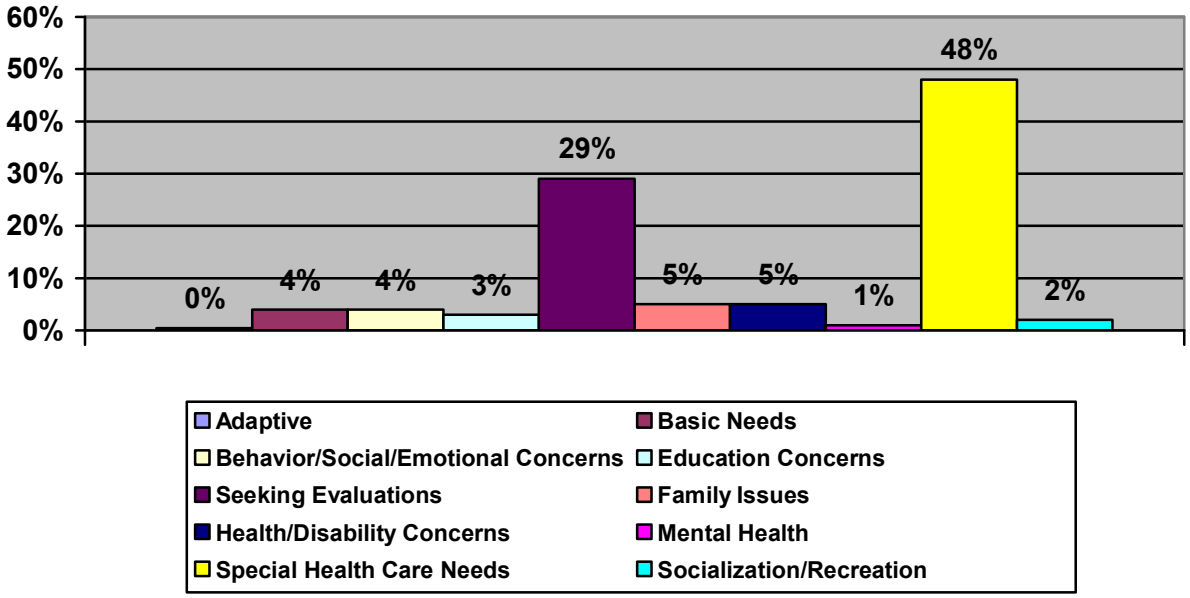


Summary analysis

- Rate of successful outcomes, i.e., family is successfully connected to a needed service, is high. Eighty percent of service needs were addressed for the 2007-2008 year.
- The slight decrease in successful outcomes (from 84% in previous year to 80% in past year) is balanced by the increase in outcomes that are pending (from 7% in the previous year to 16% in past year).

- **Story behind the baseline**: Percentage of pending outcomes by call type (Figure 13)

Figure 13. Percentage of Pending Outcomes by Call Type

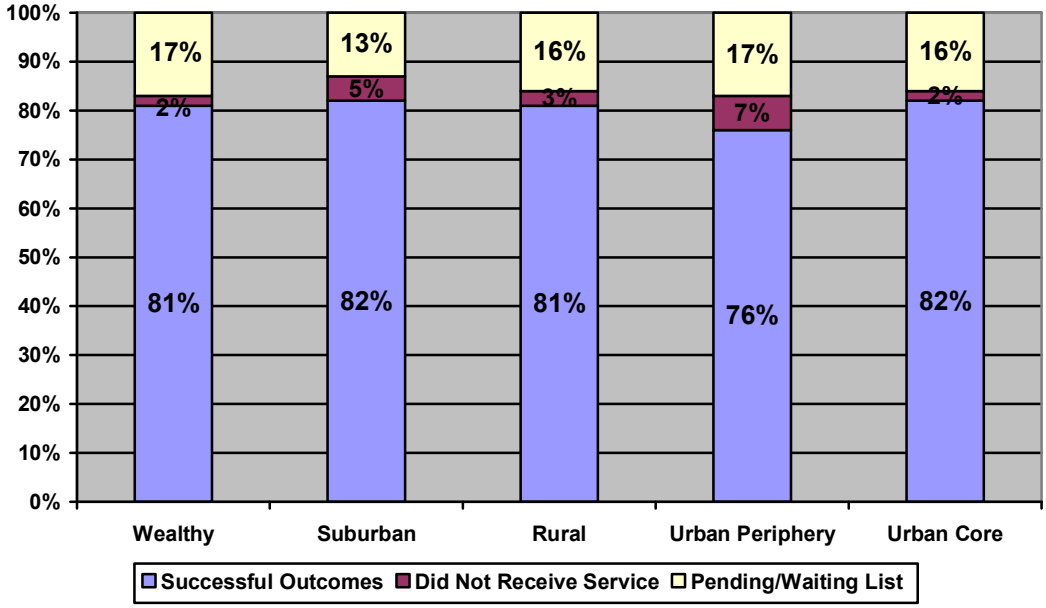


Summary Analysis

- The majority of pending outcomes are for situations where families are seeking an evaluation for their child (29%) or for children with special health care needs (48%), services where parents are typically placed on a waiting list or have an appointment pending.

- **Story behind the baseline**: Comparison of outcomes among the five Connecticut town groups (Figure 14).

Figure14. Comparison of Outcomes between the "Five Connecticuts" July 1, 2007 - June 30, 2008



Summary Analysis

- Rates of successful outcomes are similar across most of the 5 town groups: 81% in Wealthy and Rural CT and 82% in Suburban and Urban Core CT.
- The rate of successful outcomes was lowest in Urban Periphery CT (76%). In addition, situations where families did not receive services are the highest in Urban Periphery at 7% as compared with 2% in Wealthy and Urban Core communities, 3% in Rural communities, and 5% in Suburban communities.
- Rates of pending outcomes are also similar across most of the 5 town groups: 16% in Rural and Urban Core CT, and 17% in Wealthy and Urban Periphery, CT. However, the percentage of pending outcomes was lowest in Suburban, CT (13%).

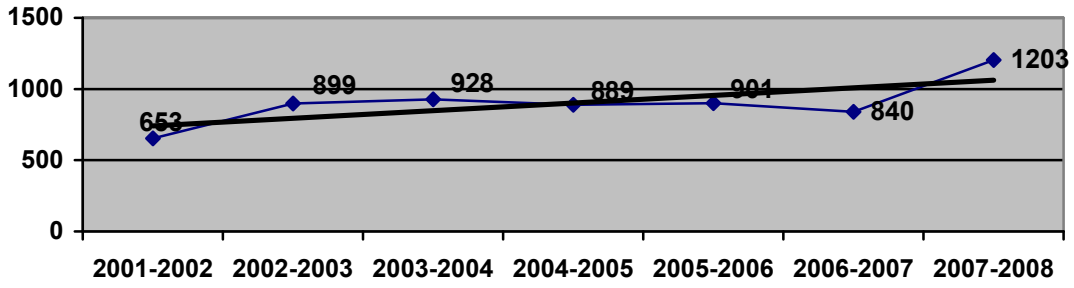
SECTION II. *Help Me Grow's* Ages & Stages Child Monitoring Program

- **Utilization of the Ages & Stages Child Monitoring Program**: A total of 3,129 children were participating in the ASQ program as of the end of the 2007-2008 program year. Table 4 shows the number of participating families at the end of each of the past five years, and Figure 15 shows only the number of families that *entered* the program for each year since the start of the program.

Table 4. Total Number of Children Who Participated in ASQ Program Per Year

2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
2,040	2,349	2,592	2,715	3,129

Figure 15. Active Ages & Stages Monitoring: Number of families entering each year



Summary analysis

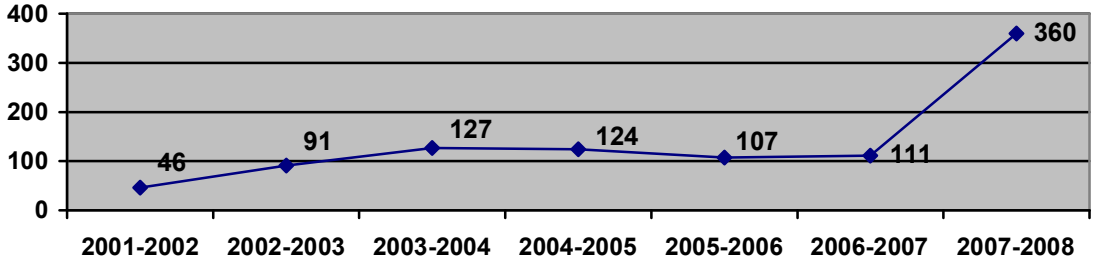
- In past years the number of families entering the Ages and Stages Child Monitoring Program has remained stable at an average of 892 since the 2002-2003 program year. However, there was a dramatic 43% increase in the number of families entering the program in the past year from 840 families in the former year to 1,203 families. This increase is explained by the increase in outreach and training to pediatricians. As already noted, during the past year CDLs provided training in how to use *Help Me Grow* - including highlighting the use of the ASQ monitoring system - for 30 pediatric offices, almost double the number of the former year.
- Approximately 70% of the increase was due to an increase in the number of families entering their child at 4 months of age (see below data and explanation).

- **Universal monitoring of development by parents:** Number of Ages & Stages at the four month developmental screens completed by parents (Figure 16).

Because early detection of developmental and behavioral problems has been shown to improve long term outcomes, community development liaisons have been making a concerted effort to inform and train pediatricians and other health care providers on how to encourage parent use of the ASQ developmental screening. During the past year the *Help Me Grow* program distributed

approximately 1,000 Ages & Stages Child Development Kits for the four month well-child visit to pediatric practices in an effort to promote *universal* monitoring of development by parents that begins at the earliest age possible.

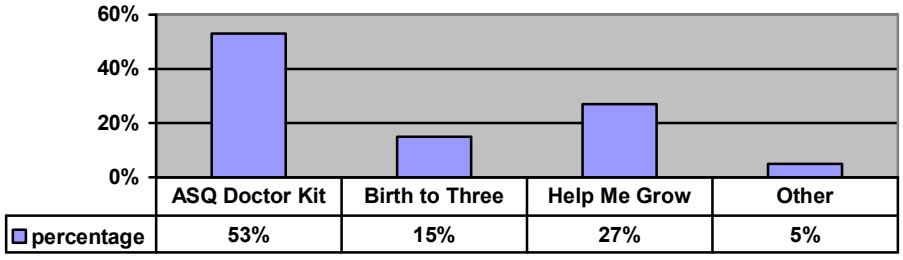
Figure 16. Number of Ages & Stages Four Month Developmental Screens



Summary analysis

- There was a 224% increase in the number of children who entered the ASQ monitoring program at 4 months of age. This is explained by efforts to promote *universal monitoring of development* by parents. Specifically, CDL's distributed approximately 1,000 Ages & Stages Child Development Kits for the *four month* well-child visit to pediatric practices statewide as part of their provider training.
- The 360 four-month ASQs from this year represent 30% of all ASQ families that began in 2007-2008.
- As shown in Figure 18, the majority of families who enrolled their children in Ages & Stages at 4 months were referred by pediatricians (53%). The majority of these referrals to Ages and Stages have come from several new pediatrician practices with one practice in particular, in the Bristol area, referring a large number of families to the monitoring program.Families are also referred to the ASQ monitoring program by care coordinators when they call *Help Me Grow* (27%) and through the Birth to Three program (15%).

Figure 17. Referring source for 4 Month ASQs



SECTION III: Tracking gaps and barriers to services

During the past year, program staff, under guidance from *Help Me Grow's* Continuous Quality Improvement (CQI) team and using feedback from evaluation of *Help Me Grow*, established a systematic process for identifying and tracking gaps and barriers to connecting families to services. These data are now being collected; that is, for each issue (and/or request for service) that is assessed at intake, care coordinators document any barrier or gap in service they identify as they research potential programs or services for individual families. This documentation occurs no matter the final outcome (i.e., whether families are connected to a service or not). For example, care coordinators typically help families who are confronted with gaps or barriers to services (one common barrier is when a family confronts a language and/or cultural barrier at the agency or program where they are seeking services). Often care coordinators are eventually able to connect families to services (as already noted, 80% of service needs were addressed for the 2007-2008 year); however, this is because care coordinators either (1) persistently follow through with an agency; (2) move their efforts to other agencies and programs that provide similar services, or (3) modify their efforts and find the next best possible program.

- **Barriers-** The following barriers to services have been identified by the care coordinators and have been included in the database:
  - Agency has not returned call in a timely manner. Use when family has called an agency but has not gotten a return call.
  - Can't afford service. Use when family can't afford to pay the fee charged for the needed service.
  - Child care issue. Use when a child care issue is preventing access to services, including when family can't find child care for sibling(s) of child in need of services.
  - Does not live in geographic area covered. Use when family does not live in the geographic area served by the agency.
  - Does not meet age criteria. Use when a child is either too old or young for the services offered.
  - Hours of operation. Use when the hours of operation are not compatible to family's schedule.
  - Immigration status. Use when family is not eligible for services due to their immigration status or fear of being reported to NIS.
  - Intake/application process to difficult. Use when family was unable to go through the intake/application because the process is too difficult to understand or follow.
  - Lack of diagnosis or DX. Use when child is not eligible for services due to lack of a diagnoses or diagnosed condition.
  - Lack of medical coverage. Use when child does not have medical coverage (insurance) to cover the cost of the care sought.
  - Language/cultural barrier. Use when family confronts a language and/or cultural barrier at the agency/program where they are seeking services.
  - Long waiting list. Use when family is put on a waiting list of 2 weeks or longer.
  - Confused/overwhelmed client. Use when client is confused or overwhelmed due to being a low functioning adult and/or dealing with household stressors including, but not limited to, physical, mental and/or environmental issues, which limits the ability to understand or follow through on applying for or obtaining services.

- No transportation. Use when family lacks the ability to travel to the agency/program either due to lack of personal and/or public transportation options.
- Over income. Use when family's income is higher than the program's income eligibility criteria.
- Phone automation problems. Use when the family's experience with the agency/program's automated phone system prevents them from accessing services.
- Program/agency too far away. Use when family is geographically too far away from the program/agency to obtain services.
- Resource exhausted (also below income). Use when the agency/program has exhausted resources such as respite care funds, and as a result stop providing the service.
- Other. Use when no other code is appropriate.

- **Gaps-** The following systems-based gaps in services are being tracked by the care coordinators:
  - Before and after school programs
  - Before and after school programs for child with special needs
  - Child care services
  - Child care services for child with special needs
  - In home services
  - Insurance coverage
  - Nursing services
  - Parent education services
  - Respite services
  - Other: when no other code is appropriate

At the end of the program year, data on barriers and gaps in services will be analyzed to determine if there are identifiable patterns for particular service needs. In addition barriers and gaps in services will be analyzed for different geographic locations and for different town groups in Connecticut (i.e., Wealthy, Suburban, Rural, Urban Periphery, and Urban Core) to determine if there are identifiable patterns based on geographic locations or differences in income and rates of poverty. These analyses will be summarized in a briefing report and presented for review by all interested stakeholders.

SECTION IV: Reaching "hard to reach" families

Help Me Grow telephone care coordinators frequently make an initial contact with a family but are unable to sustain the contact either because the family does not have a telephone, require in-home assessment, or presents complex needs. With support from the Kellogg Foundation, *Help Me Grow* conducted a pilot project during the past program year in Hartford, CT (North End neighborhoods) designed to connect hard to reach families to services. The Maternity and Infant Outreach Program (MIOP), a division of the Hartford Health and Human Services Department, contracted with *Help Me Grow* to work in partnership in developing this new outreach model and provided the services. In addition, the majority of hard-to-reach families were identified and recruited through the MIOP program. MIOP provides prenatal and prevention education including nutrition, pre and postnatal care, and immunizations to approximately twenty-five percent of mothers with newborn babies in Hartford. However, the program is designed to provide intensive services related to infant care only. There are often other (older) children who are in need of services in the home. In addition, MIOP families are no longer eligible for services after the child reaches 1 year of age (but often are still in need of services). Care coordination, designed to do comprehensive assessment of all family needs and make referrals for services as identified, was a good fit. As families were transitioned out of MIOP, the case managers (experienced and trained outreach staff) introduced them to care coordinators.

The pilot project was designed to build on the Help Me Grow and Health Outreach for Medical Equality (HOME) models. Care coordination was established through community outreach workers who met with families in their home (instead of providing care coordination by phone). The role of the outreach workers (in this case, care coordinators) was to help families navigate the complex systems of care and resources. Specifically, project care coordinators assessed child (and family) needs, provided parenting and program information and made referrals accordingly, and followed up with families to see if they were connected to services as needed.

Project results

In addition to the narrative below, interested readers can contact Connecticut Children's Trust Fund or University of Hartford, Center for Social Research for a copy of the full report.

Number of families receiving services:

A total of 99 children (51 families) received services from March 24, 2008 through October 16, 2008. The majority of the families (75%) were referred to the program through the Maternity and Infant Outreach Program, i.e., families who received or were receiving MIOP services. An additional 14% were self-referred, i.e., they learned of the program when calling or visiting at the MIOP program or other Health Department services. Eight percent (4 families) were referred through Connecticut's Child Development Infoline, and two of the families (4%) heard about the program through another Kellogg participant. In addition, 2 families who resided outside of the servicing area were referred *to* Child Development Infoline.

Neighborhood and family demographics:

The majority of the families (65%) reside within one neighborhood in the North-end of Hartford (i.e., one zip code). This neighborhood is one of the poorest in the nation with very high

rates of unemployment, poor education, single parenting, and crime. The remaining 35% of the families were spread across four other Hartford neighborhoods.

On average there were 2.2 children (54% of the children were male), and 1.7 adults per household. The average age of the child was 3 years. The race of the children included Hispanic (53%), African-American (41%) and multi-racial (6%). For 76% of the families, the primary language spoken in the home was English, and for 24% of the families it was Spanish. The majority of the children (94%) had health insurance coverage through HUSKY (Healthcare for Uninsured Kids and Youth, sponsored by the State of Connecticut).

Seventy-six percent of the 50 households were headed by a single mother while 88% of the primary caregivers had never been married. For 24% of the families, both parents served as primary caregivers (whether married or not). The majority (66%) of the primary caregivers had either a high school diploma or a GED, 6% had at least some college education, while 27% had less than a high school education. Seventy-six percent of the primary caregivers were not employed, 14% were employed full-time and an additional 10% were employed part-time.

Forty-two percent of the households did not have reliable transportation. Thirty-eight of the families had unstable housing (i.e., temporary living situation), 12% had problems with rats or mice, 10% of the homes were considered to be unsanitary; 4% (2 families) were living in a homeless shelter; and 4% were living in overcrowded homes.

Number and type of contacts for each family:

The average number of contacts for families (N=50) was approximately six, the majority of which were direct contact with the family (as opposed to an agency contact). There was a total of 276 contacts to families that included the following: successful home visit (28%), i.e., parent was home and available as scheduled; unsuccessful home visit (21%), i.e., parent was not home or available for scheduled appointment; successful call to parent (18%), i.e., Care Coordinator spoke with parent; unsuccessful call to parent (22%), i.e., no answer and no communication with parent; agency/community visits with parents (7%), e.g., diaper bank or Gifts of Love; and parent initiated phone call to the Care Coordinator (5%). There was an additional 22 contacts to agencies on behalf of a family, approximately three-fourths of which were phone contacts but there were also several visits to agencies.

Type of services requested by families:

There was a range of presenting issues and service requests; however, for the majority of the cases (84%), families initially requested services to address basic needs. Of those families requesting services for basic need, 15 families either could not find child care (9 families/16 children) or could not afford child care (6 families/11 children); 8 families had "other" financial issues (18 children); 5 families lacked shelter (11 children), 2 families lacked food (3 children), 3 families had insufficient clothing (3 children), and 7 families needed diapers. In addition, 3 families were in need of health insurance (7 children), 1 family was in need of transportation to medical services (3 children), and 1 family was in need of legal assistance. There were also 7 families that needed to test their home for lead (15 children), 4 families in need of housing (7 children), and 2 families that requested employment assistance (4 children).

Fourteen percent of the families (7 families/17 children) needed assistance to address child's educational needs, 3 families (6 children) needed help for their child in relation to a disability (e.g., respite care, information on specific condition), 3 families asked for information on child development (e.g., expressive communication). Other inquiries or presenting issues

included: evaluation request for a suspected language delay, concern regarding child's impulsive behavior, parenting issues for parents recently divorced, need for educational support, counseling, medical specialty service, and socialization/recreation.

Families typically had multiple issues; in some situations these issues were related to the health and well-being of the family as a whole, in other instances, families had more than one child with a particular need. For example, one family needed help with obtaining rent assistance, health insurance, and household furniture. This family also had a child receiving special education and the mother was seeking doctor's assistance for further determination (or clarification) of diagnosis. Another family, with four children under the age of eight, had an infant child just diagnosed with a significant health issue, and a 1st-grade child who was presenting with serious behavioral challenges and had been receiving counseling for depression. This family needed assistance with obtaining daycare and getting transportation to medical appointments. The mother was also connected with the diaper bank for free diapers.

Ages and Stages Questionnaire and Developmental Monitoring:

Many of the families were encouraged to participate in the Ages and Stages (ASQ) Child Monitoring Program through the Child Development Infoline. This program is designed to screen children for developmental delays at regular intervals beginning at four months to five years of age. It monitors child development in five core areas: communication, gross motor, fine motor, problem solving, and personal-social development. The care coordinator assisted the parents in completing the screening.

An Ages and Stages questionnaire was administered for 32 children (26 families); the age of the child ranged from 4 months to 36 months. Development delays were identified for 8 of the 32 children (25%) in the areas of communication, fine motor, problem-solving, and personal/social development. Twelve of the 32 children (8 families) entered into the Ages & Stages Developmental Monitoring Program through the Child Development Infoline, and will continue to receive screens for each development stage (and activity ideas) as long as they continue to complete and mail in the questionnaires.

Number and type of referrals for program services on behalf of families:

For these fifty-one hard-to-reach families, there were 120 referrals for services. Of the 120, 22 referrals were for household needs, 20 were for day care, 20 were for employment or education, and 19 were for housing. There was an additional 12 referrals for lead testing and, as already noted, 8 families were referred to Child Development Infoline for the Ages & Stages program. The remaining referrals were for early intervention (1 family), mental health/counseling services (3 families), medical services (1 family), recreation services (1 family), food needs (1 family) and for services through Department of Social Services (3 families).

Outcomes:

Typically the families received two or more referrals for services or information. The care coordinators were able to document follow up information on 80% of the total 183 service referrals (120) and information requests (63). For the remaining 20%, families could not be reached.

For cases with follow up information, the rate of successful outcomes was high, that is, for 91% of the situations/presenting issues, families and/or children were connected to the

needed service or received the requested information; for 7% of the known outcomes, families did not receive the service, and 2% were pending at the end of the project. In addition, 98% of families were connected to at least one service.

Gaps and Barriers:

Gaps and barriers to services were also documented: 11 families were not able to afford services; 9 families had child care issues; resources were exhausted for 4 of the families; 4 of the families continued to be hard to reach even after initiation of care coordination; 3 families had difficulty connecting to services due to learning issues; and 3 families were placed on a long waiting list. There were instances when agencies did not return a family's call and other instances when families did not follow through. There were also the following situations: family was over income; family lacked medical coverage; there was a language/cultural barrier; and there was no diagnosis for a child. Importantly, for situations where there were gaps or barriers, care coordinators were still able to help families connect to at least one service.

Lessons Learned

Allowance for the time needed to raise awareness among community providers:

It took longer than expected to establish the program and get it "up and running." Informing potential referring agencies on the need and the availability of the services as early as possible is critical. However, it is equally important to allow for the process to unfold. It is a process that should start with top administrators and requires time for the need and service to be fully understood and for a shift in awareness (and service approach) to occur.

Sub-utilization of services:

Child Development Infoline maintains and updates a database on program services and information throughout the State (titled REFER). The project supervisor, who had been doing outreach work in Hartford for many years, expressed surprise about how much she learned about local and public services through the REFER database. Furthermore, all the project staff indicated that there was very little awareness among community agency staff of Child Development Infoline, a valuable service that can be accessed by anyone with a concern about a child. It is not only the hard-to-reach families but also agency staff who are not accessing available services. In the short period of time that the project was established and running, the MIOP case managers (who transitioned families over to the Kellogg project as outlined above) learned a lot about the services and resources of CDI. As reported by the project supervisor and the MIOP director, MIOP case managers came to rely on the project care coordinators for their assistance. The focus of their case management became more comprehensive, moving beyond the needs of just the individual child or infant. By the end of project, they were turning to the care coordinators to ask for help with accessing different services through the REFER base.

Duplication of program efforts:

As noted above, many of the local agencies and workers don't know about CDI services and the REFER database. In addition, there is often more than one program working with a given family, each providing case management, working independently with little to no coordination or communication between agencies or program staff. Consequently, there is a lot of duplication of efforts and inefficiency in connecting families to services. In the words of one of the care coordinators, families "can feel bounced around," and ultimately become discouraged, miss

appointments, become passive or otherwise don't follow through or set priorities, in some instances, become too dependent on the service system (rather than looking for resources independently), or inappropriately take advantage of services or staff.

Difference between Care Coordination and Case Management:

The role and tasks of the project care coordinators were modeled after the role of Help Me Grow/Child Development Infoline care coordinators. That is, when someone calls the Child Development Infoline with a concern about a child, the Care Coordinators conduct an assessment of family needs, research programs as needed, and assist families with connecting to services (e.g., provide them with contact information and/or make the contact on behalf of the family). There was concern that face-to-face contact (as opposed to phone) could easily lead to much more time and involvement, similar to the role of a case manager. However, the care coordinators were well-trained on this issue, recognized the challenge, and were careful to explain their role to families. As one care coordinator described: Case managers develop a long-term relationship with the families and "become someone they confide in." "There is more of an emotional connection, often case managers know their entire life..." Care coordinators are more focused and task oriented, "their relationship is short-term and their tasks are specific."

Outreach and care coordination was needed and effective:

Neither families nor supporting agencies are utilizing (or efficiently accessing) available and needed program services. The pilot project, which provided face-to-face care coordination for hard-to-reach families in the North-end of Hartford, was very productive in the short period that it was implemented: With outreach, high-need families were accessible and responsive, and were connected to needed services in an efficient manner. In addition, the Ages & Stages Questionnaire was easily conducted with families within the role of care coordination and has long term prevention implications.

Summary of findings on reaching "hard to reach" families

There are many difficulties with linking hard to reach families and children to needed services in communities with high poverty rates. However, this pilot project served as a good foundational model. Face-to-face care coordination was more immediate and effective when working with hard-to-reach families. The initial presenting issues were often not the most important, rather through observations in the home, a more comprehensive assessment of needs was possible. Based on what was learned during the short period that the project was implemented (approximately 6 months of services for 51 families, 99 children), the issue is not so much a lack of services, but more one of comprehensive coordination among services. In addition, by providing families with accurate information on programs and very concrete support that addresses specific needs, families are more motivated (empowered) to access services on their own. Moreover, many families, including those with limited education, were available and receptive to learning about their child's development, and in fact, took pleasure in completing the Ages and Stages Questionnaire. Interested readers can contact the Children's Trust Fund for a full report on the project process and outcomes.

SECTION V: Summary and Recommendations

Summary

During the 2007-2008 program year, *Help Me Grow* received 2,522 calls from parents, pediatricians and other providers, and families and friends, who were concerned about a child's behavior, learning, or development. The majority of the callers were parents or guardians; however, for the first time in four years there was an increase in calls from pediatricians (14% increase), likely due to the increase in pediatrician outreach and trainings (i.e., CDLs provided training for 30 pediatric offices, almost double the number of trainings than the previous year).

The majority of calls have been inquiries about specific child development programs, questions related to general development concerns, or families seeking evaluations for their children. Families also call with questions or concerns regarding their children's social or emotional behavior, their child's health, or their child's disability and for special health care needs.

The decrease in the number of overall calls (9% decrease from previous year) and the number of inquiries about child development programs during the past year (from 48% to 29%) can be explained by changes in the Birth to Three program. The Birth to Three program increased its capacity during the past year and consequently eliminated the need for interim services (i.e., previously care coordinators would provide information on child development programs for families waiting for Birth to Three services). However, *Help Me Grow* continues to provide follow up services for families with children who are deemed not eligible for Birth to Three services (as a result of evaluation), and in 2007-2008, 584 of these families received information on child development and/or were referred for program services.

Similar to previous years, the majority of families who contacted *Help Me Grow* reside in the Urban Periphery and Urban Core town groups of Connecticut. Altogether, these towns have the lowest income, the highest poverty rates, and the highest population density. Importantly, the percentage of callers from the Urban Core town group (33%), unlike all the other groups, was disproportionately higher than the percentage of this group's overall population in the State (19%). Perhaps not surprisingly, there is a higher percentage of *prevention* related calls from families who reside in the wealthier communities (where there are the most social and financial resources) and a higher percentage of *intervention* related calls (i.e., more complex needs) from families who reside in the poorer communities.

As the program improves overall in terms of quality assurance (i.e., improvement in assessment and care coordination), the number of presenting issues that are identified (per family) at time of intake has increased over the past two years, and the number of *Help Me Grow* referrals to service programs has also significantly increased (a 26% increase from the previous year). The top five program referrals for Connecticut families for the past four years have consistently been: services related to education needs, mostly preschool special education; the Ages & Stages Child Monitoring Program; Infoline services and information (e.g., Husky health insurance); services related to disabilities; and parent education programs. In addition, there was a dramatic 43% increase in the number of families entering the Ages and Stages program in the past year from 840 families in the former year to 1,203 families. This increase is explained by the increase in outreach and training provided to pediatricians which included the promotion of *universal monitoring of development* at the earliest age possible (i.e., CDLs distributed approximately

1,000 Ages and Stages Development Kits for the 4 month well-child visit). The majority of the referrals to Ages and Stages have come from several new pediatrician practices with one practice in particular, in the Bristol area, referring a large number of families to the monitoring program.

Similar to previous years, the rate of successful outcomes (i.e., families who are successfully connected to a service) is high: 80% of service needs were addressed for the 2007-2008 year. In addition, outcome data on the pilot project showed that in-home, face-to-face care coordination for "hard to reach" families is highly effective (91% of service needs were addressed for families in the pilot project). However, these figures do not illuminate all the efforts of the care coordinators and families who are typically confronted with gaps and barriers to services. For example, in reaching "hard to reach" families, we learned that there is a need for comprehensive coordination among services (i.e., both the sub-utilization and duplication of services were issues at the program level as well as at the family level). It is through persistent follow through and coordination, a great deal of problem solving, and sometimes a modification in expectations (i.e., finding the next best program) that care coordinators are able to eventually link families to needed services. In order to understand the difficulties and problems faced by families, a system for tracking gaps and barriers has been developed and these data (now being collected), will be analyzed and used in the year ahead to inform interested parties on program services and related policy development.

Recommendations

1) Given improved effectiveness of *Help Me Grow* care coordination and relatedly, the steady increase in the number of presenting issues and the number of referrals made on behalf of families, current and future program capacity issues need to be taken into consideration by all the collaborating partners, including the Children's Trust Fund, United Way of Connecticut/211, the Connecticut Department of Birth to Three System, the State Department of Education Preschool Special Education Department, and the Department of Public Health's Children and Youth with Special Health Care needs program.

2) Address sub-utilization and duplication of community-based services (as highlighted in the pilot project) by increasing outreach and informing programs of *Help Me Grow* services. Importantly, consider current and future capacity issues as part of outreach efforts.

3) Continue outreach and efforts to raise awareness on developmental surveillance and on Ages & Stages monitoring program in particular. As much as possible, identify and track where training has occurred, who is utilizing the program, and where training is most needed. Again, current and future program capacity issues need to be taken into consideration as part of efforts and planning for increased utilization of the program.

4) Review data on gaps and barriers on a quarterly basis and use for informing staff and other interested parties on program/policy development and decision making. At the end of the program year, summarize analyses (including analyses for different geographic locations and for different town groups) in a briefing report and present for review by all interested parties.

5) Use Continuous Quality Improvement (CQI) as a forum for more closely monitoring consistency in coding and documentation of family intake information and referral processes, making changes as deemed necessary by program staff and the CQI team.