

Children's Futures' First Five Years

LESSONS AND EARLY OUTCOMES OF
A COMMUNITY CHANGE INITIATIVE



Karen E. Walker

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Public/Private Ventures is a national nonprofit organization that seeks to improve the effectiveness of social policies and programs. P/PV designs, tests and studies initiatives that increase supports, skills and opportunities of residents of low-income communities; works with policymakers to see that the lessons and evidence produced are reflected in policy; and provides training, technical assistance and learning opportunities to practitioners based on documented effective practices.

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Can a focused effort to nurture community change make measurable differences across an entire city? Children's Futures (CF), an early childhood initiative financed by The Robert Wood Johnson Foundation, set out to answer that question when it began operations in late 2002. Based in Trenton, NJ, CF focuses on children up to three years old—and their families—in hopes of improving the youngsters' health and well-being and ensuring their readiness to enter school. The program relies on a range of strategies, many with established track records of effectiveness:

- Home visiting and other programs to improve parenting practices;
- Interventions to improve the quality of subsidized child care in centers and registered family child care homes across the city;
- Activities to increase fathers' involvement in their children's lives;
- Efforts to improve preventive care in pediatric and family practices; and
- Policy efforts to ease access to health and other human services for children and their families.

Children's Futures, Inc.,¹ the organization formed to lead the initiative, monitors these activities and disburses the foundation's funds. CF, Inc., staff work closely with a broad range of agencies that offer direct services or provide technical assistance to other programs to further the initiative's goals.

With an initial five-year, \$20 million grant for CF, The Robert Wood Johnson Foundation hoped to increase access to needed services, make long-term improvements in these services and provide additional resources for Trenton's low-income families. The foundation engaged Public/Private Ventures (P/PV) to evaluate the initiative's implementation and outcomes and to provide ongoing feedback on progress. This paper compiles the results from two longer reports documenting P/PV's findings—it reviews the major strategies selected by the initiative's leaders and implemented in the first four full years of operations, including collaborative

practices that were central to CF; it also examines programmatic improvements and early outcomes for Trenton's families.

The strategies CF chose and the flexibility the program embraced have allowed the initiative to achieve short-term progress rarely seen in community-change initiatives, which often founder because of inter-agency competition, barriers posed by diverse organizational cultures or disagreements over priorities. Also, many initiatives fail to find the right balance between creating new (and therefore untested) strategies tailored to the community and using evidence-based practices—a shortcoming CF aimed to avoid.

The initiative's founders believed that by fostering greater organization of efforts across the community, by identifying and addressing challenges faced by multiple players (such as social service agencies, healthcare providers and families), by spearheading shared problem solving, and by engendering a shared commitment to the provision of high-quality services across Trenton, CF would ultimately lead to changes in families that would have been unattainable for agencies working alone. They also believed that shared and coordinated efforts would enable agencies to identify and pursue policy changes that would facilitate their work.

By the end of 2006, four years after the initiative's launch in 2002, promising signs included greater access to a broader range of family support services for Trenton's families. Many CF activities were implemented well, and the initiative saw concrete improvements in child-care and preventive health services. About 16 percent of the city's pregnant mothers enrolled in home visiting. Collaborations led to better communications among agencies and more extensive and deeper organizational networks. Participants in a variety of programs exhibited positive outcomes. At this stage of the initiative, although not surprising, only one outcome improved at the city level—preterm births for women with medical problems dropped from 2.5 times that of other women to 1.3 times.

Challenges remain, and only quantitative research in the years ahead will show whether CF reaches its ultimate goal—preparing Trenton's children for success in school by giving them a healthy, productive start in life. But, as this report demonstrates, the initiative has made strong progress in its first four years.

The CF Collaboration's Efforts and Agencies

CF brings together dozens of agencies through a range of programs—some with evidence of effectiveness, others untested—designed to improve the health and early development of the city's children.

Home Visiting and Other Parenting Programs

CF, Inc., and the Trenton Division of Health finance and monitor six home-visiting programs: four Healthy Families programs, each run by a different agency; the Nurse-Family Partnership; and home visiting provided to high-risk families by public health nurses. CF, Inc., complemented the home-visiting programs with centers offering additional parent-child development activities, such as emerging literacy and nutrition programs. Together, the programs have the capacity to serve about 425 women a year—about one third of all the Trenton women who give birth annually. At any given time, they serve about 370 mothers and their families. As a group, these activities and programs are designed to help parents make their interactions with their young children more nurturing and developmentally engaging.

Child-Care Improvement

Child Care Connection, the child-care resource and referral agency that serves Trenton, provides training and technical assistance to both family child-care providers and child-care centers. These efforts are designed to improve not only the safety and environment of the centers but also to increase the extent to which staff engage children in emotionally, socially and cognitively stimulating activities.

Father Involvement

The CF initiative established the Fatherhood Collaborative, a group of local service providers. The lead agency, the Union Industrial Home for

Children, provides a range of services to CF fathers, including case management, referrals, mentoring and fatherhood classes. The activities are designed to ensure that fathers have the supportive services—from employment programs to substance abuse treatment to father-child activities—that will enable them to maintain or establish strong relationships with their children.

Preventive Healthcare

The New Jersey Chapter of the American Academy of Pediatrics, using CF and state funds, spearheads efforts to help improve preventive care at 11 of 13 pediatric and family practices serving Trenton's young children. The academy provides on-site training to all staff members in each practice. In addition, physicians from the practices meet quarterly to discuss their challenges in providing care.

Policy Efforts

Staff members from both CF, Inc., and Child Care Connection have worked on a statewide task force to improve child-care quality. CF, Inc., staff has also worked with state legislators to change policies affecting children's health and general welfare.

Behavioral Health Services

Recognizing that many pregnant and new mothers need behavioral health services, CF obtained a commitment from local providers to give needy women priority when possible. Women are screened in prenatal clinics, and referrals are made to a local behavioral health center. The parent-child development centers offer group-based services, such as support groups, and home visitors are encouraged to refer for assessment clients who may need help.

Other Technical Assistance Efforts

CF also has sponsored a range of other trainings and services. Agency staffs, including home visitors, have participated in trainings on the identification and prevention of domestic violence. Small non-profit agencies have received training in leadership and management. These efforts are intended to increase local agencies' capacities to work effectively with Trenton's families.

The Evaluation

P/PV began its evaluation of CF in 2002 to investigate the initiative's implementation and outcomes and to provide ongoing feedback on progress. This summary is based on two reports: *Collaboration and Community Change in the Children's Futures Initiative* and *Early Outcomes for Programs and Families in Children's Futures* (both are available at www.ppv.org). The first investigates the major strategies selected by initiative leaders and implemented in the initiative's first four full years. It also highlights collaborative practices. In particular it asks:

- To what extent does the initiative implement efforts, such as home-visiting programs and child-care-provider training, that have previous evidence of effectiveness?
- What lessons about collaboration can be drawn from the initiative's early years with respect to serving clients, improving practice and changing policy?

The second report examines programmatic improvements and early outcomes for CF families. It is important to note, however, that there were limits on our ability to gauge the initiative's effectiveness related to the following factors: 1) CF's communitywide scope, an approach that produces change slowly; 2) the lack of updated citywide data; and 3) the long-term nature of CF's ultimate goal—preparing children for success in school.² With new grants for the initiative and evaluation covering an additional five years, more definitive results are expected to emerge.

Implementation Progress

As in many complex and ambitious efforts, CF implemented the initiative components with varying degrees of success. The initiative experienced considerable success in screening Trenton's pregnant mothers: About half of all Trenton's pregnant women were screened in 2006 for medical and social risks that predict adverse birth outcomes, child abuse or neglect.

Home-Visiting and Parent-Child-Center Programs

The six home-visiting programs, all implemented by early 2003, have the capacity to serve about 425 women and by 2005 were serving about 370 women at any given time—or about 87 percent of their maximum capacity. The difference between the capacity of the programs and the actual numbers of women served are due to several factors. First, if many women in a Healthy Families program are particularly needy, the program's formal capacity may be less than the 60 expected; women with extra need for the services may “count” toward more than one case because they take more of a home visitor's time. This was relatively common during the first several years of the programs, when they had many new clients. As clients went through the program process, they required fewer visits, thus increasing the programs' actual capacity. Second, turnover among staff sometimes led to periodic drops in caseloads both because clients sometimes did not successfully forge relationships with their new home visitors and because sites could not accommodate full caseloads when they were short-staffed. And third, programs had varying levels of success in attracting and retaining clients.

Past evaluations have shown that the Nurse-Family Partnership and Healthy Families produce positive results, particularly in child health and child abuse prevention (See Olds et al. 2007 for a recent review of home-visiting programs).

The Nurse-Family Partnership is very stringent in its implementation requirements,³ and the nursing staff in the Trenton Department of Health followed the guidelines carefully. Healthy Families provides more flexible guidelines; CF met the minimum standards for staff, training and curriculum use and provided an additional supervisor for the staff in each of the four programs. Initiative leaders also tended to go beyond the minimum with training, particularly in the areas of domestic violence, substance use during pregnancy and parenting.

In general, CF implemented the home-visiting programs well, with home visitors providing accurate information about pregnancy, parenting, child nutrition and child development along with concrete support, such as helping pregnant women get to doctor's appointments and enroll in social

service programs. About 75 percent of scheduled home visits were completed, and women remained in the programs for about 15 months. The figures do not meet the benchmarks of the national programs (90 percent or more of home visits completed with retention rates of two and three years), but they compare favorably to the programs in other cities.

Center-based programs, designed to provide group programs to mothers with needs that the home visits did not meet, fared less well. The programs served both women in the home-visiting programs and women who were not eligible for home visiting because their children were too old (home-visiting clients needed to be assessed by the third week after birth). Group programs included social groups, considered especially important for the large numbers of mothers who spoke only Spanish and often had few social ties. The four parent-child centers also implemented a variety of support groups, music/emerging-literacy programs and nutritional programs, but attendance levels were low and the initiative's leadership was unhappy with the frequency of programming. In part, these challenges resulted from the staffing configurations at the centers, which privileged home visiting. Staff consisted of two supervisors (a nurse and a social worker) and four home visitors.

Child-Care-Improvement Programs

The local child-care resource and referral service, with many years' experience in training providers, offered training to teachers and center administrators in the renowned High/Scope Infant-Toddler curriculum. With the resources allocated to it by the initiative, it worked with 7 centers out of the 14 that served infants and toddlers in Trenton. The agency first identified the centers that had the highest number of infants and toddlers in care and approached them. Of the centers that were approached, only one major center decided that it did not want to participate in the effort. The participating centers were then assessed using the nationally accepted Infant-Toddler Environmental Rating Scale (ITERS), and CF staff worked with center teachers and administrators to improve both practices and environments.

The improvement programs for child-care centers began in Spring 2003 with training in the High/Scope Infant-Toddler Curriculum for staff in the seven centers. Based on scores from the ITERS, CF provided individualized technical assistance for each center, designed to improve the classroom environments in areas such as health and safety practices and learning and play activities. The initiative also worked to improve center staffs' interactions with both children and parents. Five centers complied with the basic requirements necessary to continue with the training; the other two centers, suffering from serious management and fiscal problems, eventually shut down.

CF found efforts to improve family child care more challenging. The first attempt, which began in mid-2003, faltered when the three child-care centers charged with operating the program could not overcome serious challenges to recruiting and training family child-care providers. In 2005, the local child-care resource and referral agency took over operations and made significant strides in recruiting family child-care providers and ensuring that they received training and technical assistance. By the end of the year, the staff had recruited about 20 providers and had instituted assessments, individualized quality-improvement plans and ongoing home-based technical assistance and training opportunities. They focused their efforts on providers who cared for children involved in the Department of Youth and Family Services (which handles child abuse and neglect cases), reasoning that improving care for the most disadvantaged children might have a large impact in their lives.

Efforts for Fathers

CF created a collaborative designed to address the fathers' multiple needs, hoping that stabilizing the men's lives would allow them to forge better connections with their children. Across Trenton, 29 agencies joined the collaborative. The lead agency, which provided case management, mentoring and referrals, ran father-involvement classes using *Fatherhood: A Curriculum for Young Fathers* and worked with the local Head Start program to offer father-child activities. In addition, the agency also provided training in delivering the curriculum to other agencies.

The fatherhood component was the least successful of CF's programs. Although the lead agency met or exceeded its recruitment goals of 100 fathers per year, referrals to other agencies often resulted in little or no action. Fathers often missed their referral appointments, and, even when they did go, the vast majority of men discovered that they had a low priority with agencies that provided housing, behavioral health or substance abuse treatment, all services in short supply in Trenton.

CF also met challenges in trying to target the fathers who were linked to mothers and babies involved in home visiting and the parent-child centers, an original goal in efforts to strengthen the families' capacities to nurture their children. Staff at parent-child centers reported that the fathers often considered parenting women's work.

Keys to Successful Implementation

The major factors in the success of CF programs were the organizations' reliance on evidence-based practice and the fit between desired outcomes and program strategies. The creation of a network of local resources also proved to have important benefits.

The Use of Evidence-Based Practices

The Robert Wood Johnson Foundation designed CF with the assumption that there were evidence-based practices for each of the core components and that the initiative could draw on and replicate these practices in Trenton. But as CF, Inc., discovered within the first year, evidence of effectiveness was weak—or even lacking—for some of CF's programmatic goals, forcing CF partners to create their own programs in some cases.

Implementing Previously Proven Programs with Fidelity

Efforts to implement effective models were fairly strong when evidence-based models were available. Overall, staff tended to follow implementation guidelines, though in a few notable instances they supplemented programs with additional resources. In several core areas of the initiative—home visiting, boosting the quality of child-care centers and improving preventive care through community-based education for medical practices—the use of evidence-based

models proceeded successfully. In each of these cases, the staffs met minimum standards associated with program models, used preexisting assessments to identify their clients' needs and then made follow-up assessments after their interventions.

Modifying Effective Programs

The initiative faltered in several cases when making major modifications to successful models. These challenges illuminate both the dangers inherent in using untested models and the motivation to do so.

CF deviated from the Healthy Families model by placing each of the four programs in a parent-child development center because they sought to reach a broader group of parents who were not eligible for home-visiting. Staff members struggled to provide center-based activities alongside their home-visiting responsibilities. Although the initiative added an extra supervisor to the Healthy Families staffing configuration of one supervisor to four home visitors, the home visitors—whose numbers were not increased—were often needed to help with center-based activities. They provided child care for parents when activities were parent only (as some of the support and nutrition groups were). They also conducted some activities in Spanish, since not all sites had Spanish-speaking supervisors. As we noted above, the home-visiting programs were implemented well, but the center-based activities were not as rich in variety or as heavily attended as the initiative leaders had hoped they would be.

In trying to improve preventive healthcare, the initiative also made a major modification to Best Clinical and Administrative Practices (BCAP), a national initiative sponsored by The Robert Wood Johnson Foundation. The results were disappointing. BCAP helps managed-care companies that serve low-income populations identify ways to improve clinical care and administration. By improving the treatment of diseases such as asthma and gestational diabetes, the BCAP model assumes that companies achieve cost savings through reduced hospitalizations or neonatal intensive-care-unit admissions. Instead of working with large managed-care companies, CF targeted local medical providers, including two hospitals and a federally qualified health clinic. The initiative eventually abandoned the tactic because the local providers could not achieve the

economies of scale needed⁴ to save money, undermining any motivation to participate. As a result, CF, Inc., and the Center for Health Care Strategies, which replicates BCAP across the country, decided to refocus on the five managed-care plans serving all of New Jersey. This effort was just getting under way as data collection for the first four years of the initiative's evaluation ended.

Implementing Untested Strategies

In some instances evidence-based models did not exist for critical goals, and the initiative implemented untested strategies. These situations presented the largest challenges, particularly with efforts to increase the involvement of noncustodial fathers, but also with efforts to improve the quality of family child-care homes.

CF, Inc., designed the fatherhood component to help men stabilize their lives by overcoming barriers such as substance abuse, homelessness and unemployment, but with services in short supply, few men received the help they needed. In addition, the fatherhood efforts took place independently of the work with mothers, contrary to CF's original goal. This was problematic because noncustodial fathers' involvement with their children depends upon negotiations with the children's mothers.

Also without evidence-based models, CF floundered with its first efforts to improve family child care. Initially, the local child-care resource and referral service, Child Care Connection, subcontracted with child-care centers to offer technical assistance to providers, hoping to create networks. But staff members at the centers had little experience with child-care homes and little time to provide training. In addition, many of the providers who enrolled in the program had a tenuous commitment to both family child care and the assistance program.

Alignment Between Desired Outcomes and Strategies

Despite efforts to ensure alignment between desired outcomes and program strategies—by requiring agency grantees to rely on the published literature in their proposals and by asking P/PV to review the evidence for various strategies—several CF outcomes were not addressed by the initiative's strategies. One notable disjuncture was the absence of a

strategy to identify and bring into prenatal care those women who were likely to enter care late or not at all. Others included overly ambitious goals in the early years of the father-involvement efforts, which included goals such as reducing crime and violence.

Expanding Networks and Using Local Resources

An important side benefit of the initiative came from the network of agencies CF created, which enabled agencies to better use local resources to support families. In the beginning, CF experienced many of the tensions that accompany complex, collaborative arrangements. Keeping agencies abreast of each other's work was an ongoing effort, and when agencies did not understand each others' roles, resentment and confusion occasionally arose. The CF staff quickly took to heart lessons from previous community initiatives that emphasize the importance of support and buy-in, the need for strong leadership and the need for flexibility. The initiative has also contributed new lessons to the community-change field.

Numerous Benefits

To keep the lines of communication open, CF, Inc., convenes regular monthly meetings that bring together directors of the parent-child centers and other CF projects. Executives of the lead agencies meet as a group with CF, Inc., staff. Family-support and family-assessment workers participate in trainings together. In addition, CF, Inc., hosts a monthly "key communicators" meeting for faith and social-service leaders and others to share information about services and inform the community about CF's work. These venues for people to meet have expanded the providers' networks.

Home visitors say their new knowledge of community resources has helped them better serve their clients. Home visitors also report that their clients sometimes receive preferential treatment because of their association with CF. Directors of parent-child development centers report that knowing others who face similar responsibilities and challenges has been an important support.

In addition, frequent communication and meetings among partners has also increased interagency training. CF has provided training by national experts and local agencies in child health, domestic

abuse and child development. Agency staffs increasingly report that they rely heavily on staff from partnering agencies to provide other trainings. Several agencies in Trenton have extensive training programs that predate CF, and the initiative has helped social service workers learn about these opportunities.

Creative Thinking

Partnerships among local agencies have not always been smooth in CF, but they have proved fruitful, particularly in providing behavioral health services to pregnant women and new mothers. The minority populations that CF serves are often either wary of behavioral health services or, by virtue of their immigrant status, normally ineligible. To overcome these challenges, a local behavioral health agency worked with the parent-child development centers to provide center-based activities more acceptable to the women.

Synergy and Clout

The participation of a variety of agencies and providers has helped the initiative develop a strong presence in the community. The initiative has weight in statewide policy discussions, which has given the staff a voice in policy development and Trenton a reputation as a good locale for piloting early childhood health and development efforts.

Early Outcomes for Families and Agencies

Although staff from local agencies agreed that the initiative had improved the quality of some services, quantitative evidence of success with families was sparse at the end of CF's first phase, which was not surprising given the initiative's relative youth. On the positive side, several health outcomes showed improvement and child-care quality and lead screening showed significant gains.

Progress at the community level also was promising: The collaborations formed under CF hold the potential to improve services throughout the city, and public policy efforts by staff at CF, Inc., and other agencies around the state resulted in a new law providing healthcare coverage to all low-income state residents.

Birth Outcomes

In general, birth outcomes for the babies of home-visiting participants were modestly positive compared with citywide numbers, but because the initiative recruited women with high-risk profiles and the results depend, to some extent, on the women's tenure in the programs, interpreting the outcomes presented difficulties. By the end of 2006, two home-visiting programs reported that 10.2 percent and 9.2 percent of their mothers, respectively, had low-birth-weight babies, compared with 13.8 percent for the city in 2004 (the most recent statistics available as of this report).

However, at the city level, outcomes such as the number of women receiving care for the first time late in their pregnancy and the proportion of women with no prenatal care and preterm births all increased in Trenton between 2002 and 2004. Our data could not explain these findings; in the case of preterm births, Trenton's increases reflect a poorly understood national trend.

A cross-city comparison indicted that Trenton's birth outcomes also were getting worse compared with the outcomes in Camden and Newark, our comparison cities. However, that finding was primarily driven by improvements in Camden, which had also initiated efforts to improve birth outcomes.

We did, however, find consistent evidence that home visiting might be benefiting one group of women: Home visitors ensured that pregnant women with medical risks kept their prenatal medical appointments. In 2002, before CF, women with medical risks had an average of one fewer prenatal-care visit than those without risks. By 2004, the difference had almost disappeared. We also found that the odds of women with medical risks having a preterm baby were 2.5 times higher than those without risks in Trenton in 2002, but only 1.3 times higher in 2004. The comparison cities showed no changes.

Preventive Healthcare for Children

Efforts to improve preventive healthcare also showed promise. Before the initiative, only about half of the city's children were current in their immunizations. By the end of 2006, records indicated that 85 percent of the children involved in one home-visiting model were up to date and

children in the other had received 68 percent to 100 percent of their immunizations on time. In addition, 90 percent of the children had a regular healthcare provider.

CF also achieved modest success in improving preventive healthcare efforts by physicians. New Jersey has a mandatory state immunization registry, implemented in 2002 but used irregularly. Because insurance regulations often force poor families to change providers, CF's leaders considered the registry critical because it allowed physicians across the city to quickly check a child's immunization records. At CF's urging, 9 of the 11 medical practices serving Trenton's children now use the registry (inadequate computer systems hampered efforts by the other two).

A second effort focused on lead screenings. Trenton has high rates of lead poisoning among children compared with other New Jersey cities, and early identification can help prevent long-term developmental problems. Again at the urging of CF, all 11 practices now employ practices to ensure timely testing.

Child Health Outcomes

No changes occurred in the number of hospitalizations stemming from poor healthcare or preventable emergency-room visits. No changes were expected at this time, primarily because training programs for providers in child abuse prevention and asthma management were implemented fully in 2006, a year later than the city-level data available.

The Quality of Child Care

Follow-up assessments in the child-care centers and family child-care homes indicated large improvements in health and safety practices, environmental conditions and interactions among children and providers. When the initiative began, 10 of 21 classrooms in 7 child-care centers did not meet minimal standards of care, while the rest merely met the standards. The family child-care providers showed slightly stronger initial ratings, but they, too, only met minimal standards of care.

By the end of 2006, the five centers that remained open improved in all areas of quality care, including hygiene, age-appropriate techniques for play

and discipline, increased interaction and communication with children, and improved staff teamwork. Three centers achieved a score of "good" (five to six points on a seven-point scale) on the Infant Toddler Environmental Rating Scale, and a fourth was close. The fifth center only met minimal standards, but it had the lowest initial score in 2003 and had made gains equal to the other centers.

Programs still struggled with the learning components, but even there they improved significantly. In addition, higher proportions of center-based caregivers also reported receiving training in such critical areas as emerging literacy, communicating with parents, child abuse identification and reporting, violence prevention and conflict management. In only one area, child observation and assessment, did staff training fall significantly over time.

The quality of family child care also showed gains. Sixteen of 17 providers had both baseline and follow-up assessments completed by the end of 2006. Using the Family Child Care Environment Rating Scale (like the ITERS, it is a seven-point scale), 14 of 16 increased their scores, with 11 improving by at least a point. Most also posted score increases along all subscales. The two providers showing decreases recorded minor drops of 0.3. Overall program scores put three providers in the *very good/excellent* range, eight providers in the *good/very good* range and seven providers in the *minimal/good* range. Because the effort was reconfigured in June 2005, the follow-up assessments covered only one year. The range was similar to the improvements seen in the child-care centers during their first year, offering reason to believe that improvements will continue, albeit at a slower pace.

Public Policy Changes

Another success for CF has been its contribution to changing public policy. CF, Inc., staff worked with employees of other nonprofit organizations, state assembly members and others to provide coverage for low-income adults under the state health insurance program for the first time in a decade. On a recommendation by CF, Inc., the law, passed in mid-2005, also allows children to remain eligible for health insurance without reenrolling every six months. The previous insurance laws had created confusion and often left children without care.

Lessons Learned

CF offers many lessons for decision-makers involved in community-wide efforts to improve outcomes for very young children and their families. We highlight three of the most important: aligning strategies and outcomes; selecting participants; and using systematic—and systemwide—data collection.

Aligning Strategies and Outcomes Is an Ongoing Effort in a Complex Initiative

At the end of the first phase, staff at CF, Inc., the Trenton Division of Health and the Foundation agreed to more closely align CF efforts and desired outcomes. As CF moves into its second phase, initiative leaders are working to identify ways to improve the fit.

Mounting Outreach Efforts to Bring Women into Early Prenatal Care

CF lacked an explicit strategy for one important goal—increasing the proportion of women receiving prenatal care in their first trimester. Prenatal clinics recruited women, but few women came to the clinics through the parent-child centers, contrary to expectations.

Although they were less likely than their healthy counterparts to enter prenatal care early, women with medical problems who did seek early care were more likely to show improved birth outcomes over the course of the initiative, possibly because CF focused on getting women with health risks regular medical help. A focused effort to reach out to all pregnant women who might not enter prenatal care in their first trimester—or even at all—would prove useful.

Expanding Efforts to Prevent and Manage Child Asthma

Improving children's health under CF includes a range of specific outcomes: full and timely immunizations, lower rates of child abuse and neglect, fewer asthma cases and better control of asthma attacks, and higher lead-screening rates. At the initiative's beginning, home-visiting programs and the efforts to improve the quality of pediatric medical care both targeted immunizations and child abuse and neglect. Asthma, in contrast, was addressed only by working with physicians to improve management of the condition, and that

effort began relatively late in the initiative. Other services that help families better manage their children's asthma are lacking.

CF plans to address this problem with an approach based on research showing that breast-feeding for several months may prevent asthma by strengthening a child's immune system. Sustained efforts to improve both breast-feeding rates and the length of time women breast-feed did not exist in the initiative's first five years.

Selecting Participants Carefully

Community initiatives must be sensitive to serving the entire community while spending their resources most effectively. The first imperative suggests that programs should be universal, while the second suggests that efforts should target those most in need. CF struggled with these competing impulses throughout its first five years. The two home-visiting models served women and children at moderate risk of adverse outcomes, but the highest-risk women—especially those with older children—were sometimes ineligible.

Many factors contribute to the birth, health and developmental outcomes of interest to the initiative. Babies and children with adverse outcomes often have several contributing factors in their lives, and these can often vary considerably across a population. In deciding whom to target, programs should ask a series of related questions: "What is the issue we would like to address, and what changes would we like to see? Among our population, who is most likely to have the adverse outcomes that we want to change? If we target particular groups, what is the maximum number of people we could potentially affect? To what extent do our resources limit that number?" Answers to these questions will improve the fit between strategies and goals.

Moving Forward with Systematic—and Systemwide—Data Collection

Systematic data collection is crucial for self-assessment, interagency collaboration, quality improvement and successful evaluation in community initiatives. One of the persistent challenges facing the initiative was the lack of systematic data collection across the agencies—a common problem for community initiatives.

Despite agreements that CF established, agencies resisted sharing information about clients. As is often the case with funders, the Foundation was reluctant to impose its will on agencies and did not initially require a specific data-collection system. CF, Inc., did not require agencies to provide specific information on program use and client outcomes. As a result, the agencies' semiannual reports varied considerably; some agencies provided largely anecdotal evidence, others specific numbers. The lack of shared data created misunderstandings about the work being done and the challenges in accomplishing goals.

As the initiative progressed, The Robert Wood Johnson Foundation increasingly requested information from CF, Inc., about outcomes, and the CF agencies struggled to comply. For example, even though the home-visiting programs had sophisticated data systems set up by the national program offices, reporting only local information proved difficult. In addition, the smaller agencies providing direct services had little capacity to handle and analyze large amounts of data. Agency personnel knew much about specific clients but little about their clients overall. The demands and the problems of complying with data requests caused strains among agencies.

Given the increasing pressures placed upon the initiative for outcomes information, CF, Inc., decided to put a community-wide data system in place for the initiative's second phase.

Conclusion

Children's Futures showed substantial strength in its early years. Where possible, it successfully implemented evidence-based practices. When it modified one model without success, the initiative quickly changed course. When it needed to rely on the creativity of local agencies to develop untested programs, it did so—and made adjustments when new strategies proved too challenging to implement. Agencies worked collaboratively, in itself a major accomplishment in a small city where interagency competition had previously been common.

Despite the strengths in implementing CF, outcomes for Trenton's families show little—and in some cases even negative—changes. The proportion of preterm births rose slightly, as did the number of

women not receiving prenatal care. In addition, the proportion of women seeking care in the first trimester dropped slightly. However, citywide numbers at this stage mean little. Given New Jersey's calendar for releasing vital statistics data, outcomes data for the city overall are still sparse and cover only the initiative's first two years, providing no cushion for the random fluctuations usually seen. By the end of the second phase of the initiative, the data will be more compelling.

As it enters the second phase, CF will face new challenges posed by an increase in gang violence in Trenton and the major hospital's likely relocation to a nearby town. To make long-lasting change, the initiative also needs to involve the residents to act as emissaries for the initiative to hard-to-reach residents. Encouragingly, local agencies have already shown flexibility in addressing ongoing—and new-found—challenges, suggesting that the initiative is well prepared to meet these challenges.

CF already has made a difference in some children's lives. The data collection that will accompany the second half of the initiative will show whether it has reached its ultimate goal—preparing Trenton's children for success in school by giving them a healthy, productive start in life.

Endnotes

- 1 We use the term "CF" to refer to the initiative overall and CF, Inc., to refer to the organization that disburses the funds from The Robert Wood Johnson Foundation. In terms of staff, the two are not synonymous. Some of those who have helped plan and implement the initiative are employed by local Trenton agencies, not CF, Inc.
- 2 For a full discussion of the evaluation methods used, see *Early Outcomes for Programs and Families in Children's Futures* at www.ppv.org.
- 3 Public/Private Ventures is in charge of replicating the Nurse-Family Partnership in several states, including New Jersey.
- 4 It is unlikely that working with direct healthcare providers, such as hospitals, could ever achieve the economies of scale that the initiative achieves by working with managed care companies.



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