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United Way of Salt Lake Priority Area and Capacity Assessment

Best Practices and Strategies to Influence Change in Priority Area Objectives

A Review of the Literature

Research Conducted for United Way of Salt Lake by Utah Foundation

Utah FOUNDATION

Steve Kroes, President
Laura Summers, Research Analyst

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About this Report

United Way of Salt Lake (UWSL) has contracted with Utah Foundation, a non-profit research organization, to conduct a "priority area and capacity assessment" with and on behalf of UWSL. The purpose of the assessment is to help UWSL transition to a community impact United Way—one which focuses on and aligns all of its resources with a more limited number of objectives in order to have systemic and long-term impact on the underlying causes of problems. UWSL has asked Utah Foundation to collect data, including community feedback, in the areas of income, education, health, safety-net services, and immigrant/refugee integration.

After months of research, data analyses, surveys, focus groups, and both external and internal capacity assessments, UWSL has narrowed its 2011 priority framework to three overarching goals in the areas of income, education, and health.[1] These goals are:

1. Help people gain the income and financial tools to help them thrive.
2. Build a strong foundation of early learning from birth to age eight.
3. Improve child health and promote healthy behaviors.

In meeting the income goal, UWSL will focus on two objectives, workforce development and financial literacy/savings. In meeting the education goal, UWSL will focus on improving the early learning and student achievement of young children. In terms of meeting the health goal, UWSL will focus on influencing healthy behaviors and increasing children's health coverage and access to health care. These objectives are all leverage points that can improve outcomes in other areas and create change in the broader society.

The purpose of this report is to describe the best practices, strategies, and models relating to these six areas. Local, state, and national examples of successful programs and initiatives are also described. This report provides UWSL with a depth of information on promising practices, strategies, and components that can be used in a program or part of a larger initiative. It is important to note, however, that while these programs have proven to be successful in influencing change, any program or initiative UWSL decides to develop will need to be modified to fit UWSL's capacity and Utah's demographic, cultural, and socioeconomic needs.

If you have questions, or would like to talk with someone from UWSL about this report or the priority area and capacity assessment, please feel free to contact Bill Crim, Vice President of Community Impact and Public Policy at 801-736-7771 or bill@uw.org.

Immigrant/Refugee Integration

Although UWSL's work is primarily centered on income, education, health, and safety-net services, there is an additional focus on immigrant/refugee integration that extends across these four issues. Integration is a process of mutual adjustment by both newcomers and the receiving society to build secure, diverse, vibrant, and cohesive communities. It requires an active commitment as well as accommodations and adjustments be made by both sides.[2] The ability of

immigrants/refugees to contribute to Utah depends not only on the personal characteristics, knowledge, skills, experiences, and traditions immigrants/refugees bring with them, but also on the social and economic conditions they encounter upon arrival.[3]

Many newcomers require assistance in adapting to new and changing environments. While some are able to integrate into their new community quickly, others need support to ensure they can succeed in school, secure and maintain jobs, live in stable and healthy families, and are civically and politically engaged. Providing immigrants/refugees with essential settlement and integration services not only improves the quality of their individual lives, but provides them with the necessary tools to contribute significantly to Utah socially, culturally, and economically.[4]

States, like Utah, with growing immigrant/refugee populations can facilitate successful integration and acquire significant benefits by helping immigrants/refugees build a strong foundation of early learning, gain income and financial tools, and live a healthy life. However, in order to be effective, the strategies used to provide services to immigrants/refugees that promote these building blocks must be modified and targeted to their specific socioeconomic and cultural needs. The best practices, strategies, and models outlined in this report are either broad enough to include immigrants/refugees as part of the service population or can be modified to address the exact needs of these groups. Some examples of programs that target the specific needs of immigrants/refugees are also outlined.

When developing programs and initiatives targeted to immigrants/refugees, three key pieces of information will help guide decision making and program implementation.[5] First, it is necessary to know basic information about the immigrant/refugee population, like household income, size, age break-downs, percent of limited English proficient households, years of education, and employment status. Second, it is necessary to know their neighborhood and community characteristics, such as percent of homeowners and renters, school quality, crime statistics/rates, viability of neighborhood retailing, public transit issues, and whether the neighborhood quality of life is vibrant, stable, declining, or in transition. Third, and most important, it is necessary to understand their culture and their history. Having this information will help the program deliver culturally competent services, which will in turn produce more effective results.

References

[1] UWSL will still invest in and provide grants for objectives in the safety-net (redefined as "basic needs") and immigrant/refugee integration areas. Because safety net objectives have not been narrowed to a specific goal, other than meeting Utahns' health, safety, food, and housing/shelter needs, best practices for providing safety-net services are not discussed in this report. The issue of immigrant/refugee integration is described above.

[2] "Immigrant Integration in Canada: Policy Objectives, Program Delivery and Challenges" Discussion Draft (Canada: Integration Branch, Citizenship and Immigration Canada, 2001).

[3] Ibid.

[4] Erin Andrew et al., "Rising to the Immigrant Integration Challenge: What States are Doing—And Can Do," National Governors Association Center for Best Practices, Issue Brief (4 November 2009).

[5] Michael Chan, "Strategies to Enter the Financial Mainstream: Immigrants & the Unbanked," (presented to the Northeast Community Federal Credit Union, San Francisco, CA, 27 October 2007).

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Workforce Development: How can one best help a population improve their employment and income situations?

Strategies

Workforce development programs prepare workers for employment or further postsecondary education. Traditional programs target the clients' individual skill development in areas of basic education as well as soft and hard skills. However, many programs and initiatives now include additional components as well, such as incentives, support services, and social marketing. The following is a list of components that can be used in a program or part of a larger initiative. Items one through ten are components that can enhance workforce development programs. Items 11 through 14 are strategies that can be used as part of a workforce development initiative.

1. **Workforce readiness certifications:** Certifications range in purpose and can be awarded to workers who complete a soft skills training program or who demonstrate a basic competency level through testing. They are also awarded to participants who complete an industry-sponsored training program or program at an applied technology center. They are intended to help workers find employment by providing them with proof of a competency-based skill. They also help employers hire workers with the appropriate skill sets. Certifications can either be offered directly through a workforce development program, or a program can provide funding for workers to seek certifications offered by other training programs and centers. For example, in the past Deseret Industries has provided its employees with up to $3,000 to enroll in certification programs.
2. **Apprenticeships:** Apprenticeships are on-the-job training completed with the guidance of an employer in a skilled trade. It involves the combination of work and education and is offered in a variety of fields from construction and manufacturing to health care and cosmetology. There are three main benefits associated with apprenticeship programs. First, they provide employers with a competent, skilled workforce that is ready to work. Second, they provide workers with an applied, marketable skill set. Third, apprenticeship program participants earn money while receiving their education, which reduces the opportunity cost of foregone income often associated with participating in an education or training program.

   The Utah Building Trades Union operates apprenticeship programs in conjunction with the U.S. Department of Labor. Each apprenticeship program has different requirements by craft and is funded through trust funds administered by a Joint Apprenticeship and Training Committee (JATC). The programs are sponsored by the union and/or signatory contractors. Programs offering college credit for completion may require tuition, fees, and books. Apprentices must be 18 years of age and are selected based on past education and work history. In terms of requisite education, apprentices must demonstrate sufficient educational knowledge to complete on-the-job and related technical instruction. Some programs require a high school diploma or GED, but this is not necessary for all apprenticeship programs. Apprentices must also posses a valid driver's license, pass a drug test, and be physically able to perform functions of the occupation.

The purpose of the union apprenticeship programs is to develop a qualified, versatile, and safe work force. A skilled work force creates profit for the worker and the contractor. Owners of projects expect contractors to produce a quality project at a competitive price. Contractors must have skilled, safe workers in order to be competitive. Apprenticeships provide workers with a combination of on-the-job experience and related training to help them become valued workers. On-the-job apprentices work with Journey workers who mentor and instruct them on the various skills of the craft.

Apprenticeship programs require 4,000 to 9,000 hours of on-the-job experience and a minimum of 320 to 920 hours of related classroom training. Depending on program requirements as well as the availability of work and local training schedules, it can take an individual from two to five years to complete an apprenticeship program. During the apprenticeship the individual has salary, pension, and health insurance. Wages begin between 60% and 80% of the Journeyperson scale and increase as elements of the apprenticeship program are completed.

The electrician apprenticeship program is one example of the many apprenticeship programs available. Apprentice electricians work 37 to 40 hours per week under the supervision of a journeyman electrician. For their work they receive both pay and benefits. Apprentices spend an additional six hours per week in classroom training. At the end of the training, apprentices become journeymen or certified electricians. They are considered to be highly skilled by employers and are able to command high pay and benefits. The training is offered at no charge, except for the cost of books (which is approximately $200 per year).[1]

The downside to apprenticeship programs is that they are limited in their capacity. Apprenticeships programs require long-term time and financial commitments from industry employers, unions, and associations. Because of this commitment, not all industries offer apprenticeships. The individualized supervision also limits the number of workers who are accepted as apprentices. The ratio of apprentices to supervisors ranges from 1:1 to 1:5, depending on the industry.

3. **Basic adult education and English as a second language (ESL):** These classes are designed to increase workers' skill levels and prepare them for employment or postsecondary education. Programs focusing on these components typically offer adult literacy tutoring and training as well as preparing for and taking the GED. ESL training is designed to help non-English speakers improve their competency in English. In terms of workforce development, ESL training is most effective when provided in the context of job skills training; this allows workers to learn job-specific skills while simultaneously learning English.
4. **Postsecondary education:** This includes both vocational training and higher education that results in a degree and/or certification. Postsecondary education is a valuable approach to workforce development because in addition to providing workers with an applied knowledge of their chosen field, it provides workers with the ability to incorporate abstract concepts, ideas, innovative thinking, and creativity to a problem or situation. Postsecondary education also teaches teamwork, highly effective communication, leadership, and facilitated problem-solving.

5. **Soft skills training:** Soft skills training includes counseling and workshops designed to help individuals who are harder to employ develop the job seeking, behavioral, and attitudinal skills needed to find and maintain employment. Training is typically targeted to those with multiple barriers to work, particularly those with limited or no work histories and who demonstrate a difficulty in staying attached to the workforce. It is generally geared toward entry level employment.

   Individualized soft skill training, done through job coaching, is extremely effective in helping people overcome personal barriers to work. This is because it allows the trainer to be creative in addressing the trainee's personal needs. Many disadvantaged persons are completely capable of working, but lack the social skills necessary for maintaining employment. Helping people improve their social skills increases their chance for success in the workplace, as well as their chance for success in life.

6. **Career counseling or job coaching:** Counseling or job coaching provides one-on-one guidance and support to workers who seek new education and/or employment opportunities. Sessions may include assessment of an individual's existing skill set and career goals, with referral to appropriate education, training, and employment opportunities. Career counselors and job coaches also help workers address barriers that prevent them from completing training programs and/or maintaining employment. Counseling can benefit persons with a range of skill sets, but is most beneficial to disadvantaged workers who need culturally competent and individualized attention.

   High School to College and Career Pathways

   Career counseling targeted at junior high and high school students is an effective way to help people understand the importance of postsecondary education and influence a person's education and workforce choices at an early age. In order to help junior high and high school counselors provide appropriate and applicable information to Utah's students, the Utah State Office of Education (USOE) has developed the High School to College and Career Pathways initiative. Through partnerships with post-secondary institutions, school districts, businesses, and industries, USOE has identified and grouped courses within areas of study that offer students a depth of knowledge and skill, and are linked with specific postsecondary programs culminating in degrees or certificates.

   Each pathway lays out what classes a student should take from 7th grade through 12th grade that will best help them achieve success in their chosen field. The pathways also layout the various options for education and training beyond high school, depending on the student's career goals. The expected wages associated with each degree are listed as well. USOE has currently laid out 60 different pathways. Pathway information is provided to all of Utah's junior high and high school counselors, as well as made available to students on UtahFutures.org.

   The information provided by these pathways is extremely valuable to both students and parents; many parents do not understand that their children need at least a two-year degree to succeed in the 21st century workforce. Pathways are a tool parents can use to understand what jobs are available, how much money their children will make, and what certificates or degrees are necessary to qualify for jobs. Parents can then better direct and influence their children's educational choices.

7. **Internet-based job searching sites:** Providing job seekers with access to a job searching website increases their ability to rapidly find and apply for available jobs. Effective interfaces also supply job seekers with information about resumes, necessary training, available training, and how to establish a career path. An example of a successful multifaceted job search site is UtahFutures.org. This website, which is geared toward both adults and 6^{th}-12^{th} grade students, provides information on available occupations and jobs, education and training, and other workforce-related resources.

   Visitors can fill out questionnaires to help them determine which careers best fit their interests. They can learn about the salaries and requirements of hundreds of occupations, and even do a "Reality Check," which involves answering questions to find out how much money an individual would need to earn in order to a have a certain lifestyle in different Utah cities.[2] Students can use the website to find financial aid and scholarships based on their interests, grades, need, achievement, and other factors. Adults can use the website to create resumes, pursue job listings, and get advice on how to deal with coworkers or ask supervisors for raises.

   The site is sponsored by USOE's Adult Education, the Utah Department of Workforce Services, the Utah System of Higher Education, the Utah Office of Rehabilitation, the Utah Higher Education Assistance Authority, and the federal GEAR UP program. Many junior highs and high schools across the state have already started using the program as part of their career counseling services. For example, counselors can help students navigate through a number of career exploration phases, starting with fantasy, and then moving to a stage in which they learn about multiple careers, and then a realistic phase in which they're ready to follow a particular pathway.[3]

8. **Incentives/rewards:** Both long-term and intermediate rewards can be used to provide program participants with the incentive to complete a workforce development program. Small rewards given for intermediate outcomes achieved provide tangible positive feedback to participants. This in turn can improve program retention, especially for participants who fail to see the long-term benefits of the program or are forgoing immediate income to participate in the program. A larger reward given at completion of the program also improves retention and increases participant morale.

9. **Support services:** Workforce development programs targeting high-risk populations (low-income individuals, high school dropouts, and immigrants/refugees) can increase job placement, job retention, and other outcomes by helping participants attain stability in other areas of their lives.[4] This is achieved by either providing participants with support services directly through the workforce development program or connecting them to support services offered by other programs. Examples of services that are typically provided by workforce development programs include food stamp and childcare referrals, clothing, and transportation assistance.

10. **Evaluation and follow up:** Programs need to be evaluated and outcome driven in order to determine if employment is achieved and sustained over time. Many workforce development programs monitor the progress of individuals in their program, but do not have the ability to track the individuals after they leave the program. Success is best measured through systematic follow up with program participants.

One way to measure and assess student progress and success, as well as the outcomes of publicly funded educational and skills-development programs, is to incorporate postsecondary and workforce data into statewide longitudinal data systems.[5] These systems are established and monitored by state agencies to measure the educational transitions, completions, and labor market outcomes of adult students and workers. It is recommended that the systems: 1) follow the educational progress and labor market outcomes of all adult students and workers; 2) track and measure the educational and skills-development progress, completions, and outcomes of all participants; and 3) track and measure the labor market outcomes of all participants. It is also recommended that the systems be compatible with other states for cross-state comparisons.

11. **Innovative education policies:** Low completion rates in basic skills and postsecondary education and training programs pose a central challenge to meeting the financial needs of adult workers and skilled-labor needs of employers. However, there is a growing consensus on the key elements of state policies that can be enacted to help address this issue.[6] The National Center for Higher Education Management Systems, for example, has summarized critical educational reforms in the following points:[7]

    - Increase access to postsecondary education by increasing grant aid and scholarships for part-time students, including help with non-tuition expenses.
    - Schedule classes in more flexible ways; offer classes on a wider range of days and times and in less rigid sequences.
    - Deliver instruction more creatively by combining distance and face-to-face learning. Distance learning programs are effective because they are a better fit for non-traditional students' schedules.
    - Create clearer, more direct, and faster paths to postsecondary credential completion. Break longer diploma and degree programs into shorter certificate modules that build on one another as they lead to a final degree.
    - Focus postsecondary education and training on providing certificates that have a high value in the labor market. Improved adult access to postsecondary education does not automatically translate into worker advancement or more competitive businesses. States can increase workers' success by using state capacity to analyze labor markets in order to identify promising sectors and occupations.[8]
    - Connect postsecondary education to the needs of the workforce by collecting information from local employers about how the postsecondary system can better teach and train future workers.[9]
    - Adopt radically different and more effective remedial education strategies. Connect remedial services to occupational pathways in colleges and training programs; for example, some programs have found that delivering remedial education on college campuses promotes transition to college and helps to demystify college processes.[10]
    - Engage in major marketing efforts targeted to adult learners to promote the value of education, the educational opportunities available, and how these opportunities can connect adult learners to employment.[11]

Utah's 21st Century Workforce Initiative studied Utah's current system for training workers after they leave school and concluded there is a need for a strong, seamless, connection among education, training, and 21st century skill sets, including soft skills and work ethic focus.[12] Research has also shown that sustaining and scaling up innovative workforce development and postsecondary education initiatives is only possible when supported by action to align key state policies across adult basic education, postsecondary education, and workforce development systems.[13] Establishing innovative education policies is the best way to effectively connect education, training, and 21st century skill sets and to address the needs of Utah's current and future workforce.

12. **Creating new paths to credentials and careers:** As mentioned above, creating new paths to credentials and careers involves breaking longer diploma and degree programs into shorter certificate modules as well as prioritizing industry and occupational sectors that offer good jobs in career pathways. Career pathways "offer a series of connected education and training programs and support services that enable individuals to get jobs in specific industries, and to advance over time to successfully complete higher levels of education and work in that industry."[14] They include "embedded" or "stackable" credentials connected to each step in the pathway. These credentials, such as occupational certificates, have value to employers by themselves, and build toward longer technical diplomas and degrees.

    An example of a state effort with this focus is Wisconsin's RISE Career Pathways. This initiative features new modular degrees and technical diplomas within the Wisconsin Technical College System. The RISE initiative provides an avenue for local technical colleges to break longer programs into shorter modules and certificates that are easier for adults to complete quickly and can be tracked at the state level for accountability and funding purposes. RISE career pathways are connected through common guidelines (both short definitions and more detailed operational elements) to complementary policies in workforce development efforts overseen by the state Department of Workforce Development, such as federal Workforce Investment Act (WIA) services and apprenticeships, Opportunity Grants, student aid pilots, and the new Wisconsin Industry Partnership initiative.[15]

    Wisconsin's policy work to scale up RISE pathways statewide includes steps to:

    - Create a new, streamlined state process for approving technical diplomas and recognizing occupational certificates that are embedded within existing Wisconsin Technical College System State Board-approved programs.
    - Add new course and program-related codes to the Wisconsin Technical College System Client Reporting System to allow the state to track enrollment and report on student outcomes for courses using RISE bridge instruction, embedded certificates, and embedded technical diplomas.
    - Define WIA training as including adult basic education, English language, and occupational training along a career pathway for a high-demand industry. Local workforce boards must spend at least 70% of Recovery Act WIA Adult and Dislocated Worker program funds and 35% of formula WIA Adult and Dislocated Worker program funds on training and count career pathways and bridges toward this requirement.

- Weave the RISE concept of pathways and bridges into state and local WIA plans for regular federal workforce development funding as well as funding through the Recovery Act. State guidelines require local Workforce Development Boards to incorporate RISE career pathways principles into training and the state's WIA and the Recovery Act plans mirror this focus.
- Expand apprenticeship and pre-apprenticeship programs as part of the RISE career pathway and bridge models. The Department of Workforce Development held joint WIA and apprenticeship training for local WIA program staff, gave grants for development of new health care apprenticeships and is partnering with Community Action Agencies to link initial weatherization training with skilled apprenticeship programs in green construction and energy-related occupations.
- Link RISE career pathways and related bridge instruction to the state's new regional sector strategy, Wisconsin Industry Partnerships. The state is funding regional industry partnerships in targeted growth industries. They embrace a wide definition of "career pathways," one which incorporates RISE's critical focus on adult workers, but also prioritizes the transition from secondary to postsecondary education as addressed by Wisconsin's career clusters and pathways initiative.

13. **Connecting basic skills to college and career success:** These "bridge" models combine basic skills content with workforce readiness, support services, and the knowledge and skills needed for a specific occupation (or cluster of occupations). While the bridge model can be applied to a variety of adult education and technical education courses, the common threads among existing bridge models are that they contextualize basic skills and English language content to a specific occupational focus, coordinate instruction by basic skills and technical education faculty and staff, and seek to articulate academic and technical content and credentials to the next step in college and career pathways.[16]

    An example of a state effort with this specific focus is the Illinois "Shifting Gears" initiative. This initiative began as pilots in three priority economic sectors, which helped the state develop and refine a single, common definition for bridge programs for use in funding and tracking these services within existing adult basic education, workforce development, and career and technical education funding streams. Bridge programs must have three components: basic skills instruction contextualized to specific industry clusters and occupations, career development, and transition services. Designed to serve students whose skills range from the 6th grade level, or low/intermediate ESL-level, through pre-college, bridge programs prepare students to enter employment and credit coursework in one of four priority sectors: health care, manufacturing, information technology, and transportation/warehousing/logistics. Almost 20 adult education bridge programs are currently approved or in the approval process.[17]

    To facilitate the coordinated use of funds from adult basic education and career and technical education, Illinois' goals are to:

    - Revise the state's definition of WIA training to allow bridge programs to count toward meeting the state requirement for local workforce areas to spend at least 40% of adult and dislocated worker funding on training.

- Create new bridge program classification structures and course codes for adult basic education, developmental education, and career and technical education. Developmental education bridge programs meeting the new definition qualify for a higher reimbursement rate than regular developmental education courses because they are more expensive to operate.
- Continue to use state discretionary funds strategically to support bridge program design and implementation. The adult basic education office of the Illinois Community College Board, for example, issued two rounds of competitive grants in 2009 for bridge programs and the Department of Commerce and Economic Opportunity gave priority in awarding the federal Recovery Act funds to bridge programs for incumbent workers that meet the new state definition.
- Approve the new "Adult Basic Education Strategic Vision." The Illinois Community College Board developed this vision in meetings throughout the state and formally adopted it in November 2009. It provides the basis for future state grants and contracts with local adult basic education providers.
- Link Shifting Gears bridges more closely to regional and sector workforce needs by ensuring they are part of career pathways in the Illinois Career Clusters framework. Career Clusters are "groups of occupations and industries that have in common a set of foundational knowledge and skills." The federal Perkins career-technical education law has spurred national recognition of 16 career clusters, with many career pathways in each cluster.
- Create standardized curricula for bridges aligned with pathways in priority sectors. The Illinois Community College Board, with funding support from Department of Commerce and Economic Opportunity, is creating standardized curricula for bridges, beginning with the healthcare sector, and will expand this to other career clusters over time.
- Incorporate additional performance measures for bridge programs into the state's data systems so that education and training services and outcomes, as well as employment and earnings, can be tracked over time at the student level for bridge participants. The state also hopes to use transition measures developed for Shifting Gears bridge programs to measure Illinois Community College Board transition performance more broadly, and to link these transition measures to the Illinois Career Cluster framework.
- Make student transition data available to colleges and adult basic education providers in a web-based format to help them improve their program performance.

14. **Social marketing:** An effective way to increase community and legislative awareness of the importance of postsecondary education is through social marketing campaigns. While most workforce development programs are aimed at adults, influencing a person's education and workforce choices at an early age can help prevent many of the problems typically associated with needing adult workforce development programs (dropping out of high school, dropping out of college, etc.). This is especially true for low-income or immigrant/refugee communities who are unfamiliar with or have experienced problems

with the educational system. Culturally competent social marketing campaigns led by community-based organizations can help parents and children in these communities become engaged in the educational system. Campaigns can also increase a community's awareness of the different types of postsecondary education and workforce development programs that are available (college, vocational, trade, technical, etc.).

Increasing legislative awareness of the importance of postsecondary education programs is most successful when it comes from the community, particularly businesses. Partnering with businesses in creating social marketing campaigns is an effective advocacy tool, especially in a state like Utah that has a pro-business focus. Advocacy campaigns can be used to encourage the legislature to increase postsecondary education funding, provide more education/training opportunities, or provide more scholarships/reduced tuition for low-income or disadvantaged persons. They should help legislators understand the long-term economic benefits associated with investing in postsecondary education. Creating a shared vision of the importance of postsecondary education among key stakeholders in education, workforce development, and economic development is crucial.[18]

Models

When evaluating the various models used to improve workforce development in a particular community, two models stand out as best practices: Alternative Staffing Organizations and Sectoral Employment. While these two models use very different approaches to workforce development, they both can be used to help populations with varying skill levels (new graduates, displaced workers, low-income individuals, immigrants/refugees, and persons with disabilities).

Alternative Staffing Organizations

Although the workforce development system has experienced a shift of focus from developing skills to helping individuals find career-advancing jobs, job training and readiness programs remain critical to advancing low-wage, low-skilled workers in self-sustaining jobs.[19] Alternative Staffing Organizations (ASOs) are job placement enterprises that specifically help high-risk, disadvantaged job seekers gain entry into the labor market and build their work experience. In its basic form, ASOs resemble traditional for-profit staffing agencies in that they act as the employer of record. This involves paying the wages, benefits, and related taxes for the workers placed in work assignments. In exchange for placing the workers, ASOs either charge fees to employers for the job brokering services or receive contract funding from the employer for the duration of the worker's assignment.[20]

An ASO's primary role is to connect job seekers to the labor market. In this sense, ASOs operate as social-purpose enterprises that are driven by both job seekers and paying employers. Unlike their traditional staffing-industry counterparts, however, ASOs focus on a specific population—high-risk, disadvantaged workers. Because these workers often need additional supports and soft-skills training, many ASOs offer basic job readiness and job retention assistance, one-on-one counseling services, basic education and job training, transportation to jobs, clothing, childcare referrals, or emergency cash assistance.[21] These support services both prepare the worker for employment and improve retention in the workplace, which in turn provides a better-quality service to the employer.

Philanthropic and public dollars, rather than being the core of ASO revenues, are often used to fund the support services that help workers obtain and maintain employment.[22] The revenue that comes from employment contracts or the fees charged for job brokering services are predominantly used to pay the wages, benefits, and related taxes of workers placed in work assignments. However, some community-based ASOs have been able to generate some revenue through the fees charged to employers, which is then funneled into other programs.

ASOs serve people with a range of barriers to employment—including criminal records, disabilities, a history of homelessness, and limited educational attainment. However, an evaluation of ASOs, done by Public/Private Ventures, revealed that combining job brokering with employment supports helps offset the negative effect certain, and even multiple, barriers can have on job placement, retention, and wages.[23] An analysis done by Public/Private Ventures found that workers who experienced multiple barriers to work often experienced negative employment outcomes such as lower wages and fewer days on assignment. However, when workers with similar barriers received job brokering coupled with supporting services, the relationship was reversed and workers actually experienced higher wages.

The strategic approach underlying ASOs is to help certain job seekers access opportunities that might otherwise be closed to them. However, not only do these organizations benefit disadvantaged workers, but they provide a benefit to employers as well. Using an ASO for staffing needs reduces employer burnout and often allows them to build a relationship with a potential employee before fully committing to hiring them. An additional benefit of the increased emphasis on serving the dual customer (job seekers and employers) is that it leads to rapid placement of job seekers in the workforce and allows ASOs to be flexible in meeting the needs of both customers.

The primary obstacle ASOs face is finding a sufficient number of employers and/or contract work. In order for ASOs to succeed they need a robust network of industry partners who are willing to hire disadvantaged workers.[24] Another potential drawback to ASOs is their focus on placing job seekers in temporary work. Despite the advantages temporary work can provide to employers, and some workers, in terms of flexibility, it is also associated with decreased job security, lower wages, and limited access to health insurance and other benefits.[25] This can run contrary to the broader goal of workforce-development organizations to help disadvantaged job seekers achieve family-sustaining wages and escape poverty.[26] In order to avoid these drawbacks, some ASOs have moved away from using temporary work as a viable source of placement. Instead they focus on placing workers in permanent positions or use federal contacts that ensure workers receive a living wage and benefits.

Sectoral Employment

Sector-based strategies are an emerging trend used by both public and private entities to promote workforce development.[27] Years of evaluation of publicly funded job training programs revealed job training best works when it is tied to real employment prospects and treats employers as customers of the workforce system. Sectoral employment seeks to address both of these issues

by focusing on training programs for a particular industry or sector that builds career pathways to help low-wage workers advance into better jobs.

By identifying growing local sectors that lack workers—which might range from health care to manufacturing to construction—sectoral employment programs can help low-income workers acquire the specific skills they need to fill available positions.[28] Organizations using such an approach seek out entry points for less-educated workers and identify achievable ways for them to advance within the targeted sector. They typically offer or facilitate training with strict attention to the current needs of employers and the workplace environment. Unlike more traditional programs, sectoral programs also intervene on the demand side of the labor market by attempting to improve employment opportunities within an industry. They concentrate on developing a strategic role for their organizations, identifying key players in the sector, and working to gain allies and leverage that will help them create systemic changes.[29]

A successful sectoral employment program generally involves five key strategies. 1) Target a growing industry or cluster of occupations, developing a deep understanding of the interrelationship between business competitiveness and the workforce needs of the targeted industry. 2) Intervene through a credible organization or set of organizations, crafting workforce solutions tailored to that industry and its region. 3) Support workers in improving their range of employment-related skills, which will improve their ability to compete for higher-quality jobs. 4) Meet the needs of employers, improving their ability to compete within the marketplace. 5) Create lasting change in the labor market system to the benefit of both workers and employers.[30]

An evaluation done by Public/Private Ventures of sectoral training programs found that while each organization pursed a unique approach in developing their training program, the program development shared several key elements. First, the organizations focused on a high-growth industry, or set of small industries and used industry data to create a baseline of high-demand, high-wage occupations within the industry, as well as a list of skills and training programs necessary for each identified occupation. The organizations then developed industry-specific expertise and relationships that supported their training programs' design and ongoing adaptation. The strategies used to engage industries include programs that work one-on-one with employers, programs that work with discrete sets of employers, and programs that work with an employer/union membership association to organize employers from targeted sectors.[31]

Second, the organizations all had recruitment, screening, and intake processes aimed at making appropriate career matches for participants. These processes identified candidates with an interest and aptitude for success in the target industry as well as the basic skills needed to benefit from training. Occupation-specific requirements such as driver's licenses for construction jobs were also screened for in the process. The downside to this approach is that it does not address the needs of disadvantages persons who would most likely not pass the initial screening process.

Third, programs provided technical job-specific training as well as job-readiness workshops that taught basic English and math skills through the perspective of a particular industry. Some organizations provided all of the components of the job training, while others contracted part of the training out to other agencies such as applied technical centers, vocational schools, and community colleges. Contracting out training to other agencies allows participants to earn

certificates or credits during training that can later be used toward a degree. Training was usually conducted in small groups and by industry specialists.

Fourth, organizations offered a range of support services such as child care, transportation, housing, and financial assistance to program participants. Some organizations also helped individuals get a driver's license or provided tutoring to pass a qualifying exam. The programs either provided these services directly or in partnership with outside agencies.[32]

Fifth, organizations and programs were flexible enough to adjust to a changing environment. Some organizations shifted their occupation or industry focus during the period of evaluation in order to better reflect industry needs. Other organization made changes to their curriculum. Programs also altered the mix of services they provided, responding to changes in partner agencies or available funding.

A three-year longitudinal study of sector-based training programs found that these programs resulted in more consistent working patterns among low-income adults, higher-quality jobs with higher incomes, and improved worker morale for workers who had lower levels of education, low incomes, and multiple periods of unemployment in their work histories. They found the percent of adults who worked year round increased from 23% to 66% after the training and a greater percent of workers had access to health insurance, paid sick leave and vacation time, and a pension plan through their employer.[33]

Even though there are many benefits associated with sectoral-based strategies, there are challenges as well. Most of the challenges are associated with training individuals for jobs in specific sectors and extending an organization's influence in ways that produce systemic change. An analysis of existing sectoral employment programs has shown the main challenges include:

1. Recruiting sufficient numbers of skills-training participants who meet the enrollment qualifications of employers, colleges, or the program.
2. Surmounting participants' negative images of the manufacturing field and its future potential (for the skills-training organizations targeting this sector).
3. Encountering mixed results in obtaining referrals from public systems that could support participants while in training, such as Temporary Assistance for Needy Families (TANF) or WIA.
4. Retaining and graduating participants who needed income to support themselves and their families during training or were dealing with personal issues that make program completion difficult.
5. Securing funding to continue organizing and advocating for systemic changes that could improve low-wage working conditions.[34]

Examples of ASOs

First Source Staffing (FSS) – Brooklyn, NY
Annual operating budget: $3,000,000

FSS is a for-profit subsidiary of the Fifth Avenue Committee (FAC), a community development organization that runs a range of service programs. Using the money it received from the Mott Foundation, the Fifth Avenue Committee started FSS as an additional job placement service to supplement its current workforce development program and expand the size of its employer-customer base. It was envisioned as a profit-sharing model that would enhance workers' wages and offer a socially responsible alternative to traditional staffing agencies.[35]

FSS is located within a residential neighborhood in a densely populated urban area. Job seekers served by the larger workforce development program primarily come from the surrounding neighborhoods, and clients specific to FSS are draws from this core client base. Because of its relationship to the larger program, no recruitment of job seekers is necessary. FSS's annual operating budget is around $3 million. It serves about 500 individuals per year.

FSS is made up of three to four staff members who have the dual goals of generating revenue (finding employers) and serving disadvantaged job seekers. One of these staff members is focused exclusively on the provision of social services. FSS always has more applicants than positions, so recruiting employers is an important part of staff members' jobs. About 70% of FSS's applicants have multiple barriers to employment; however, FSS's clients are also better educated and have fewer indications of poverty than the typical population served by ASOs. Most of FSS's job placements are in clerical positions or light industrial jobs.

FSS provides temporary placement, direct placement, and convertible temp-to-permanent arrangements. It uses an Employee Assistance Program (EAP) to help employees with personal issues and improve job performance through education or counseling. FSS's EAP counselor runs biweekly orientation sessions and checks in with workers post-placement to offer additional help. The EAP counselor also establishes referral relationships with other service providers in the area in order to assist people with issues such as substance abuse, stress, marital troubles, and financial difficulties. The counselor identifies the workers who are most in need of support and tailors services to suit their needs.

While all clients are informed of available services, the EAP counselor specifically seeks out and provides services to those with the most severe needs. This means FSS provides a wide array of services to a small number of individuals; about 7% of its clients receive an average of five different services. The services offered through FSS include instruction in job readiness and job retention, one-on-one counseling, education and training, clothing, child care, elder care, food, money, health services, and transportation assistance.[36] In partnership with Fifth Avenue Committee, FSS clients also have access to the following programs:

1. *Neighborhood Employment Services:* This program provides job coaching, resume workshops, computer literacy education, referrals to skills training, and direct job placement to South Brooklyn community residents.

2. *Building Works:* This is the New York City District Council of Carpenters' pre-apprenticeship Training Program. Participants are recruited and prescreened through FSS.
3. *Single Stop & IDA Programs:* The Single Stop Program offers entitlements advocacy, legal representation, free tax preparation services, and financial counseling to all FSS participants as well as other members of the FAC community. Through one-on-one counseling and workshops, Single Stop helps participants navigate the complexities of transitioning from unemployment and informal income to permanent employment and self-sufficiency. FSS participants also have access to federally-matched Individual Development Accounts (IDA) to save for further training, education, or investments.

A study by Public/Private Ventures found that job seekers at FSS who utilized services were more likely to be placed in positions than those who did not receive services. FSS job seekers who faced multiple barriers to employment and received services also earned 93 cents more per hour than workers who did not receive services.[37] In terms of conversion, turning a temporary placement into a permanent job, a little less than a quarter of FSS temp workers were hired by their employer. The average starting wage for a FSS graduate is $13.50 per hour.

Individuals best served by FSS, however, are those with previous work experience. The types of job orders FSS most often fills are for skilled office work—positions that required job seekers to have some work experience, even if they had not worked for some time. In addition to its clerical placements, FSS has light industrial and service work placements (janitorial positions at a network of charter schools) that are appropriate for people with fewer skills.

Goodwill Staffing Services (GSS) – Idaho
Annual operating budget: $2,500,000

GSS is run by the Easter Seals-Goodwill of the Northern Rocky Mountains. It was launched as an extension of the traditional services offered by Easter Seals-Goodwill to provide employment opportunities to the disabled and disadvantaged clients of Goodwill programs. With the support it received through the Mott Foundation's Alternative Staffing Demonstration, GSS opened a second office in Nampa, ID, co-located with the organization's welfare program. Both GSSs are located in commercial districts and therefore attract job seekers from a wide region.

In theory, GSS works with the Easter Seals-Goodwill's public assistance program and greater workforce services program to identify job training clients who could find placements through the staffing service. However, few applicants are referred by the other programs and limited information is shared about potential applicants. Therefore, GSS staff members began recruiting outside of the traditional Goodwill client base to fill its high-skill clerical assignments. Currently, GSS-Boise primarily serves individuals from the broader Boise population and competes with other staffing agencies in the area. GSS-Boise's annual operating budget is around $2.5 million. It serves about 400 individuals per year.

Both GSS sites employ two to four staff members. All staff members are expected to engage in sales activities to attract new employers and raise revenue. Most of GSS-Boise's clients have received their high school diploma and very few are on food stamps or other types of cash

assistance; however, more of Boise's applicants have been convicted of a crime compared to the typical population served by ASOs. Consistent with its connection to Goodwill, one-fifth of GSS-Boise's applicants have a documented disability. However, because GSS-Boise primarily recruits applicants for positions, rather than finding positions for applicants, its screening process has created an applicant pool with characteristics that directly reflect its job orders (which tend to be more appropriate for people with fewer disadvantages). Close to 95% of GSS-Boise's job placements are clerical jobs. Workers are placed in legal offices, medical offices, government agencies, and a variety of small businesses.

GSS-Nampa applicants are poorer and have less education; many have children, lack a high school diploma, and have been homeless at some time in their lives. Many applicants are non-custodial parents, individuals with substance abuse issues, and previous offenders. Like FSS, GSS-Nampa always has more applicants than positions, so recruiting employers is an important part of staff members' jobs. Most of GSS-Nampa's job placements are in office or clerical positions or light industrial jobs.

The main services offered to applicants by GSS include testing applicants' skills and providing relevant training resources. After job seekers have been placed, GSS staff members also offer advice on how to be successful within the office environment, mediate performance issues with employers, and refer workers who ask for help to outside agencies. The Nampa site's co-location with Goodwill's public assistance program allows its staff members to refer workers to more structured services such as job training and counseling. While services are open to all job seekers at GSS, take-up is higher at the Nampa site, which serves a more disadvantaged clientele.

Both sites provide limited job-readiness, job-retention, education/training, and job counseling services, but Nampa workers have access to more extensive supports through referrals to the co-located public assistance program. These services include transportation, child care, food, health services, clothing, and money. Because GSS-Boise's clientele are higher-functioning than clientele at most ASOs, it focuses on "quick fixes;" helping people make good decisions, providing interview clothes, or giving instruction on how to use a copy machine.

A study by Public/Private Ventures found that both GSS-Boise and GSS-Nampa were able to procure placements that were appropriate for applicants with significant barriers to employment. For example, receipt of services increased the likelihood of placement and the time spent in placement at both sites. At GSS-Boise, applicants who had not received a high school diploma were more likely to be placed compared to non-applicants in the same demographic. At Nampa, applicants who had been on TANF and those who had never held a job for more than three years were more likely to be placed compared to non-applicants in the same demographic. Both GSS-Boise and Nampa had high rates of conversion, largely attributable to the fact that the primary employer—a call center—sought temps with the intention of finding workers it could hire.

Pioneer Adult Rehabilitation Center (PARC) – Clearfield, UT
Annual operating budget: $8,500,000

PARC is a community rehabilitation program administered by Davis School District in Clearfield, UT. In partnership with public and private entities, PARC provides employment and training for persons with disabilities so they can gain the skills required to function at the highest level of economic and social independence. It provides services to people with all types of disabilities who cannot obtain employment without external support.[38]

Programs are supported by a combination of local, state, and federal dollars or through a fee for service. Private sponsorships are also available on a tuition payment basis. It operates on a budget of around $8.5 million per year. Agency sponsorships are provided by the Division of Rehabilitation Services (Voc Rehab), the Division of Services for People with Disabilities (DSPD), PARC revenue, and other funders such as the United Way of Salt Lake. United Way of Salt Lake funds are a valuable resource to PARC because it provides assistance for persons who do not quality for DSPD funds (low-functioning individuals) or Voc Rehab (higher functioning individuals who can be placed in stable employment in about three months). PARC primarily serves Davis and Salt Lake County residents, although it does have some employment opportunities available in Brigham City and the Tooele Army Depot.

PARC offers three employment opportunities:

1. *Employment of Choice:* PARC provides a day training program where people with disabilities are trained and employed on production projects through contracts with local businesses. The highly structured environment with continual supervision is designed to help each client achieve his/her maximum level of self sufficiency. It is best suited for persons with severe disabilities who are not capable of or had sufficient training for community employment. Most of the production projects are completed at the PARC site, but a few community-supervised employment opportunities are also available.
2. *Community Employment:* This program provides assistance in obtaining and maintaining successful employment through integration within community-based jobs. In the program, persons with disabilities are assigned a job coach who works with them on an individual basis to obtain a local job. Job coaches provide whatever supports the individual needs through training and quality control. Once the training is completed and a job is secured, the job coach will provide ongoing support as needed throughout the individual's employment to ensure retention and success.[39]
3. *Federal Contracts or AbilityOne Program:* AbilityOne provides employment at federal entities for people with disabilities. PARC currently has six major government contracts within its AbilityOne program. It provides Hill Air Force Base with custodial work and sorts excess mechanical parts. PARC also cleans Tooele Army Depot and Deseret Chemical Depot in Tooele and federal buildings at the Freeport Center in Clearfield. The work is routine and provides employees with a livable salary. Employees are employed by PARC who pays them through a federal grant.[40] The benefit associated with this program is that it provides people with the most severe barriers the ability to work in well-paying jobs. The downfall is that it can be difficult to secure the limited number of federal contracts available due to competition from similar agencies.

4. *Temporary work:* While not an official employment program, PARC occasionally places its clients in temporary positions. In these scenarios, PARC pays the employees' wages and benefits by charging the employer a finding fee.

Most of the job training provided by PARC is done on an individual basis through job coaches. However, the organization does offer some basic training and educational programs. "First Impressions" is a training program that addresses soft skills such as resume building, job seeking, interviewing, appropriate behavior, and even personal hygiene. PARC also offers a three-day custodial training program. At the end of the program, clients receive a certificate of skills. Multiple training programs are also offered in conjunction with Employment of Choice program. On occasion, PARC also offers educational and service programs such as VITA, ESL courses, and GED preparation.

In its last fiscal year (July 2009 - June 2010), Park served a total of 777 individuals, with about 330 new entries. To address these individuals' needs, PARC employs 22 job coaches. While the average caseload for each job coach is 12 clients, the number varies depending on the needs of the clients and specialty of the job coach. For example some coaches work with as few as three clients, while others, who focus exclusively on finding community jobs for clients, serve up to 40. Most job coaches are part-time employees.

In terms of results, 119 individuals with disability were placed in community jobs and 162 gained competitive employment in the community, meaning they no longer need PARC services. These individuals are earning and spending money which contributes to the economic development of the state. It also means they require fewer welfare and other safety net services, which saves the state money in the long run.

In terms of best practices, PARC works well because of the following:

1. *It offers a series of powerful programs that create pathways for prosperity:* Clients are able to progress both within and between programs, which allows PARC to accommodate people with varying needs. Being able to progress between the programs also promotes self-sufficiency and allows clients to achieve intermediate success.
2. *It offers individualized assistance through job coaches:* Job coaches are able to walk clients through every step of the employment process, which increases success for both obtaining and retaining employment. The one-on-one relationship also allow job coaches to develop training that is creative and individualized the clients' needs. One program that takes this concept even further is the PARC Pre-Employment Determination (PPED). Before beginning the job search, a job coach spends 40 hours with a client, talking with former employers, family, friends, neighbors, etc. This determination period gives the trainer a much better sense of the person, which in turn results in better job matches.
3. *It includes social entrepreneur aspects in its overall plan:* PARC is always looking for new ways to provide employment and training opportunities to its clients. For example, it is opening a café at Hill Air Force Base that will provide part-time jobs for its clients. The café will have a full time manager and assistant manager, but the rest of the employees will be PARC clients. The goal of the restaurant is not to create profit, but simply to provide employment and training opportunities.

The greatest difficulties PARC face are securing sufficient funding and finding employers. Generally, PARC has to reach out to companies in order to find interested employers, which takes time and resources. Fortunately, PARC has maintained a good reputation so it retains a fair number of repeat employers. PARC also works on building strong relationships with employers, which has led to job carving for PARC clients by some organizations like the IRS.

In terms of measures, PARC focuses on achieving both effectiveness and efficiency goals by meeting measurable outcomes. For example, in 2009 its overall goal was to increase employment and training opportunities for clients participating in Employment of Choice and Community Employment Services. One way PARC measured success of this goal was to increase the number of people served in Community Employment Services by 50%. PARC also focuses on meeting quality measures for its client- and employer-customers, which ensures both sets of customers are being satisfied. PARC representatives also mentioned a pilot program being implemented by Voc Rehab that rewards PARC with money for each milestone it achieves—for example, it would receive $1,000 for taking on a new client, receive another $1,000 for finding that client a job, etc. There would also be incentives for finding clients jobs where they work 30+ hours per week, receive benefits, and earn a livable wage.

Examples of Sectoral Employment

Jewish Vocational Service (JVS) – Boston, MA
Annual operating budget: $8,000,000

Founded to assist Eastern European immigrants in the 1930s, JVS provides an array of educational and training programs in the Boston area. In 1996, JVS won a contract to run The Work Place, one of Boston's three WIA-funded One-Stops. Operating independently, the One-Stop provides Bostonians with employment-related services such as training referrals, career counseling, and job listings.[41]

JVS has also developed services for incumbent, or currently employed workers. Beginning by offering English-language training services to employers who had hired a large number of refugees, JVS went on to provide such services to incumbent workers with funding from the federal National Workplace Literacy Program and then Welfare-to-Work Program grants. JVS continues to offer this training on a fee-for-service and grant-funded basis.

In 2000, JVS launched a newly organized Center for Careers and Lifelong Learning (CALL) that was intended to replace departments organized around siloed government contracts. CALL focuses on career pathways and provides long-term (up to two years) follow-up with participants. The reorganization also strengthened JVS's employer services; during this time JVS developed a centralized employer account management system that consolidates contacts, relationships, and knowledge about employers in one department.

Established in the early 1990s, JVS's training curriculum program provides technical skills training and certifications as well as job readiness workshops and basic skills support for three

industries: medical assistant, culinary arts, and computerized accounting.[42] Building on a long history and individual relationships with local employers, JVS has established sector-based employer advisory boards that helped the agency craft its occupational skills training curriculum. It uses the employer account management system (described above) to identify and address employer needs and to cultivate and strengthen ties with employers.

Training is provided over 21 to 25 weeks for 20 to 25 hours per week. All students begin with core classes in computer software (Windows, Excel, Power Point and Access), and then participate in specialized training in medical office skills or accounting, including a four- to six-week internship. Job readiness classes (writing resumes and cover letters, job interviewing, and employment retention) and soft skills training (communication, decision-making, conflict resolution, workplace ethics, and customer service) are also offered. Students can also access instruction in basic skills or ESL if needed.

JVS provides strong support to students by offering case management and referrals to outside agencies as well as access to other services like tax preparation assistance at the program site. Case management services address attendance, behavioral issues, or challenges on site, while legal matters, childcare needs and transportation difficulties are handled through partnerships with other agencies and organizations. JVS leverages resources from federal, state, and local public agencies and private foundations to offer these services.

All program participants receive job placement assistance and employment retention services. Committed to providing long-term follow up, JVS staff continues to help program graduates stay in their jobs or find new ones. In a follow-up survey of recent program participants, 90% reported having been contacted after graduation, while 31% reported having been contacted at least once a month and 30% said they had been contacted more often.

In 2009, JVS helped over 700 clients get jobs, and 467 clients retain their jobs or get promotions. They also helped 1,661 clients gain job skills, 1,158 to attain basic skills gains in a variety of educational areas, and 724 individuals to participate in family support activities for children with disabilities. An additional 8,424 people attended their career workshops last year, another 7,993 utilized their computer access to search for jobs, and 1,872 former clients received follow up services and supports.[43] JVS operates on a budget of around $8 million per year; the cost per person served in its sectoral employment program is between $5,000 and $6,000.

Most JVS participants have either a high school diploma (55%) or a GED (19%); another 18% have completed some postsecondary education, only 8% have not finished high school. A sixth-grade reading level is required for entry into all JVS programs. JVS also serves a large number of young adults. Among participants, almost one-third is between ages 18 and 24, and almost half is between ages 18 and 26. The 18- to 26-year-olds are almost entirely female (96%) and have less education than JVS participants overall.[44]

A study by Public/Private Ventures found that JVS program participants saw a 21% earnings gain over the two-year study period and a 35% earnings gain in the second year alone, largely as a result of JVS participants being more likely to find employment than their control group counterparts. Participants also worked more hours and were more likely to earn at least $11 an

hour. Young adult program participants did particularly well, perhaps reflecting the high level of support provided by program staff; these younger participants earned almost 50% more than young adults in the control group.[45]

Wisconsin Regional Training Partnership (WRTP) – Milwaukee, WI
Annual operating budget: $2,300,000

WRTP is a membership organization that was founded in the 1990s with the goal of reviving the region's traditional industrial base. Today, WRTP brings together businesses, organized labor, and workers to identify and meet industry needs. It is a membership organization that enlists major area employers and unions. Members form sector-specific committees staffed by people from within each industry. Each committee works to develop WRTP services that will meet identified business needs, with the goal of supporting local businesses. At the same time, WRTP identifies the best jobs for low-income area residents. WRTP's member services include pre-employment training, incumbent worker training (advances the skills of currently-employed workers), and technical assistance to businesses in areas such as new technology adoption.

Although WRTP originally focused its efforts on the manufacturing sector, in 2000 the organization received a U.S. Department of Labor grant to develop a similar approach for other regional industry sectors. WRTP then began collaborating with BIG STEP, a local apprenticeship preparation program, to offer services in the construction sector. WRTP and BIG STEP eventually merged and combined their efforts in both manufacturing and construction, establishing WRTP's Center of Excellence for Skilled Trades and Industry. In addition, WRTP began developing services to meet the high demand for healthcare workers in Milwaukee.[46] WRTP has expanded its services to include training in road construction, lead abatement/ hazardous materials, and Commercial Driver's License preparation.

WRTP's pre-employment training program was developed in response to member demand. In most cases, specific employers work with WRTP to develop training in order to hire successful graduates. In other cases, such as in the healthcare sector, labor market information indicated job opportunities were growing. Staff relationships with local leaders can also alert WRTP to upcoming job opportunities such as those related to publicly financed construction projects. In all cases, a WRTP industry coordinator leads a committee of employers and union representatives to identify needs among member businesses, market services to current and potential member businesses, and ensure that course curriculum and content are aligned with industry needs. WRTP also works to determine that demand for trained workers is evident prior to running a training program, often assembling a particular training class only after an employer has made a firm commitment to new hiring.

Because of this commitment to hire, the training period is relatively brief—ranging from one to eight weeks, or 40 to 160 hours—as workers are needed to fill vacancies immediately. Training focuses on the participants' industry sector of interest and includes an "essential skills" component to help participants with timeliness, attendance, strategies for dealing with child care, workplace issues, and operating within the industry culture. To provide technical training, WRTP relies on a range of service providers, including member company employees,

community college instructors, and industry experts recommended by members and others. Student supports and remedial education are offered through a network of public and community-based agencies. A combination of public funding, such as WIA training vouchers, welfare-to-work and workforce attachment and advancement resources, support these services.

WRTP is funded through a mix of private and public donations (in some cases, companies pay employees' wages during their participation in training). It operates on a budget of around $2.3 million per year. More than half of this amount (57%) pays for program services, including personnel costs. The remaining 43% is divided between training (16%) and overhead (27%). WRTP places around 500 community residents, including BIG STEP apprenticeship placements, in jobs every year. About 400 individuals graduate from WRTPs program annually. The jobs residents are placed in have an average wage of $14.82 per hour, plus benefits.

Almost 40% of WRTP participants report having received welfare at some point in their lives and 14% are receiving welfare at the time of enrollment. WRTP also serves significant numbers of young adults; about 28% are between ages 18 and 24 and 34% are between ages 18 and 26. Young adults, defined either way, constitute a subgroup of WRTP participants who are somewhat less educated, with about 20% having less than a high school education and 4% having (compared with 8% overall) some postsecondary education.[47]

A study by Public/Private Ventures found that JVS program participants earned significantly more even though their employment rates were similar to the control counterparts. Participants were significantly more likely to work in higher-wage jobs, to secure union jobs, and to work in jobs that offered benefits. They were also more likely to obtain certifications in both the healthcare and constructions tracks. Earnings gains varied across sectors; construction participants saw the highest gains, followed by health care.[48]

Center for Employment Training (CET) – San Jose, CA
Annual operating budget: $5,000,000

CET is a private, 501(c)(3) non-profit organization dedicated to fighting poverty and dependence on public aid by making hands-on job training available to youth and adults of all educational levels and backgrounds, but especially to those most in need and hardest to serve.[49] The mission of CET, an economic and community development corporation, is to promote human development and education by providing people with marketable skills training and support services that contribute to self-sufficiency.

Since CET started in 1967, the non-profit has received funding from two primary sources: over 50% comes from state and federal government and the remainder from the private sector.[50] Because CETs are an accredited institution, students are charged tuition fees, which range between $4,000 and $12,000 per program, depending on the training (general employment training is the cheapest, while electrician training is the most expensive). Average tuition is around $8,000 per student. Federal grants, loans, and other financial aid are available to students. The San Jose center, one of the largest CETs, operates on an annual budget of about $5 million. It has a capacity to serve 400 students per year and offers nine training courses, including

accounting clerk, automotive specialist, green building construction skills, culinary arts, early childhood teacher assistant, medical administrative assistant, medical assistant, electrician, and business office technology. Smaller centers, which serve less than 100 students and offer two training courses, have annual operating budgets around $900,000. In program year 2008-2009, all CET training centers provided training and placement services to 5,929 individuals in 17 communities across the nation (most CETs are located in California).

CET programs offer a variety of training and support services. In term support services, CET offers life skills instruction, workplace simulation, human development, support services, and job placement. Examples of some of the support services offered by CET include vocational guidance, ESL, GED preparation, transportation services, childcare development services, and immigrant citizenship training.[51] The Citizenship and Immigration program is located in San Jose and offers free citizenship, ESL/EL Civics, and Spanish literacy classes. Remedial education is integrated directly into training for a specific job, rather than provided prior to job training or concurrently in a separate class.

In terms of training, CET does not conduct testing as a pre-requisite to entry; it provides participants without high school diplomas or GEDs access to job-specific training with no upfront assessment of basic skills. It uses an open-entry and exit model; students can enter training at any time and training has no set course length. Students progress through training at their own pace, progressing to the next level only when they have shown competency in a particular area. Courses are highly individualized and non-competitive; with over 60% of the training conducted in a hands-on environment. Training is conducted in small groups which reinforces the individualized training focus. Classes are offered year-round and students can attend six hours a day, five days a week. At completion of the competency-based training, students receive an accredited certificate of completion. Over 30 skill-training options are offered, determined by industry demand in the local economies in which the CET is located.[52]

Job placement is an important aspect of the CET model. CET Job Developers and Instructors work closely with employer recruiters and human resource representatives to match job-ready students to employer needs. Because of this, CET's training curriculum is carefully developed in partnership with local industry employers in the form of local Industrial Advisory Boards and Technical Advisory Committees.[53] With the input from these employer advisors, training programs are kept abreast of technological advancements and the current requirements for entry-level positions in each industry. Instructors are hired straight from industry and often have veteran experience in a given field. CET offers training only for in-demand occupations. Although trainees prepare for employment from the start of training, job search training intensifies when a student is deemed ready for placement. A CET Industrial Relations Specialists works with the student on resume building, interviewing techniques, and filling out applications.

CET trains and places unemployed, low-income, and underserved persons of all ethnic backgrounds in paid employment. Students range in age from 17 to over 50. Training is available to anyone over the age of compulsory school attendance who wants to learn a skill for job placement. Many students are farm workers, single mothers on welfare, and disadvantaged youth. Unemployed youth make up a large proportion of enrollees, partly because the program demands a full-time commitment that many older and/or working people cannot make. Hispanic

individuals also make up a large proportion because centers tend to be located in areas with large Hispanic populations.

Two different studies have demonstrated that CET's blend of vocational training and basic education substantially increased employment and earnings in its target population.[54] These studies found that participation in CET training not only produced earning gains in a short time frame, even for participants without high school diplomas or GEDs, but that these gains were still apparent five years after program completion. For example, after five years women who participated in CET earned an average of $95 more per month and worked eight more hours per month compared to control group members. Earning potential was substantially higher for program participants who had a high school diploma or GED.[55]

One important issue to be aware of, however, is that while the original CET, based in San Jose, has experienced tremendous success in helping a population improve their employment and income situations, similar outcomes have not been sustained in replicated sites. This is partly due to the fact that CET-San Jose has taken more than 30 years to establish and refine its own program of employment and training services, yet replication sites sought to develop a similar model in as few as three years. Evaluation of these replication sites found that that the greatest difficulty in replicating CET was sustaining funding for the program.[56]

State-Based Initiatives

Some state-based workforce development initiatives were outlined above; however, these initiatives were specific to the strategies being described. Other successful workforce development initiatives utilizing different approaches have and are being implemented around the country. Brief descriptions of some of these initiatives are outlined below.[57]

Shifting Gears in Illinois aims to increase the economic competitiveness of the state by helping more lower-skilled adults advance along career pathways and acquire postsecondary credentials that employer's value. Shifting Gears Illinois has specifically focused on creating and strengthening adult basic education and developmental education bridge programs. These bridge programs integrate basic skills instruction with occupational instruction in key sectors (see description above). In addition to bridges implementation, Shifting Gears has two other important priority areas. One area is state-level work to find ways to expand support services for low-income, lower-skilled adults, and other at-risk populations who participate in Shifting Gears bridge programs. The second priority area is creating a new website that allows local administrators and decision-makers greater access to student transitions data. Future data work will include exploring new transitions measures and analyses to help the state track student progress across adult education, developmental education, and career/technical education services and understand better the factors that contribute to student success and completion.[58]

Michigan's "No Worker Left Behind: Everybody In!" ("NWLB: Everybody In") effort builds on the state's "No Worker Left Behind" initiative, which provides up to two years of tuition at any Michigan community college, university, or other approved training program for workers pursing credentials in high-demand occupations or emerging industries. Michigan also continues

work started by the Adult Learning Work Group of the state workforce board, which created a new vision for regional adult learning partnerships. Through "NWLB: Everybody In," the state plans to create better on-ramps to NWLB training using regional partnerships between the adult basic, postsecondary, and workforce education systems. State policy changes are underway to secure commitments from the program's three core partners to align investments in basic skills and postsecondary transitions within regions.[59]

Minnesota's FastTRAC (Training, Resources and Credentialing for Pathways to Sustainable Employment) initiative will create programming that aligns and integrates adult basic education, non-credit occupational training, and for-credit postsecondary certificate and degree programs. The pathways will identify and align various credentials offered by the different postsecondary institutions that "stack" on each other and allow participants to build to degrees over time. Like, Illinois, Minnesota has the goal of building "integrated data capability" for tracking student success across education and employment programs by adopting a charter for a new longitudinal data system that includes both adult education and college students. The state also plans to focus on eliminating or reducing commonly-faced barriers to postsecondary education such as high college and training costs and insufficient student support services.[60]

The Governor's Workforce Investment Board (GWIB) in Maryland is using a cluster-based approach to identify businesses or industries with growth potential that are currently experiencing or projecting worker shortages and determine how to serve their workforce needs. In 2004, GWIB received a grant from the U.S. Department of Labor to establish the Center for Industry Initiatives. The five-phase cluster-based industry initiative process guides industry, government, and education leaders in collaboratively identifying, quantifying and addressing an industry's workforce issues. The GWIB first targeted the healthcare industry and is replicating the healthcare workforce initiative process in other industries such as aerospace, biotechnology, hospitality, and tourism.[61]

New Mexico has identified Arts and Entertainment; Business Services; Communications and Information; Energy and Environmental Technologies; Engineering; Construction and Manufacturing; Health and Biosciences; and Hospitality and Tourism as the 7 strategic market sectors that will serve as the foundation for the state's future economy. These 7 strategic clusters now guide the makeup of education and training programs available in the Workforce Connection Centers, community colleges, GED and adult literacy programs, and through TANF case managers so that workers are prepared for high-demand jobs and employers have ready access to the highly skilled workers they need.[62]

Kentucky's "Open for Business" initiative emphasizes the need to support businesses seeking to locate and expand in Kentucky. The state now helps businesses find and develop the right situation for themselves, their employees, and the citizens of Kentucky by directing the state's resources towards increased investment in job creation. The state's broad system of public workforce programs is used to prepare future and current workers for the new economy and create stable, reliable, higher-wage jobs.[63]

Immigrant/Refugee Workforce Development

As mentioned in the introduction, most of the strategies and models outlined above address, or can be modified to address, the specific needs of immigrants/refugees. However, because these populations face a variety of specific challenges relating to the workforce, including obtaining education/job training and transferring licenses and credentials from other nations, research has identified some best practices currently being implemented that are specific to immigrant/refugee workforce development.[64] Brief descriptions of these practices are outlined below.

Welcome Centers

Some states, such as Iowa, place immigrants at the core of their workforce strategy. This state has developed plans, set goals, and committed resources to attract immigrants as well as help all new arrivals, native born or foreign born, connect with employers.[65] At the New Iowan Centers immigrants can receive help with everything from filling out immigration forms to finding a job. Companies can learn about cultural issues associated with immigrant workers, about training in Spanish for new employees, and about labor regulations that apply to immigrants. The New Iowan Centers are part of the Iowa Workforce Development Agency, funded by a combination of Governor's Workforce Investment Act (WIA) discretionary funds, local matches, and a grant from the U.S. Department of Labor.

Pennsylvania created its Welcome Center in 2003 as part of a strategy to attract immigrants to make the state more vibrant, more creative, and a more dynamic competitor in the global economy. Funded by the state, with support from the City of Philadelphia, business, and the nonprofit community, the center has brought together employment and a referral operation for Pennsylvania's growing immigrant population.

Sectoral Employment

Immigrant-based initiatives in other states target particular economic sectors, with the idea of preparing immigrants for high-demand occupations. For example, in Massachusetts a "sector strategy" involves the hospitality industry and the Hotel Career Center, a partnership of the International Institute of Boston, the Vietnamese American Civic Association, and Hilton Hotels Corporation. The center offers pre-employment training to job seekers and education and training for employees at five Hilton-affiliated hotels. Much of the education focuses on learning English, but training also includes job readiness skills and internships.[66]

A similar sector strategy is under way in North Carolina, where Central Piedmont Community College's Community Development Department initiated Pathways to Employment in 1998. As in Washington (see below), Central Piedmont uses an I-BEST ("integrated basic instruction and technical skills") approach, combining basic skills, English instruction, and job training in such fields as medical office work, which can lead to employment, to a college degree, or both.[67]

Credentialing

Because credentialing is such an important issue in moving qualified immigrants into the workforce, some states are making it a priority. California has created the Welcome Back Initiative to guide healthcare workers who were educated in other countries into the U.S. workplace. Welcome Back does not issue licenses, but it provides a central location in each of the state's three biggest metropolitan areas (San Francisco, Los Angeles, and San Diego) for foreign-trained healthcare workers to learn about licensing requirements, work permit procedures, and job opportunities. The program is funded largely by foundations. Since its inception it has been expanded to other local areas and states, including Rhode Island and Washington (Puget Sound).

Illinois has joined with the nonprofit organization Upwardly Global to explain common licensing processes to foreign-educated professionals through a new website.[68] The site gives step-by-step instructions for the licensing process in a variety of languages. It also provides new Illinoisans with tips on transferring credits from their home country and lists resources and locations they can go to for support.

Maryland is piloting the program Licensure of Foreign-Trained Nursing Professionals. This program, a multi-institutional collaboration of the Latino Health Initiative (LHI), Montgomery College, Holy Cross Hospital, Washington Adventist Hospital, and the Workforce Investment Board, provides a comprehensive, integrated, and coordinated approach to address the barriers that Latino nurses encounter in obtaining a Maryland nursing license. The program is designed to address the particular issues that were uncovered in studies conducted by the Montgomery County Department of Health and Human Services. These studies found a large pool of highly skilled, foreign-trained health professionals, with a strong willingness and commitment to practice their profession if given the opportunity. They found that local Maryland hospitals and other employers in the healthcare industry had not considered unlicensed, foreign-trained professionals living in the area as an answer to the shortage of nurses and other health professionals. Based on examples from the California Welcome Back Initiative, the program incorporates four components: a support and guidance system, academics, practical exposure to the U.S. healthcare system, and mentoring.

Washington's I-BEST Program integrates adult education and English language services with postsecondary education and training to increase attainment of credentials leading to family-supporting jobs. It teaches basic skills and English language in the context of particular occupations with the goal of helping students increase skills to the level needed for the next education step on a career pathway—while allowing them to simultaneously complete an initial occupational credential. This in turn decreases their need for college remediation. Each I-BEST program must be part of a certificate or other occupational program with a proven ability to place its graduates in higher-wage jobs (the current wage standard is greater than $12 an hour, with a wage standard in Seattle of $14 an hour). I-BEST pairs Adult Basic Education/ESL instructors with professional/technical instructors in the classroom to provide integrated basic skills and job training. Instructors co-teach about half time, and the rest of their time each teaches the same students contextualized basic skills and occupational skills separately. By shortening the timeline for helping adults earn marketable credentials more students are able to finish their programs.

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Entrepreneurship

Most states have strategies to promote entrepreneurship and homegrown businesses, but a few are beginning to understand the need to target them to immigrants. For example, in Massachusetts, the Latino Economic Development Center, in Boston, provides assistance in writing business plans, learning about sources of capital, and related issues. Latino Economic Development Centers are also located in the state's other metropolitan areas.

In North Carolina, Rural Entrepreneurship through Action Learning (REAL), a nonprofit organization that partners with the state's community colleges, offers a Spanish-language business planning curriculum taught by bilingual facilitators and provides business start-up training to Latino immigrants.

Some states are helping entrepreneurs gain access to capital through microenterprise loan programs. Nebraska, for example, provides funds to the Nebraska Enterprise Fund, a nonprofit intermediary that, in turn, provides loans, technical assistance, and training to self-employed businesses with five or fewer employees. For immigrant entrepreneurs who are ready to start a business, the technical assistance addresses language and cultural barriers, distrust of financial institutions, and lack of conventional credit histories.[69]

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[22] Shayne Spaulding et al.

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[32] Ibid.

[33] United Way National Professional Council.

[34] Anne Roder et al.

[35] While FSS was hoping to distribute profits earned from its enterprise among its worker-customers, it generally found that surplus revenue was not large enough to facilitate meaningful profit sharing.

[36] Shayne Spaulding et al.

[37] The study found that job seekers with less work experience were more likely to use services offered by FSS.

[38] Disability types include, but are not limited to chronically mentally ill, developmentally disabled, learning disabled, physically disabled, traumatic brain injury.

[39] Examples of possible measures of success for this program include the ability to eliminate a person's need for a job coach over time or to reduce the number of hours a job coach spends with a particular person to less than 20 hours per week.

[40] The federal contract requires 75% of the grant money be used directly toward labor costs. Employees must also be paid wages and benefits that meet federal standards.

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[45] Ibid.

[46] WRTP has had to suspend its manufacturing training because of the economic downturn in this sector.

[47] Sheila Maguire, et al., "Tuning in to Local Labor Markets."

[48] Sheila Maguire, et al., "Tuning in to Local Labor Markets."

[49] Several CET offices exist around the nation. The National Headquarters is located in San Jose, CA. To see other locations go to http://www.cetweb.org/aboutcet/index.html.

[50] CET is also sponsored by the United Way of Silicon Valley.

[51] To see a complete list of support services go to http://www.cetweb.org/training/training_program.html.

[52] To see a complete list of course options go to http://www.cetweb.org/training/courses.html.

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Financial Literacy: How can one best improve the financial literacy and use of financial tools by a population?

Strategies

Addressing socioeconomic factors, such as poverty, has the largest potential impact on improving people's lives.[1] One way to address these factors is through helping people gain knowledge of and access to financial tools.[2] The following is a list of components that can be used in a program or part of a larger financial literacy and income building initiative.

1. **Social marketing:** Social marketing campaigns are community-level strategies for changing behavior and/or supporting long-term behavior change. It is a process that applies marketing principles and techniques to create, communicate, and deliver a message that will influence target audience behaviors in order to benefit both the target audience as well as society.[3] In terms of helping people gain knowledge of and access to financial tools, social marketing campaigns can be used to increase awareness, provide education, and build social pressure around saving and planning for the future.

   To be truly effective, social marketing campaigns require carefully developed messages and pervasive media presence. Both media partnerships, which extend the value of paid advertising, and grassroots outreach, which promotes word-of-mouth awareness and provides the on-going individual support needed to create changes in behavior, are necessary components of a successful social marketing campaign. Grassroots efforts are especially effective because their ability to embed messages in all aspects of an individual's life, constantly reinforcing the message. Examples of grassroots outreach include partnering with employers and schools to disseminate information and/or include the teaching of financial literacy principles in their daily operations.

   An example of a local social marketing campaign is Utah Saves. It is based on the national America Saves campaign, which is managed by the nonprofit Consumer Federation of America. Utah Saves was kicked off in 2005 with a media event and a push from the governor. Two non-profits, United Way of Salt Lake and AAA Fair Credit Foundation, and Utah State University Extension took leadership of the campaign. A key component of the program is enrollment of individuals as Savers, who develop a wealth-building goal and then work to achieve this goal. Utah Saves combines broad public education and motivational forces to persuade individuals to select a savings and/or debt reduction goal, develop a plan to achieve the goal, and then stick with it until the goal has been achieved. In addition to sending a monthly electronic newsletter to participants, Utah Saves provides support and resources to Savers through a website, free classes and workshops, no-fee or low-fee savings accounts, income tax assistance, and wealth coaching.[4] Analysis of the Utah Saves campaign found the no-fee or low-fee savings accounts and the free classes and workshops had the greatest impact on respondents taking actions that were associated with successful Savers.

2. **Low- or no-cost financial products and automatic enrollment:** As mentioned in the example above, some of the most successful strategies for increasing savings are the use "automatic" (or extremely simple) savings opportunities and options.[5] Barriers to saving for many low-income families include cost (account minimums and fees), complexity of

choices and products, lack of trust or confidence in banking institutions, and lack of time and access to savings vehicles. Working with financial institutions to develop low- or no-cost financial products, as well as provide options for automatic enrollment in savings accounts and programs, can help eliminate these barriers. Programs can also work with employers to promote automatic enrollment in 401(k) and retirement plans.

3. **Financial education:** Financial education provides information and skills that enable individuals and families to make informed decisions regarding their personal finances. Financial education is generally provided through local programs and is geared toward saving, credit management, home ownership, and retirement planning. Beyond classroom-style instruction, financial education courses can also include actions like opening a checking and/or savings account with a mainstream financial institution, signing up for direct deposit, and/or filing for the Earned Income Tax Credit (EITC).

   The Treasury's Office of Financial Education has outlined eight elements of a successful financial education program. The first two relate to content, the next two to delivery, the next two to impact, and the final two to sustainability. The list is as follows:[6]

   1. The program focuses on basic savings, credit management, home ownership and/or retirement planning.
   2. It tailored to its target audience, taking into account the audiences' language, culture, age and experience.
   3. It is offered through a local distribution channel that makes effective use of community resources and contacts.
   4. It follows up with participants to reinforce the message and ensure that participants are able to apply the skills taught.
   5. It establishes specific program goals and uses performance measures to track progress toward meeting those goals.
   6. It demonstrates a positive impact on participants' attitudes, knowledge, or behavior through testing, surveys or other objective evaluation.
   7. It can be easily replicated on a local, regional, or national basis so as to have broad impact and sustainability.
   8. It is built to last as evidenced by factors such as continuing financial support, legislative backing, or integration into an established course of instruction.

   While adult financial education programs have proven to be very successful, the effectiveness of youth financial education is less known. This is partly due to the fact that many of the strategies and approaches listed above cannot be easily simplified and made age-appropriate for youth. For example, it is difficult to tailor youth financial education programs to address the individual needs financial goals of each student. Instead, most youth programs, especially school-based programs, use a one-size-fits-all approach.

   Although more rigorous longitudinal research is needed to assess the effectiveness of youth financial education, some promising practices have emerged:[7]

   1. Rather than introduce financial education in middle or high school, financial education should be introduced early and continue throughout the K-12 setting.

2. Financial education must demonstrate relevance to students in order to engage their motivation. For example, students need to not only understand the earning potential of various careers, but what that earning potential will buy in terms of cars, homes, and other luxury items.
3. Beyond teaching students to handle their cash, financial education must be designed to forge understandings of the relationships among money, work, investments, credit, bill payment, retirement planning, taxes, and so forth.
4. To implement financial education in the schools and to ensure that all students receive financial education, it must be mandated by state academic standards in order to gain widespread implementation as well as time and resource commitments from teachers and school systems.
5. Teacher training and professional development opportunities are a necessary corollary to successful program implementation.

Both in-school and out-of-school approaches, combined with parental involvement, are needed to target youth. Integrating school-based education with youth-targeted programming occurring outside the classroom, such as in after-school programs, and at home has produced promising results.

4. **Financial coaching:** In recent years, organizations have been shifting from classroom-based education to one-on-one financial coaching. Coaching is characterized by a long-term relationship between a client and a financial expert who mentors the client on an array of financial concepts such as how the banking system works to how to find and interpret a credit score. Early results from programs using financial coaches indicate it is a very effective method for changing the financial behaviors of individuals.[8] Success comes from the ongoing and trusting relationship that is built between the coach and the client over time.[9] Because of the importance of this relationship, it is imperative that financial coaches understand the needs of the population they serve as well as of the types of social services and other programs that are available to them. This is especially true for financial coaches serving low-income individuals and immigrants/refugees.

   There are at least three models nonprofit programs providing financial coaching services to low-income clients can use: volunteer coaches, paid financial planners, and trained in-house staff. There is also a fourth category that blends planners, volunteers and in-house staff. Each model has advantages and disadvantages, depending on the context and type of clients served. Blended models are the most cost-effective, assuming that an organization has staff capacity, access to skilled volunteers, and the resources to hire professional planners or recruit pro bono planners as needed. Volunteer models are also a low-cost delivery option, but volunteers can require extensive training and support. Turn over in volunteer models is also high; volunteers generally cannot provide coaching to individual clients for more than one year.

   In-house programs are equipped to provide coaching for a longer duration, although staff requires significant training and support, especially on financial content issues and how to coach low-income clients. The paid planner model provides valuable services to clients, but can be expensive to deliver. Like the volunteer model, the paid planner model requires training and support, in addition to paying for the planners' services. This is

because professional planners are highly knowledgeable about personal finance, but not necessarily skilled at coaching or dealing with the issues associated with low-income clients. Novice planners are less expensive option and can be easily trained if the community has a local training program for planners.[10]

5. **Incentives/rewards:** Both long-term and intermediate rewards can be used to provide program participants with the incentive to complete a financial education or savings program. Small rewards given for intermediate outcomes achieved provide tangible positive feedback to participants. This in turn can improve program retention and reduces the impulse to spend.

   An example of an extremely effective incentive program is matched savings accounts, or Individuals Development Accounts (IDA). IDAs encourage individuals to build savings for purposes such as higher education or home purchase by providing a match for every dollar saved. Matching funds are contributed through government grants, philanthropic funds, or employers. Although the program is restricted in the number of people it can serve, it is considered to be one of the most successful ways to get very low-income people to save because of the rewards and supports it provides. An external evaluation of IDA programs found the typical participant saved about $700 per year.[11] The IDA model can be used to target specific populations with specific spending goals.[12]

   Children's Development Accounts (CDA) is another effective matched savings program. CDAs are long-term, matched savings accounts established for children as early as birth and allowed to grow over their lifetime. In their ideal form, CDAs are seeded with an initial deposit and built by contributions from any number of sources including family, friends, and the children themselves, as well as organizations such as churches, schools, foundations, and the government. These groups can augment the accounts through progressive savings match amounts and other incentives. Savings in CDAs are typically restricted for uses such as funding higher education, starting a small business, buying a home, or saving for retirement. The accounts are often accompanied by age-appropriate financial education for accountholders and/or their parents.[13]

6. **Accessible and appropriate:** As mentioned above, the most successful programs and strategies are those that are accessible and appropriate for the target population. Simply providing an overview of financial concepts is insufficient to change the saving behavior of individuals—especially if the information is presented in a way that is not understandable by those receiving it. Financial education classes need to be accessible (available during non-work hours) and appropriate (taught in a way that is culturally/ socioeconomically understandable). This ensures betters outcomes and helps create ongoing behavior and peer supports aimed at creating positive and social pressure to save in a community.

7. **Evaluation:** Programs need to be evaluated and outcome driven to determine if financial gains are present and can be sustained over time. While self-reported data are useful, and sometime the only data source available, it is important to note that these data are generally biased and may not produce accurate results. Vague measures of improvement based on pre- and post-test assessments are also not useful in analyzing the effectiveness of a program. Analyzing aggregate data can produce meaningful results, but the downside is it can be difficult to discern changes in individuals' behaviors from aggregate data

samples. Utilizing financial coaches in this sense is beneficial because of their ability to track actual outcomes of the individual clients they serve. IDAs, and other matched-savings programs, are also able to track the amount saved by individuals.

Models

Multi-Faceted Behavior Supports

Interventions used to alter existing socioeconomic conditions, such as poverty, often require broad societal change. Therefore strategies aimed at building knowledge and creating opportunity must be supported by strategies that motivate individuals to save and sustain their saving habits.[14] A successful financial literacy and income building initiative needs to be implemented in a way that embeds the financial education and tools provided by the initiative into all areas of people's lives through a multi-faceted approach.

Research has shown that environmental change is critical to support and maintain individual change.[15] This implies community-level changes are best achieved through influencing individuals and families, personal networks, neighborhoods, organizations (such as places of employment), and systems (such as K-12 education and state legislation). A multi-faceted approach focuses on making changes needed at both the individual and community level to support good financial decisions. It also ensures community representation at all program levels by using social relationships in families, schools, neighborhoods, and communities to target intervention. For example, while some of the strategies described above target and provide support for individuals and families, many are strategies that can be pursued through community networks, employers, school systems, and the media.[16] Utah's Believe Campaign is an example of a program that targets multiple levels of the community, including workplaces and schools, through its social marketing campaign.

Using a multi-faceted approach also implies providing different tools for income building beyond basic financial education. For example, the best way to promote asset building among low-income families is through matched savings programs. This is because automatic enrollment in low- or no-cost financial products eliminates the barriers of enrollment many low-income individuals face such as cost and access to savings vehicles. School-based programs, on the other hand, prepare students to enter adulthood with a strong financial education and the capacity for financial success. Including a workforce development aspect in financial literacy programs can help individuals obtain the income needed to save and build assets.

A multi-faceted approach is based on the understanding that income building is gained not only through educational activities, but through advocacy, organizational change, policy development, economic supports, environmental change, and multi-method strategies. It also proposes that there are multiple leverage points that may be important in modifying an individual's financial decisions.[17] Some of these occur through individual behavior supports, such as one-on-one coaching, and others occur through organizational change, such as employer's implementing automatic enrollment in 401(k)s. Some leverages come from increasing an individual's financial literacy, while others come from providing incentives to save through matched savings accounts.

The multi-faceted approach suggests that change is maximized by influencing as many of these leverage points as possible.

Examples of Multi-Faceted Programs

Cottages of Hope – Ogden, UT
Annual operating budget: $200,000[18]

Cottages of Hope is a no-cost, step-by-step program that assists referred individuals in obtaining financial stability by offering income enhancement, career development, educational support, financial literacy, and talent development programs that lead to asset growth and greater independence.[19] It is a relatively new program; beginning operations in 2008. The main goals of Cottages of Hope include helping individuals: 1) find ways to increase household income through decreased spending, tax refunds, workforce development, and education and training; 2) learn basic financial principles, develop savings and other financial goals, and become an educated consumer of major purchases; and 3) save three to six months of living expenses in an emergency fund, develop habits of completing financial goals, purchase productive assets, participate in investing opportunities (401(k) or IRA), and increase net worth.

To accomplish these goals, Cottages of Hope has established six "cottages" or areas of income building development. The Cottage of Workforce Development is dedicated to assisting individuals obtain assessment, instruction and development that will help them map out a clear career path and teach them necessary skills to obtain and maintain employment. The Cottage offers a free computer lab where individuals have access to on-line employment services, job interview tips, resume preparation, and career and education research. A volunteer employee is also on-hand to help with resume building and to make referrals to partner agencies focusing on workforce development. Career and education coaching is also available by appointment.

The Cottage of Education and Training is dedicated to assisting individuals with their desire to obtain the training and education they will need to achieve their employment and financial goals. The Cottage plans to support ESL and GED prep courses, as well as assist individuals with their application and financial aid forms for the Ogden/Weber Applied Technical College and Weber State University. It also plans to include a small business development focus that will assist individuals understand what it takes to start and maintain a small business. Currently the Cottage offers free computer classes that cover the basics of using a computer, email, and the internet.

The Cottage of Talent Development is dedicated to assisting individuals in identifying and developing personal talents. The Cottage plans to help individuals pursue areas of hobby or skill that have the potential of improving their financial stability.

The Cottage of Income Enhancement is dedicated to assisting individuals obtain financial stability by providing finance programs geared around increasing and managing income. By partnering with the IRS, the Cottage currently offers Volunteer Income Tax Assistance (VITA) programs to help increase the number of EITC and Child Tax Credits claimed. While clients wait for their taxes to be processed, they watch a slideshow on how best to use their tax return money.

The Cottage also offers a course on debt management and basic budgeting principles, titled "Stretch Your Bucks...Without Breaking Your Back," as well as helps individuals develop a budget that best suits their needs.[20] Cottages of Hope takes many of these classes on the road, offering them at high schools, drug rehab centers, and other community centers.

The Cottage of Financial Literacy is dedicated to teaching basic financial principles geared around effective spending and saving strategies as well as assisting individuals in becoming active in the financial mainstream. In partnership with local financial institutions, the Cottage helps individuals open their own checking and/or savings accounts and understand core responsibilities associated with these accounts. The computer lab also provides access to online banking and credit scores. Finally, by partnering with the Utah Individual Development Account Network (UIDAN) and AAA Fair Credit Foundation, the Cottage offers financial coaching and access to the IDA program.

The Cottage of Asset Management is dedicated to instructing and supporting individuals and families in the process of obtaining and managing long-term assets, such as home ownership, auto purchases, and financial investments. By partnering with local agencies and using tools such as IDAs and VITA, the Cottage assists individuals in acquiring assets through incentive based matched savings and claiming of the EITC. The Cottage plans to offer on-site counseling about the opportunities and benefits, as well as potential threats, related to major purchases and loans.

Cottages of Hope currently provides services through three channels; a Prosperity Center (computer lab), a classroom, and coaching. The Prosperity Center is an open access computer lab that provides individuals with access to many of the services mentioned above (employment services, computer classes, etc.). Individuals are expected to use the computers and resources at their own pace with limited guidance from staff. The Prosperity Center also serves as an access point for the Cottages of Hope VITA site and referral network. Staff, online resources, and a physical reference guide help individuals get connected to other community partners that provide workforce development, food stamps, and childcare services.[21]

The Cottages of Hope staff currently consists of two paid employees who act as coordinators for all the programs and outreach activities. The rest of their staff is made of up a small number of volunteers from AmeriCorps VISTA, Easter Seals, the Department of Workforce Services, and Weber State University (students completing their service-learning requirements). The Cottage also works with 20-30 former accountants and IRS and bank employees who volunteer specifically for the VITA program.[22]

In terms of best practices, Cottages of Hope works well because of the following:

1. *It offers a series of powerful programs that create pathways for prosperity:* Clients are able to progress both within and between programs, which allows the Cottage to accommodate people with varying needs (middle class individuals who just need access to computers compared to low-income individuals who need one-on-one assistance). Being able to progress between the programs also promotes self-sufficiency.
2. *It implements a business-based customer service model:* Cottages of Hope plans to remain small so its staff can continue to develop strong relationships with its clients. Part of building a strong relationship is treating the clients with respect. Cottages of Hope's

goal is to provide short wait times for both VITA assistance and other programs so clients feel respected by the organization.

3. *It develops and maintains strong community connections:* When clients first enter the site, whether for VITA assistance or another program, they fill out a "Get Connected" card, checking boxes next to all the programs and topics they would like to hear more about. This card serves as a reference point for Cottages of Hope, allowing it to connect clients to community partners offering such programs. Due to limited resources, Cottages of Hope cannot address clients' every need, but it can use its network of partners to help.
4. *Its flexibility allows it to address current economic needs:* The original plan of Cottages of Hope was to focus on underemployment, or improving people's work skills and helping them gain promotions. Then the recession hit and the organization knew it needed to focus on helping people find jobs. Because it is a small organization and receives few federal/state grants that can limit an organization's focus, it is able to quickly change its programs in order to address the community's current needs.
5. *It provides culturally competent services:* Using the principles outlined in "Bridges out of Poverty," Cottages of Hope's services are provided in a way that is culturally/ socioeconomically understandable to its clients. The Cottage also tries to recruit volunteers who speak Spanish in order to address the language barrier experienced by many of its clients.

The majority of the Cottage's funding comes from the organization's original founder, but it also receives grants from UW of Northern Utah and local banks. Currently, its annual budget is about $200,000; however, because the organization is still in its start up phase and is currently spending a fair amount of time developing programs, this amount is not an accurate reflection of what the costs may be two to five years from now. Cottages of Hope focuses on serving two populations; low-income individuals who are moving out of the safety net and middle-income individuals who need help avoiding falling into the safety net. As mentioned above, its primary goal is to guide people to self sufficiency.

Prosperity Centers and Campaign – Palm Beach, FL (United Way of Palm Beach County)
Annual operating budget: $570,000[23]

The vision of the Prosperity Campaign is to empower low-income residents of Palm Beach County to secure adequate income, accumulate savings, and live in economically viable neighborhoods. The campaign links individuals to family and economic support systems that promote long-term self-sufficiency.[24] This approach encourages individuals and families to develop plans (called Prosperity Paths) which include specific, timely goals and objectives. The campaign then links these individuals to support systems that provide the knowledge, processes, and resources that increase the individuals' potential for sustained economic growth.[25]

The first phase of the Prosperity Campaign involved expanding the existing Palm Beach County VITA program. United Way of Palm Beach County (UWPBC) opened 18 additional VITA sites, to complement the existing ten sites operated by the local Community Action Program. For tax year 2002, the existing Palm Beach County VITA Program completed 641 returns. The next

year, under UWPBC leadership for the first time, 4,035 returns were completed and $6.8 million in refunds were returned to working families. For tax year 2005, 8,166 families at 41 sites received $14 million in refunds, $6 million of which was in EITC refunds.

Using conservative estimates tailored to local socioeconomic conditions, it is estimated that consumer spending associated with the EITC refunds collected by clients of United Way-sponsored tax preparation sites generated additional economic activity in the region on the order of $5.10 million in 2004, $7.50 million in 2005, and $8.76 million in 2006.[26] Because UWPBC targets its interventions in some of the lowest income communities in Palm Beach County, EITC returns boost incomes and spending in economically disadvantaged communities, providing a much needed stimulus to the local economy. In this way, EITC refunds and the VITA programs operate both as a way to move families along a path of economic security and as a local economic development program.

The VITA program has one full-time program manager who works on promoting EITC and recruiting volunteers year round. Volunteer tax preparers for the VITA program speak the three major languages of the region—English, Spanish, and Creole. For less common languages, the sites work closely with a local translation service. The program also has tax preparers who are deaf, can read lips, and use American Sign Language.

Volunteers were initially recruited through a website; but word of mouth has become best means of promotion. VITA volunteers are recruited from local colleges, churches, professional organizations (the Black Accountants Association, the National Association of Hispanic MBAs, etc.), local major businesses, civic/retiree associations, TV and radio public service announcements (PSA), and press releases. VITA volunteers have a high rate of retention, which is attributed to: 1) volunteers understanding the difficulties low-income families face; 2) the face-to-face interaction with clients while preparing their taxes; and 3) the appreciation clients have for their tax refunds. Trust is built between clients and tax preparers, with some clients asking for the volunteer who prepared their taxes the year before.

Because 46% of Palm Beach County's population earns less that $40,000 per year, UWPBC knew that working families needed additional economic supports, such as career counseling, job-skills training, and credit counseling, to give them the skills and tools needed to increase their potential for economic growth and self sufficiency. Also, once taxpayers had their tax refunds in hand, UWPBC wanted them to leverage the money in the best ways possible. Realizing existing services were fragmented, which led to gaps in the provision of services, UWPBC implemented phase two of the Prosperity Campaign by opening four Prosperity Centers.

Prosperity Centers are one-stop neighborhood resource centers located in specifically-targeted communities that have high concentrations of low-income residents. However, these centers are not the typical one-stop facility; rather than just being facilities housing a mixture of loosely organized community providers, Prosperity Centers are a coherent collaborative effort of several service providers. Through grant funding, UWPBC contracts with various organizations, which provide full-time dedicated staff to the centers. As a result, UWPBC manages the entire network of service providers within each center.[27] Services offered at a Prosperity Center include:

1. *Home ownership and IDA programs:* The IDA Program is a matched-savings program for homeownership or for a micro-enterprise small business. It helps families create a plan to grow personal assets. In the past, if the client saved $2,000, UWPBC matched it with an additional $4,000 to be used for down payment assistance on a new home or to start up a small business.[28]
2. *Money management:* Through the money management service, residents can receive credit counseling and help in resolving credit issues, learn how to manage a checking or savings account, and learn how to manage a budget.
3. *Educational and vocational assistance:* Prosperity Centers can help residents learn how to obtain a better job, earn their GED, and receive educational and vocational planning, college placement, and financial aid.
4. *Free income-tax preparation assistance:* The free tax service provides year-round tax service for filing present and past taxes. In the past, residents who use the free tax service together saved $1 million per year in filing fees.
5. *Benefits assistance:* This service screens residents to see which benefits they are qualified to receive (for example, food stamps, KidCare, Medicare, and/or Medicaid).
6. *Family crisis support counseling:* Families First provides support counseling to families who are experiencing undue stress caused many of today's most pressing problems.[29]

UWPBC has integrated several other programs and initiatives into the Prosperity Campaign over the years. For example, UWPBC worked with Consumer Credit Counseling Services, Inc., to determine the ability of medical providers to write-off medical debt from Prosperity Campaign clients' credit reports.[30] It also focused on educating the disabled population through a campaign called TaxFacts+; this campaign focused on how to utilize tax incentives and existing resources to help disabled persons gain economic stability.

Prosperity Centers also worked closely with local community development corporations (CDC) to help clients find additional subsidy programs for down payment assistance.[31] One of the objectives of the Prosperity Campaign is to integrate the VITA Program with the IDA Program by encouraging VITA clients to enroll in the IDA home buying program. However, because it can be difficult for low-income residents who qualify for the IDA Program to purchase a home in Palm Beach County where the median home prices is $395,000, UWBPC has worked with several local CDCs and Community Land Trusts to address the shortage of affordable housing.

The 2-1-1 phone service is an integral part of the Prosperity Campaign as well. For example, all VITA materials read, "To find your nearest VITA site, call 2-1-1." UWPBC typically sees an increase in the number of 2-1-1 calls after advertising on radio or TV. The marketing for the campaign includes: 1) distributing flyers printed in English, Spanish and Creole throughout Palm Beach County, including all Title I public schools; 2) providing TV and radio PSAs in three languages (English, Spanish, Creole); 3) issuing weekly press releases from December through April (tax season), which generate local news stories; 4) full-page newspaper advertisements; and 5) partnering with IRS representatives to speak at local neighborhood associations, non-profit groups, and corporations.

Initially, UWPBC spent around $200,000 per year on staffing and providing services at each of the four Prosperity Centers. This amount did not include overhead expenses as these were paid by UWPCB's partners who housed the one-stop shops. After years of implementation and streamlining funds, however, UWPCB now pays a lead agency $228,000 per year to coordinate the staffing and service delivery of all four centers. The lead agency uses this money to leverage additional funds, primarily federal funds, for the Prosperity Centers. It is estimated that the $228,000 provided by UWPBC covers about 35-45% of the centers' total operating costs, and the remaining amount (around $342,000) is covered by additional funds brought in by the lead agency. Initial funding for the EITC and IDA services provided by Prosperity Centers came from a one-time Knight Foundation grant.

**A report published by United Way Worldwide detailing the components and effectiveness of one-stop financial centers implemented by nine United Ways across the country is expected to be released within the month. For more information about this report, please contact Kasha Owers, Director of the United Way of Palm Beach County's Prosperity Campaign at (561) 375-6617.*

Immigrant/Refugee Financial Literacy

As mentioned before, most of the strategies and models outlined above address, or can be modified to address, the specific needs of immigrants/refugees. However, because these populations face a variety of challenges specific to obtaining access to U.S. financial systems, research has identified some best practices currently being implemented that are specific to increasing immigrants/refugees' financial literacy and use of financial tools.[32] Brief descriptions of these practices are outlined below.

One innovative effort to address basic financial literacy among immigrants came about as a result of the New Alliance Task Force in Illinois, a joint effort by the Chicago office of the Federal Deposit Insurance Corporation and the Mexican Consul in Chicago. Among other things, the Mexican Consulate now provides Mexican citizens with identification they can use to open a bank account. Bank representatives are stationed at the Mexican Consulate, so immigrants waiting in line for identification cards can learn about the benefits of banking.

The Latino Community Credit Union (LCCU) in North Carolina seeks to use the customer-owned credit union model as a means of reaching immigrant communities where people are cut off from the financial system. LCCU uses an innovative, bilingual financial education program to bring people in immigrant communities into the financial system. LCCU has eight branches across North Carolina and is the fourth-largest community development credit union in the United States.

Because the percent of immigrants without a bank account is so high in California, Governor Arnold Schwarzenegger launched Bank on California in 2008. This state initiative was the first in the nation to help individuals open starter bank accounts. Bank on California helps low- and middle-income Californians, many of them immigrants, establish savings, build a credit history, gain access to sources of lower-cost credit, and invest for the future. The state collaborates with

financial institutions, city mayors, federal bank regulatory agencies, and community groups to help individuals establish banking relationships.

The state of Washington targets immigrants through the Washington Asset Building Coalition. The initiative was launched in 2006 to increase asset building by low- and middle-income individuals in the state. A collaborative effort among community development entities, nonprofits, and the state, the initiative focuses on expanding financial literacy, providing education about smart banking, and ultimately helping the targeted populations, including immigrants, build savings and assets for the future.[33]

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[1] Thomas R. Frieden et al., "Reducing childhood obesity through policy change: Acting now to prevent obesity," *Health Affairs* 29, No. 3 (2010): 357-363.

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[6] Martha Henn McCormick, **"**The Effectiveness of Youth Financial Education: A Review of the Literature," New America Foundation Policy Paper (July 2008).

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[8] Overall, financial coaching has demonstrated strong potential to facilitate asset building among low-income families; however, best practices to deliver coaching are still being developed.

[9] J. Michael Collins et al. "Financial Coaching: A New Approach for Asset Building?" A report for the Annie E. Casey Foundation (Madison, WI: Policy Lab Consulting Group, LLC, 2007).

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[11] Gregory Mills et al., "Evaluation of the American Dream Demonstration," Prepared for The Ford Foundation (Cambridge, MA: Abt Associate Inc., 2004).

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[15] G. M. Budd and L. L. Hayman, "Addressing the childhood obesity crisis: A call to action," *MCN, The American Journal of Maternal/Child Nursing* 33 (2008): 111-118.

[16] Ibid.

[17] S. L. Booth et al., "Environmental and societal factors affect food choice and physical activity: Rationale, influences and leverage points," *Nutrition Reviews* 59 (2001): 21-39.

[18] Because Cottages of Hope is still in its start up phase and is currently spending a fair amount of time developing programs, this amount is not an accurate reflection of what the costs may be two to five years from now.

[19] Cottages of Hope, http://www.cottagesofhope.org/. Chris Swaner, Co-Director and CFO, offered to let Cottages of Hope serve as pilot project if UWSL seeks Federal grants for a similar program.

[20] The "Stretch Your Bucks...Without Breaking Your Back" course is free of charge, open to persons of any income level, and taught by Utah State University and Weber State University extension programs.

[21] Cottages of Hope staff serves as case managers by helping clients complete and fax applications to other support service agencies.

[22] Last year, Cottages of Hope prepared over 1,100 returns with 35 staff (including 21 accountants).

[23] UWPBC gives around $228,000 to the Prosperity Centers' lead agency which coordinates activities for the four centers. It covers about 35-45% of the centers' operating costs. The rest is paid for by additional funding raised by the lead agency.

[24] For questions about UWPBC's Prosperity Centers and Campaign, contact Kasha Owers, (561) 375-6617.

[25] National Community Tax Coalition, "United Way of Palm Beach County Prosperity Campaign," http://tax-coalition.org/our-coalition/our-coalition/program-profiles/united-way-of-palm-beach-county-prosperity-campaign.

[26] Amounts are in 2006 dollars. Kimary Lee and Nik Theodore, "EITC and Family Economic Security Programs: An Assessment of Community Capacity," Second Report to the John S. and James L. Knight Foundation (November 2006).

[27] These services, all offered under one roof, are provided through contracts with service providers in the county, including: Consumer Credit Counseling Services, Inc., Palm Beach Community College, Northwest Riviera Beach Community Redevelopment Corporation, Families First, Workforce Alliance, Inc., Housing Partnership, Inc., and Local Initiatives Support Corporation.

[28] To qualify for the IDA program, an applicant's income must be at 200% of the federal government poverty guidelines.

[29] Community Partnership Group, "Prosperity Centers," http://www.gocpg.org/ProsperityCenters.

[30] Research indicates there is a high correlation between income levels and medical debt. Low-income and low-wealth individuals tend to have high medical debt, and as a result, poor credit. This medical debt, in turn, provides a barrier for low-income individuals to sustain economic growth.

[31] Kimary Lee and Nik Theodore.

[32] Erin Andrew et al., "Rising to the Immigrant Integration Challenge: What States are Doing—And Can Do," National Governors Association Center for Best Practices, Issue Brief (4 November 2009).

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Education: How can one best help build a strong foundation of early learning from birth to age eight for children?

Strategies

Early childhood generally encompasses the first eight years of a child's life. The education given during these years plays a critical role in the proper development of children. High quality early childhood programs and initiatives have shown to improve school readiness and decrease crime, teen pregnancy, substance abuse and welfare dependency.[1] The following is a list of education strategies that can be used in a program or part of a larger initiative. Items one through ten are components that can enhance early childhood education programs. Items 11 through 14 are strategies that can be used as part of an early childhood initiative.

1. **Low teacher-child ratios:** Research has shown that large class size is a systemic barrier to high levels of achievement in grades K-12. Smaller classes mean more individual attention for students, more orderly classrooms for teachers, and a better learning environment.[2] A longitudinal study analyzing Tennessee's *Project STAR* (Student-Teacher Achievement Ratio) found students in small classes experienced a definite advantage in achievement. At the end of first grade, students in small classes were outperforming students in regular and in regular/aide classes by substantial, statistically significant margins on standardized tests. This pattern continued in grades two and three.[3] The significant effects of class size reduction on student achievement appear when class size is reduced to a point between 15 and 20 students (for younger children, an adult to child ratio of 1:10 is recommended). These effects continue to increase as class size approaches the situation of a 1-to-1 tutorial.[4]

2. **Quality age-appropriate intentional instruction:** While there is some disagreement on the exact teaching methodology to use in early childhood education programs, research has shown that high-quality, age-appropriate instruction in early literacy, numeracy, social-emotional, physical, and cognitive growth can enhance a child's learning and development as well as help create a competitive workforce.[5]
   The principal elements of early childhood instruction that have consistently produced positive impacts include:[6]
   1. Age-appropriate curricula and stimulating materials in a safe physical setting.[7]
   2. A language-rich environment.[8]
   3. Warm, responsive interactions between staff and children.[9]
   4. High and consistent levels of child participation.[10]
   5. Curricula that is designed to be responsive to the needs of the specific children, families, and community in which the program is located.

   Based on a review of approximately 800 studies—including a rigorous analysis of the High/Scope Perry Preschool Project, the Abecedarian Project, and the Chicago Child-Parent Centers—Craig and Sharon Ramey of Georgetown University, found the most

successful curriculum provided children with firsthand, engaged learning experiences.[11] In order to provide children with engaged learning experiences, the Rameys have outlined the following seven essential steps for caregivers with young children:[12]

1. Encourage exploration.
2. Mentor in basic skills.
3. Celebrate developmental advances.
4. Rehearse and extend new skills.
5. Protect from inappropriate disapproval, teasing, and punishment.
6. Communicate richly and responsively.
7. Guide and limit behavior.

The National Association for the Education of Young Children (NAEYC), a leading national organization dedicated to improving the quality of education and care provided to children birth through age eight, developed a position statement on curriculum in conjunction with the National Association of Early Childhood Specialists in the State Departments of Education (NAECS/SDE). The highlights from this statement follow:[13]

> *Policymakers, the early childhood profession, and other stakeholders in young children's lives have a shared responsibility to implement a curriculum that is thoughtfully planned, challenging, engaging, developmentally appropriate, culturally and linguistically responsive, comprehensive across all developmental domains, and likely to promote positive outcomes for all young children.*[14]

Based on the NAEYC's statement, the National Center for Children in Poverty (NCCP) developed a list of characteristics they believe are necessary for a high-quality intentional curriculum. These characteristics follow:[15]

- *Research-based:* A longitudinal study to identify important preschool predictors of elementary school reading success found that specific pre-reading skills such as knowledge of print (knowing letter names), phonological awareness (being able to rhyme), and writing (being able to print one's name) were strong predictors of reading success well into elementary school.[16] Using an intentional curriculum in mathematics is effective as well—especially when it helps children understand how to verbalize basic mathematical methods used to solve every day problems.
- *Emphasizes active engagement:* Successful early learning occurs when both teachers and children are actively engaged. The challenge for teachers is to help children to think, explore, talk about concepts, and practice new skills.
- *Includes attention to social and regulatory skills:* Research on early brain development and the impact of a child's earliest relationships and experiences makes it clear that children who have strong social, emotional, and behavioral skills are more successful in the classroom. An intentional curriculum addresses both social and regulatory skills in addition to academic skills. It also focuses on

promoting a warm and nurturing classroom climate and encouraging interactions between teachers, children, and their peers.

- *Responsive to cultural diversity and English language learners:* An intentional curriculum should be responsive to cultural diversity and children with limited English proficiency. Research has found that high quality bilingual preschool programs—those in which teachers use children's first language at least part of the time—promoted development in both languages rather than impeding growth in the first language.[17] Other studies have found that teaching academic skills such as reading in the first language is more effective in terms of second language achievement than simply immersing children in English.[18]
- *Not teacher-proof:* It is important to recognize that a curriculum itself, however rich in activities and conceptual understanding of how young children learn, is simply a tool in the hands of a teacher. Even the best curriculum can be implemented poorly, while a talented teacher can make up for a poor curriculum.
- *Requires new ways to measure classroom quality, teacher effectiveness, and student progress:* One of the consequences of the recognition of the importance of an intentional curriculum is the need measure how well teachers *teach* an intentional curriculum. Structural variables, usually defined and monitored by state licensing regulations and national accreditation systems, are typically used as proxies for quality. A second measure of quality looks at the "process variables" of teaching. These include things like the actual experiences of teachers and children in classrooms, teacher and child interactions in social, emotional, and instructional areas, and how well teachers are teaching the content-linked aspects of the curriculum. Both measures should be used in evaluation.

3. **Parental involvement:** School-based early childhood programs have shown to be very effective in increasing school readiness and active learning in children. However, behaviors and concepts learned at school need to be reinforced at home so they can be retained over time. If an early childhood program does not involve the community and the families of the children in the program, long-term changes will be difficult to achieve and sustain in both children and their parents.

   Early childhood, preschool, and kindergarten programs that train parents to work with their children at home tend to have significant, positive effects. Longitudinal studies have confirmed there is a significant relationship between parents' involvement in their children's lives and reduced delinquency.[19] Children's grades and ratings from teachers tend to improve the longer their parents are involved in the program, and they make greater gains than children whose parents are not involved in the program. The studies that compared levels of involvement found that achievement increased directly with the extent to which parents were engaged in the program. Children from all family backgrounds and income levels made gains. In some cases, the children having the most difficulty in school made the greatest gains. To be effective, the form of involvement should be focused on improving achievement and be designed to engage families and students in developing specific knowledge and skills.[20]

Some strategies that can be used to increase parental involvement include:

1. *Get the parents involved in the learning/school process early in a child's life:* Establishing a relationship between parents and the learning process early in a child's academic career will help parents stay more connected to and better understand the school district model as the child progresses. A local example of program that makes these connections early in a child's life is Guadalupe Schools. In the school's home-based preschool program, six parent educators visit families with children ages birth to three. During the weekly hour-long visits, educators work collaboratively with parents on basic child development, health, nutrition, activities to stimulate learning, and topics of parents' choosing.[21]
2. *Give parents an active role and responsibility in the process:* Allowing parents to sit on school boards and other committees increases and retains their involvement in their child's educational career. A local example of a program that implements this model is Neighborhood House. At Neighborhood House, parents sit on the board and therefore have say in how the program is built. This also encourages them to take responsibility for their child's program.
3. *Better understand cultural relationships:* Programs need to provide a culturally comfortable center for parents that helps ease them into the educational system. This is true for both low-income and immigrant/refugee families. Parent involvement programs that are most effective in engaging diverse families recognize, respect, and address cultural and class differences.[22]
4. *Build trusting relationships with the parents, family, and children:* Parents can be very sensitive to "experts" telling them what is best for their children. They are much more receptive to information if it is presented by a culturally-competent community member or advocate with whom they have an established and trusted relationship. Effective programs that engage families and communities embrace a philosophy of partnership. The responsibility for children's educational development should be a collaborative enterprise among parents, school staff, and community members. Afterschool programs and community centers are examples of organizations that have built such relationships with parents and children.[23]
5. *Increase awareness of the importance of early childhood education through social marketing campaigns and neighborhood connections:* A review of the literature found that lack of awareness of early learning opportunities and traditional ideas about the importance of educating young children are two of the greatest barriers to children having early learning opportunities.[24] Social marketing campaigns—especially those with direct grassroots community involvement—can increase awareness of the importance of early childhood education, as well as the awareness of the different educational opportunities.[25] Social marketing campaigns are also a great starting point for developing an early childhood initiative. Targeting low-risk individuals (those who just need referrals, resources, tools, classes, etc.) helps build grassroots level support for continuing the program and raising the necessary money to target high-risk individuals.

4. **Support services for the child and family, including health and nutrition services and parent workforce supports (comprehensive programs):** For young children from families experiencing significant adversity, two-generation programs that simultaneously provide direct support for parents and high-quality, center-based care and education for their children can have positive impacts on both. Some of the best-known early childhood evaluation research studied programs that provided a combination of services for children and parents. These include the High/Scope Perry Preschool Project, the Infant Health and Development Program, Early Head Start, and Head Start. Each of these programs has been associated with producing positive long-term child outcomes.[26] While available research does not tell what mixture of program components best meets the needs of particular families and children, it is suggested that offering a mix of health and nutrition services and parent workforce development supports produce positive outcomes.

   Health and nutrition services: Given the multitude of preventable threats to brain architecture early in life, high-quality health care and adequate nutrition before birth (for pregnant women) and after birth (for both the primary caregiver and baby) are fundamental to the promotion of healthy child development. Providing access to affordable health services (including mental health care) is, therefore, one of the most effective policies available for reducing prenatal and early childhood health impairments.[27] Continuing these services through age eight increases the probability the child will remain in good health and maintain healthy eating habits throughout their life.

   Parent workforce supports: For families living under the poverty level, work-based income supplements for working parents have been shown to boost the achievement of some young children. Studies suggest that these benefits are most likely to occur in the later preschool years. Policy options available for those who wish to pursue this strategy include expanded income tax credits for low-income families, welfare reform policies that provide more money for low-income parents who are working, and employment support programs that reward full-time work with wage supplements for working parents with dependent children.[28]

   The Early Head Start national evaluation tested a two-generation model that provided intensive family support services (including assistance with parenting, child health promotion, and guidance in formulating parents' own life goals) with services provided directly to children (through center-based child care or during child-focused home visits) from the prenatal period to age three. A 17-site experimental evaluation reported small positive effects when the children were 36 months of age.[29] These effects included multiple domains of improved cognitive, social, and emotional development, as well as several areas of parenting and economic self-sufficiency.[30] The strongest positive effects on parents and children were found in programs that mixed center- and home-based services, those that implemented the Head Start Performance Standards early, those that enrolled parents during pregnancy, and those serving children in families at medium levels of risk as defined by demographic characteristics.[31]

Early Childhood Comprehensive Systems

An alternative to providing support services directly through a program is to coordinate them though an early childhood comprehensive system. An early childhood comprehensive system supports families and communities in their development of children who are healthy and ready to learn when entering school. Its purpose is to promote positive development and improved health outcomes by creating a culturally responsive, comprehensive, and accessible service delivery system that links service providers, empowers families, and engages communities.[32] Components of a system often include a medical home, mental health services, early childhood care and education, and family support and education. A permanent guidance structure provides oversight of a comprehensive, integrated service system for young children prenatal to age eight. Local and regional partnerships between parents, health and social services, early care and learning programs, elementary schools, local boards, and organizations ensure continuity of quality, comprehensive services for young children and their families.

Example of a large scale early childhood comprehensive system: Early childhood partners in Colorado embrace the vision of a comprehensive, connected network of early learning, health, mental health, family support services, and parent education resources in order to impact positive outcomes for young children and their families. This collective vision is illustrated in the Early Childhood Colorado Framework. The framework defines common outcomes for private and public, state and local partners and facilitates planning, policy change, program creation or expansion, and financial investment.[33]

The framework focuses on four primary areas: 1) early learning; 2) family support and parent education; 3) social, emotional, and mental health; and 4) health. The framework focuses on outcomes that increase access, quality, and equity for young children.[34] In terms of early learning, one of the outcomes the framework plans to achieve is increased availability of formal education and professional development opportunities for early childhood professionals. Another outcome is increased number of programs that are accredited and/or quality rated. In terms of family support and parent education, an example of one of the outcomes is increased availability and family use of high quality parenting/child development information, services, and supports. In terms of social, emotional, and mental health, one of the outcomes is increased availability and use of high quality social, emotional, and mental health training. In terms of health, some of the outcomes include increased access to preventive oral and medical health care and increased number of children who receive a Medical Home approach.

The framework uses a results-based approach to link the foundation of systems work to strategies for actions in order to obtain Colorado's overarching goal of "all children are valued, healthy, and thriving." For example, one outcome the framework hopes to achieve is decreased gaps in school readiness and academic achievement between populations of children. In order to achieve this goal, the framework identifies measurable state indicators and baselines, such as achievement gaps for 4th and 5th grade students scoring proficient or advanced on reading tests by population (low-income, minority, and special education students). The state then develops strategies, with

detailed actions, to achieve this goal and produce measureable outcomes. These strategies are based in the foundation of the framework, which includes 1) building and supporting partnerships, 2) obtaining funding and investments; 3) generating education and leadership opportunities, 4) changing policy, 5) building public engagement, and 6) sharing accountability.[35]

The Lieutenant Governor's Early Childhood Leadership Commission led the development of the framework and specific efforts are still being coordinated through the Lieutenant Governor's office. The state has taken the lead role in providing oversight of Colorado's comprehensive, integrated service system. However, it works closely with teachers, administrators, public and private organizations, and community leaders who share the same goals outlined in the framework.

Example of a small scale early childhood coordinating system: An example of a local program that helps coordinate early childhood services is "Help Me Grow," a specialized 2-1-1 program sponsored by Partners for Infants and Children and the United Way of Utah County. The core of the program is its "infoline," a call center that connects parents with children from birth to age eight to community services through a comprehensive database of all community resources in Utah County. It provides parents, healthcare providers, educators, and anyone else in the community with a single point of access to multiple resources and services for children.

As part of the infoline, Help Me Grow utilizes a monitoring system of referrals and follow-up to ensure that parents using the program will be referred to community resources that best fit their situation. The program hires professional staff that is trained to provide quality and knowledgeable service to their clients. Through the monitoring system, staff acts as case managers, helping direct clients to correct community resources and providing them with information and application assistance.

Help Me Grow also provides families with access to a screening tool called the Ages and Stages Questionnaire (ASQ). This national questionnaire is a low-cost assessment tool used by parents for early detection of developmental delays in communication, gross motor skills, fine motor skills, problem solving, and personal/social skills. Parents who utilize the ASQ receive a blank questionnaire from Help Me Grow. Parents answer the questions and then send the questionnaire back to Help Me Grow in the provided envelope. Help Me Grow staff scores the questionnaire and send the results to both the parents as well as to the child's pediatrician. Parents also receive a packet containing appropriate resources relating to the child's diagnosis.

By using the tool, parents better understand their child's strengths and weaknesses. Understanding their children's developmental needs also allows them to become stronger advocates for their children. Because of its proven effectiveness and low cost, Help Me Grow is looking to extend the use of the ASQ to both medical homes and childcare providers (with assistance from the Department of Workforce Services).

5. **Home visitations:** Home visiting programs are an especially useful tool for impacting change in children from birth to age three. While most families successfully adapt to the challenges of preparing for a newborn's birth and caring for a young baby, this transition can be a difficult time, particularly for first-time parents who may be socially isolated or experiencing severe adversity or stress. Under such circumstances, home visiting services can provide critical support and have positive impacts on a variety of outcomes.[36]

   Home visits can be used to link parents to community services such as health and mental health, child abuse and neglect prevention, and early care and education services. They can also be used to help parents learn appropriate expectations for each stage in their child's development as well as involve parents in activities with their children that encourage learning.[37] For example, the Parent-Child Home Program (PCHP) in South Carolina was a two-year home-based program for low-income parents and their two- and three-year old children who were at risk for educational disadvantage. Home visitors provide twice-weekly play sessions with parents and their children, showing them a curriculum of conceptual verbal interaction and demonstrating other positive parenting techniques.[38] An evaluation of the program found participants scored higher on 1st grade school readiness tests, outperforming all 1st graders in South Carolina.

   Not every home visiting program, however, has proven to be equally effective. It should be noted that in terms of early childhood education, programs that couple home visitation with a high quality preschool program tend to produce better long-term results. Few consistent impacts on child outcomes have been found in studies of low-intensity home visiting programs, services provided by poorly trained visitors, and programs with relatively low levels of family engagement.[39] A study reviewing the characteristics of home visiting programs found that those serving targeted populations (parents with mental health or substance abuse problems, parents experiencing high levels of conflict or violence, parents at risk for child maltreatment, or rural families) were more likely to have measurable benefits.[40] It was also found that home visitation was more likely to be successful when provided by well-trained and adequately supervised professional staff who implement a range of services, guided by clear goals, and who are successful in engaging families with frequent visits for the duration of the program.[41]

   Nurse Family Partnership: The home visiting program with the strongest evidence of success, which has been replicated in multiple settings across the country, is the model introduced by the Nurse Family Partnership. This program provides home visits by trained nurses, starting in the second trimester before birth (although some families begin services later in the prenatal period). The relatively high intensity of this service model (roughly 50 visits from the prenatal period to age two, with weekly visits at the beginning of the program and immediately after birth) differentiates it from other home-based services. Visits focus on improving pregnancy outcomes, enhancing child health and development through improvements in parenting and access to health care, and enhancing the mother's life course by facilitating goals in education, employment, and partner/family involvement. The downside to the program is that it is extremely expensive to implement, with costs ranging from $7,200 to $9,100 per child.[42]

United Way of Utah County has found a way to provide a low-cost home visiting program through the use of volunteers. Their Welcome Baby Program (part of Success by Six) uses experienced mothers and grandmothers to visit first-time mothers who request visits. These mothers generally don't need medical assistance, but simply need access to resources and experiences. The mothers and grandmothers who provide the visits are trained volunteers. Currently the program has 50-100 volunteers who visit around 200 families on a monthly basis. The benefit of the Welcome Baby Program is that by focusing on low-risk mothers it is a low-cost alternative to the Nurse Family Partnership program. It also acts as a referral resource to the Nurse Family Partnership program by indentifying families who would benefit from a more rigorous home visiting program.

6. **Year-round access:** As mentioned above, school-based early childhood programs have proven to be very effective in increasing school readiness and active learning in children. However, long-term changes are difficult to achieve if behaviors and concepts learned at school are not reinforced year-round—particularly after school and during summer vacation.[43] Summer and after-school programs can help fill the gaps in public school schedules, especially for low-income children who may not receive family support and reinforcement at home.

7. **Trained/certified teachers in early childhood development:** Research has shown that the most successful early childhood education programs are those with teachers who have at least a bachelor's degree (B.A.) in education.[44] Reviews of early childhood research that have looked at the relationship between teacher education and quality child care have found that the presence of a B.A.-level teacher with specialized training in early childhood education leads to better outcomes for young children.[45] For example, findings from the Cost, Quality, and Outcomes study suggest that teachers with a B.A. or A.A. (associate's) degree in early childhood education or a related field have better structured and higher quality classrooms.[46]

   Several national and local programs have established goals of only hiring teachers with a bachelors degree in early childhood development, or a related field, by 2015 (Head Start) or 2020 (Neighborhood House). However, it is important to note that inadequate funding is a major barrier to both attracting and retaining quality teachers. Programs that pay early childhood education teachers a salary equal to, or slightly above, local public school teachers experience the best teacher-retention rates.

8. **Professional development:** Not only do successful programs hire teachers with at least a B.A. in education, but they provide teachers with many contact hours of in-service, program-specific training and place a strong emphasis on teachers' ongoing learning.[47] In terms of professional development, programs should first make sure that teachers are provided with both the time and the resources to reflect on what the students are learning in order to find ways to improve their teaching practice.[48] As mentioned above, high-quality early education curricula should be designed in a way that is responsive to the needs of the specific children, families, and community in which the program is located. Teachers have to be able to adapt and tailor their curricula to ensure their students are learning and maintaining appropriate concepts in the classroom.[49]

Ongoing interaction with other early childhood educators about how to improve one's teaching practice is also beneficial. In-service, credit or noncredit professional development has the potential to improve the skills and knowledge of the early childhood workforce. Yet, while state policies require that teachers attain specific amounts of in-service training, merely participating in any activity labeled as "professional development" may not lead to improved knowledge or practice. For example, those new to the field might first need access to training that provides basic knowledge of standards and expectations for teaching and caring for young children.

Whether teachers are new or more experienced, professional development should be situated within their daily work, rather than being a top-down mandate with little relevance to their current needs. Training opportunities should also be linked to each other and provide opportunities for continued learning through ongoing conversations and coaching.[50] These conversations have the potential to increase teachers' creativity and improve teaching quality.

9. **Assessment and evaluation:** A necessary component of any early childhood program is assessment and evaluation, including establishing measurable standards and collecting and evaluating outcome data. Turning successful model interventions into effective, single- or multi-site programs is a formidable challenge that can be somewhat mitigated by establishing quality standards and monitoring service delivery on a routine basis. Successful large-scale programs typically hire outside organizations to provide rigorous assessment and periodic monitoring of the quality of individual implementation sites as well as provide training and technical assistance for continuous quality improvement.[51]

   Part of this assessment and evaluation includes establishing instruments for measuring child development. To be most effective, instruments should be based on common standards and, therefore, comparable to other measures, especially to measures used by similar program sites. The instruments should also be able to track individual children from birth to 3rd grade—and potentially beyond. Longitudinal data produce the best outcomes and can lead to very persuasive arguments for continuing a program.

   Currently, there is a wide array of tools, tests, and observational assessments used to measure a child's development at different ages that have been well validated through research. Some are designed to measure a specific aspect of child development (social and emotional, language, physical, etc.) and others are multi-dimensional in scope. In general, most of the available assessment instruments have been developed for purposes related to the individual child's education: 1) for screening for participation in specific programs; 2) for diagnosis of special needs or gifts and subsequent specialized instruction or treatment; or 3) for assistance in general school and classroom instruction.[52]

   Recognizing that assessments are needed, but must also be appropriately designed and applied to serve the purposes for which they are intended, the Early Childhood Assessments Resource Group of the National Education Goals Panel established a set of

principles that should guide both policies and practices for the assessment of young children. These principles include:[53]

- Assessments should be tailored to a specific purpose and should be reliable, valid, and fair for that purpose.
- Assessment policies should be designed recognizing that reliability and validity of assessments increase with children's age.
- Assessments should be age appropriate in both content and the method of data collection.
- Assessment should bring about benefits for children.
- Assessments should be linguistically appropriate, recognizing that to some extent all assessments are measures of language.
- Parents should be a valued source of assessment information, as well as an audience for assessment results.

The group also made the following conclusions about using assessments for program evaluation and monitoring trends:[54]

- Beginning at age five, it is possible to provide a reliable assessment of child learning outcomes on an aggregate basis.
- Such large scale assessment data must meet high standards of technical accuracy.
- Methods, such as a matrix sampling (a statistical technique where each participating child takes only part of the total assessment), can be employed as a safeguard against the inappropriate use of assessment information.
- Child assessments should be augmented by demographic characteristics (especially first- and second-language status, age, and pre-school experience).

10. **Affordability:** Families with modest incomes (under $60,000) have the least access to preschool education.[55] For four-year olds, participation in preschool is lowest for families with annual incomes between $20,000 and $40,000. It is slightly higher for families with incomes less than $20,000, likely due to the positive effects of Head Start. Four-year-old enrollment rises sharply for families with incomes of $60,000 or more; reaching nearly 90% for families with annual incomes more than $100,000.[56] A review of the literature found cost to be one of the greatest barriers to individuals having early learning opportunities. For example, a national survey conducted by the Tomas Rivera Policy Institute found affordability to be one of the most common reasons given as to why Latino parents do not enroll their children in early learning programs.[57] In order to be effective, early childhood education programs must be affordable to low-income and high-risk families in the community.

11. **Public/private partnerships:** Public/private partnerships are beneficial because they bring together diverse resources, perspectives, and expertise that can inform state priorities to build public awareness of the importance of early childhood development

and improve the quality and availability of early education programs. In terms of early childhood education, the private sector has a vested interest in supporting the development of a competent and globally competitive workforce, which begins by ensuring the developmental needs of young children are met. Investing in early childhood development also aligns with the publics' broader philanthropic agenda to promote quality education and, in doing so, support children, families, and communities.[58]

The goal of all early childhood partnerships should be to leverage resources and expertise to increase the quality and availability of programs and services provided to children from birth to age eight. Although private resources are not intended to supplant public investment in the healthy development and school readiness of young children, these resources can be used to increase action and innovation. Current public commitments to partnerships range from $1 million to more than $200 million annually. Likewise, private and philanthropic investments in partnerships range from $2 million to more than $30 million annually.[59] Typically, most of the resources are allocated through community grants to pursue locally identified initiatives that align with the state-level mission.

Through grants, training, and technical assistance, partnerships can improve the quality or availability of early childhood programs by pursuing one or more of these objectives:[60]

- Provide flexible funding for locally identified needs, such as improving early care education programs, increasing access to health services, or providing professional development opportunities for early childhood practitioners.
- Build the state and local infrastructure needed to coordinate an early childhood system across the state.
- Increase public awareness and outreach efforts to engage the public and educate parents on the importance of early childhood.
- Promote best practices and bring promising models of high-quality programs to scale at the local state or community level.

Examples of Public/Private Partnerships: Connecticut and Oklahoma

Philanthropic leaders in Connecticut conducted a scan of current investments, documenting more than $75 million in private and philanthropic funds allocated to early childhood programs and services. Using the results, state, private, and philanthropic leaders developed a plan to align current investments to the priorities of the Connecticut Early Childhood Education Cabinet's Early Childhood Investment Framework. A leading Connecticut philanthropy, the William Caspar Graustein Memorial Fund, proposed a public-private matching plan to the state cabinet, which subsequently voted to allocate $1.25 million in new state funds to leverage $800,000 in additional philanthropic investments. Funds are used to support local capacity building and enhance the state's Parent Trust Fund, which provides funding to train parents in civic leadership. Connecticut's state and philanthropic leaders continue to explore avenues for further collaboration, which may include new formal structures for managing public and philanthropic resources.[61]

For several decades, Oklahoma's public and private leaders have championed early childhood education through partnerships. These champions, both in the private work of early childhood and the public, have become nationally recognized experts who have successfully advocated for and implemented a model public-private partnership the state legislature has now adopted as the Early Childhood Pilot Project for birth to four-year-olds. During the 2006 legislative session, Oklahoma appropriated funds to the state education department for a new public-private early childhood pilot program for infants and toddlers. The state committed up to $5 million in funding in the first year to match $10 million from private and philanthropic sources. In 2007, the state appropriated $10 million, with a $15 million private-sector match. The Oklahoma Department of Education, which oversees implementation of the state's universal pre-kindergarten program through local school districts, contracted with the Community Action Project of Tulsa County to roll out the infant-toddler pilot program statewide. Smart Start Oklahoma, a 29-member nonprofit partnership organization, is providing project coordination and technical assistance. The pilot model allows for nationally accredited childcare providers to expand their slots for infants and children up to age four for low-income families, with state money earmarked for operating expenses and private funding directed to capital costs. In the first year of operation, 1,200 slots were added, 150 classrooms were added, and 15 community providers were working in 20 communities.[62]

Mixed Delivery Systems

Expanding upon the private/public partnership theory, many states deliver early childhood education through mixed delivery systems that include both schools and community- based settings. These settings may include privately operated child care and federally funded Head Start providers, among others. States may contract directly with these providers or may allow schools or other entities to subcontract with them to provide pre-kindergarten programs.[63] The benefits of the mixed delivery system include:

1. *It breaks down the traditional barriers between early education and childcare policies:* Successful involvement of childcare centers in pre-kindergarten initiatives promotes collaboration among schools, childcare providers, and other early care and education programs, enabling them to take advantage of the expertise each partner brings and to make effective use of early childhood resources.[64] For example, in many communities, schools simply do not have the space to provide pre-kindergarten classes. Communities may find it more efficient to invest resources in existing childcare centers that have experience working with young children than to add a new early childhood program to schools. This is especially true if the centers already offer high-quality programs that meet state pre-kindergarten requirements.[65]
2. *It addresses the needs of children in working families in a coordinated way:* State-funded pre-kindergarten programs are typically not structured around the schedules of parents who need full-day, full-year services for their children. Most state pre-kindergarten programs are only funded for a part-day schedule—sometimes as little as two-and-a-half or three hours a day—and only during the school year.[66] While not every family needs a full-day, full-year pre-kindergarten

opportunity, it is important that families who do need such programs have quality options. Offering pre-kindergarten in a childcare center provides full-day, full-year programs at a single location.

3. *It strengthens the quality of community-based childcare programs by requiring them to meet high early education program standards and pairing them with additional resources, supports, technical assistance, and monitoring:* Providing pre-kindergarten in childcare centers can also inject needed resources into childcare programs and help sustain and enhance the quality of these programs. Offering a pre-kindergarten program can help sustain a center by: 1) bringing in new children; and 2) providing a stable source of funding for children already enrolled in the center. Pre-kindergarten programs can enhance the quality of a center as well by providing new resources and requiring the center meet state pre-kindergarten standards that are generally stronger than state childcare licensing requirements. Finally, participation in pre-kindergarten can benefit children in the entire center, including infants and toddlers.
4. *It allows for the braiding of available funds:* Private dollars spent on early childhood education programs can be counted in the state's total amount considered for federal match dollars. Mixed delivery systems leverage private and philanthropic dollars to increase the amount of federal funds the state can obtain and redirect toward early childhood programs and initiatives.

12. **Birth to eight initiatives:** Early nurturing and learning experiences from birth to age eight greatly impact success in school, college, career, and life. Brain architecture is constructed through an ongoing process that begins at birth. Early experiences affect the quality of that architecture by establishing either a sturdy or fragile foundation for learning. For example, income disparities in cognitive outcomes emerge at nine months and are more distinct by 24 months. By the time they enter kindergarten, children from low-income families are typically 12-24 months below national norms in language and pre-reading skills.[67] Starting early childhood interventions at an early age reduces the effects of social and economic influences that cause developmental delay in children.

    Aligning the curriculum in early childhood programs from birth to age eight creates seamless transitions between each stage in the child's development. This in turn improves information and program retention, which increases kindergarten readiness and provides the child with the tools they need to achieve success. It also improves parental involvement in the program and the child's life by helping parents understand each stage of their child's development.

13. **Address vulnerable populations:** As mentioned above, research has found that programs serving targeted populations (vulnerable neighborhoods, disinvested neighborhoods, or poor, immigrant, and minority communities) were more likely to have measurable benefits and long-lasting effects. Because children in these neighborhoods face the greatest challenges, both on an individual child and on a collective neighborhood basis, these are the populations that need and benefit most from early childhood interventions.[68]

Young children in vulnerable neighborhoods need access to both professional services and community supports in order to identify and provide early intervention for special healthcare needs and/or learning delays and disabilities. Parents also may need professional services to address issues that can compromise their capacity to care for their children (depression and other mental conditions, substance abuse, or lack of education/skills necessary for obtaining an adequately paying job). Many of these issues relate to community rebuilding in general, but they have special implications for young children's development and school readiness.

As indicated above, building an early learning system to ensure that all children start school "ready to learn" must start from a different base in vulnerable neighborhoods. It requires building an infrastructure of supports that may be taken for granted within the larger community. This includes:[69]

- Creating places, spaces, and opportunities for young children, as well as their parents and other adults, to enrich their language and literacy.
- Broadening the roles, responsibilities, and capacities of caregivers and professional service systems to provide developmental support to young children as part of their work.
- Reducing the distance between the culture of professionals and service providers serving the neighborhood and the culture of the neighborhoods they serve.
- Giving parents and residents the opportunity to have a voice and a hand in designing that system in their neighborhoods and communities.

Fortunately, building this infrastructure of supports does not require separate and distinct efforts to create spaces and opportunities, build community capacity to support child development, and create more developmentally appropriate neighborhood-based services. In fact, this infrastructure works best if it is connected and integrated through a family support center. While the term family support defies neat categorization, "family support centers" generally are envisioned as warm and welcoming places where families with young children can congregate, receive support and information about parenting and child development, organize activities for themselves and others, get help in accessing needed services, and advocate for community needs. They are designed to be embedded within the neighborhoods they serve, usually with governing boards that include center parents and neighborhood residents. Often, the centers hire personnel from within the community and provide staff development and career opportunities.

Centers can offer an array of interconnected services, designed specifically for the needs of the neighborhood. For example, depending on physical capacity, centers may house child care, pre-school, or Head Start programs. They can serve as community places for WIC (Women, Infant, and Children) nutritional counseling sessions and for other public programs and professional services. Centers usually do significant community outreach, including home visiting to parents not yet able or ready to engage in center-based activities. Family support centers are similar to early childhood comprehensive systems,

except all the services are coordinated within one center, rather than through a separate agency that coordinates the services offered by multiple centers.[70]

As a side note, United Way of Utah County is interested in promoting the implementation of a kindergarten assessment tool, the Early Development Index (EDI). This index is based on five domains, targeting 18 points within each domain. More importantly, however, the EDI is population based and can be used to determine areas or neighborhoods in the community that have a high rate of at-risk children. This tool can be used by organizations to select the location of community programs and services. Two University of Utah physicians are interested in piloting this project in Salt Lake and can help provide funding and support for districts willing to participate.[71]

14. **Public awareness:** As mentioned above, increasing public awareness is an important part of building support for early childhood initiatives. A review of the literature found that lack of awareness of early learning opportunities and traditional ideas about the importance of educating young children are two of the greatest barriers to children having early learning opportunities.[72] Social marketing campaigns—especially those with direct grassroots community involvement—can increase awareness of the importance of early childhood education, as well as the awareness of different educational opportunities.[73]

    The *PNC Grow Up Great* initiative is one example of how the business sector can be involved in increasing awareness for early childhood investments. This initiative, launched in September 2003 by The PNC Financial Services Group, Inc., is a ten-year, $100-million program to improve school readiness for children from birth to age five. The PNC initiative encompasses several components, including investing in direct services to disadvantaged children, developing and disseminating information about child development and school readiness through television and print media, promoting employee volunteerism in programs serving children from birth to age five, supporting objective research on the costs and benefits of early childhood programs, and advocating for increased access to quality early childhood programs.

    PNC has partnered with Sesame Workshop, the producers of *Sesame Street*, and Family Communications, Inc., the producers of *Mr. Rogers' Neighborhood*, to develop content for the initiative. The entire effort is guided by a 12-member advisory council of experts in the early childhood field. In *PNC Grow Up Great's* first year, $950,000 in grants was provided to selected early childhood programs in PNC's service area (Delaware, Indiana, Kentucky, New Jersey, Ohio, and Pennsylvania).[74]

    Another example of how the business sector can be used to increase public awareness is the Minnesota School Readiness Business Advisory Council (MSRBAC); established by Ready 4 K, MSRBAC emphasizes awareness around early childhood development issues, identifies and promotes best practices in the workplace, and impacts public policy. The primary purpose of the council is to encourage the involvement of businesses in addressing school readiness for pre-kindergarten children. MSRBAC also helps raise money and awareness of the importance of early childhood education through marketing campaigns developed in conjunction with the Minnesota Early Learning Foundation

(MELF). Created through a partnership of foundation, corporate and civic leaders, MELF was established in 2005 to address growing concerns about the lack of school readiness among many children entering kindergarten. Its mission is to recommend cost-effective strategies to prepare children for success in kindergarten by evaluating non-traditional, market-driven approaches to improving both the quality of early learning programs and access to those programs.[75]

Barriers Specific to Utah's Culture

As mentioned during the June 2010 Education Change Council, Utah's culture has and may continue to deter the implementation of early childhood education programs because of the resonating idea that early childhood education should be the responsibility of the parents and therefore taken care of in the home. This concept is reinforced by the limited amount of funding dedicated to early childhood education in the state.

In order to overcome this barrier, several steps need to be taken. First is to increase the awareness of the importance of early childhood education through a rigorous social marking campaign. Both residents and legislators need to be aware that early learning experiences from birth to age five greatly impact success in school, college, career, and life—and that because of the growing diversity in the state, not all families have the opportunity to provide these experiences at home. The vernacular used to address early childhood experiences needs to change from "child care" to "child development."[76]

Second, legislators need to understand that investing in early childhood programs is a fiscally conservative idea. Quality early childhood education programs have shown to improve school readiness in the short run and decrease crime, teen pregnancy, delinquency, substance abuse, and welfare dependency in the long run.[77] Early childhood education programs also reduce the number of children in remedial education, which saves money spent on special education. An analysis of early education shows the cost savings from reducing the need for special education range from $2,000 to $8,000 per child.[78] The cost savings from reducing grade retention range from $200 to $800 per child. Currently, only 2% of Title I dollars are spent on preschool. Redirecting federal funds to preschool would save the state more money in the long run and have a bigger impact on the economy.

Third is changing the focus of the Department of Education and school districts to include preschool and other early learning opportunities. This may be difficult because school district superintendents and principals have to direct so much of their time and energy to helping students meet state and federal academic standards. Because putting money and time into preschool has no immediate effect on 3rd grade test scores, superintendents and principals may be hesitant to change the current system.[79]

Models

Family Relationship Model

Since the original design of the Head Start program in 1965, the concept of providing support for low-income parents in conjunction with high-quality, center-based care and educational experiences for their children has been the base of many programs. For example, UWSL's Community Learning Centers (CLC) build partnerships between schools and community programs to provide resources to both students and their families with the objective of empowering and supporting parents. The integrated focus on academics, services, supports, and opportunities leads to improved student learning, stronger families, and healthier communities. Evaluations of CLCs show significant improvements in student achievement and behavior, community involvement, and access to needed services. The rationale for this blended approach is to focus broadly on the environment within which young children develop as well as to strengthen the aspects associated with improved cognitive, linguistic, social, emotional, and health outcomes for children who are at risk for problems.[80]

While high quality preschool programs have proven to be very effective tools in increasing school readiness, programs that couple intentional instruction with family-based support services have produced positive long-term child outcomes in multiple areas. This is because they target intervention at both the child and the child's environment—namely the child's parents and family. Research suggests that environmental change is critical to support and maintain individual change.[81] Using a comprehensive approach to early childhood education makes the changes needed at the family and community level to support a child's educational success.

Efforts to build a strong foundation of early learning from birth to age eight for children should reach across the individual to the family and social networks, organizations, broader community, and even government agencies. The family relationship model is based on the understanding that early childhood education includes not only educational activities, but also advocacy, organizational change, policy development, economic supports, environmental change, and multi-method strategies. Multiple leverage points affect early childhood development, and the family relationship model attempts to influence as many of these leverage points as possible.

Several approaches can be used in designing a program based on the family relationship model. Comprehensive programs, early childhood comprehensive systems, home visitation, and even mixed delivery systems all fit into the family relationship model. This is because these programs either directly offer support services to children and their families or connect children and their families to other programs that offer such services. Support services generally include, but are not limited to health and nutrition services, parent education, and parent workforce supports.

Descriptions and examples of these programs and systems are provided above. Because comprehensive programs, those which offer support services directly through the program, have been studied the longest and have the most recorded success, three examples of programs using this approach are detailed below. An example of a local high-quality preschool which maximizes funding through the braiding of public and private dollars is also given.

Examples of Comprehensive Early Childhood Programs

The Chicago Child-Parent Centers (CPC) – Chicago, IL
Average annual cost per child: $6,692

Funded by Title I, CPC first opened in 1967 with four sites in the city's poorest neighborhoods. Today there are 24 centers, each serving approximately 100 to 150 three to five year olds. CPCs include a pre-k program for three and four year olds, a full-day kindergarten program, and at some sites, a school-age program lasting through third grade (age nine). CPC is a high-quality pre-k program that features: 1) teachers with bachelor's degrees and certifications in early childhood education who are paid on par with K-12 teachers; 2) small child-adult ratios (17:2); 3) a curriculum based in early reading and math skills; and 4) a parent-resource teacher and a school-community representative that conduct home visits and provide referral, health, and nutrition services.[82] The preschool program runs three hours per day, five days a week during the nine month school year and usually includes a six-week summer program.[83]

In each center, teachers work with a lead teacher, who is responsible for the curriculum, as well as with the principal of the elementary school to implement the center's learning goals by selecting the curriculum materials and by designing activities for the children (as part of the school system, CPCs are administrative centers housed in separate buildings or in wings of their parent elementary school). In creating the curriculum, the staff also draws on the best of other early childhood model programs, including High/Scope, Bank Street College, Direction Instruction activities, Peabody Development Kits and the Chicago EARLY learning activities.[84]

CPC also hosts an intensive parent program that includes parent room activities, volunteering in classrooms, attending school trips, and completing high school.[85] At least one-half day of parent involvement in the center is required per week. The full-time parent-resource teacher organizes a parent room within the center to implement parent educational activities, initiate interactions among parents, and foster parent-child interactions.[86]

The full-time non-instructional school-community representative provides outreach services to families in three related areas. First, they identify families in the neighborhood who are in most educational need. They make door-to-door visits of likely participants, distribute brochures and advertisements of enrollment, and communicate in formal and informal ways. Second, the school-community representative conducts a home or school visit with all enrolled families and children. One visit upon enrollment in the program is required. Additional visits occur on an in-need basis. Multiple informal conferences are also held between parents and the school-community representative. Finally, the school-community representative mobilizes resources by referring families to service agencies that offer employment training, mental health services, and welfare services. Transportation services are provided by CPCs to children and parents.

Upon entry into the program, children undergo a health screening from a registered on-site nurse. Tests are given for vision and hearing. Parents are expected to provide records of their child's immunization history. Special medical and educational services such as speech therapy also are available. All children receive free breakfasts and lunches while in the program.[87] Eligibility for CPCs is based primarily on neighborhood poverty.

Analyses of the CPC program have found that its students have experienced reductions in special education and grade retention relative to non-center students. CPC students also had higher reading and math achievement scores through ninth grade than children in comparison groups. Center students were less likely to commit serious criminal and violent offenses as well. Finally, students had higher rates of high school graduation at ages 20 and 22 than the comparison group.[88] In general, participation in two years of CPC pre-K was associated with improved school readiness, kindergarten achievement, lower grade retention and special education-placement rates (especially in the early grades), and reduced child abuse and neglect.[89]

An analysis done by Pre-K Now in 2007 found the average cost per child at CPC was $6,692.[90] Another evaluation of the program found that for every $1 investment, $7.14 was recouped in terms of total benefits.[91] The largest proportion of the benefits was obtained by society, in the form of medium-term and long-term cost-savings (such as reducing the incidence of special education, preventing grade repetition, reducing crime, and decreasing welfare dependency). CPC was also the most effective program in terms of short-term child outcomes as evaluated by the RAND Corporation. The program achieved significant child outcomes in cognitive achievement, behavioral/emotional development, education, child maltreatment, and crime (teen delinquency and arrests).[92]

The High/Scope Perry Preschool Program (Perry) – Ypsilanti, MI
Average annual cost per child: $8,540

The Perry program provided high quality preschool and home visits to 58 low-income three and four year old African American children from 1962-1967. The program was funded by the Ford Foundation and the U.S. Administration of Children, Youth and Families.[93] It is the longest-running longitudinal study of a pre-k program. One hundred twenty three African American three and four year olds with significant risk factors (poverty, low parental education and initially low IQs) took part in the study, with 58 of them participating in the preschool program. The remaining 65 received no preschool.

The program was a high-quality, two-year, center-based program. Classes were held for 2.5 hours each day, five days a week for nine months a year. It used a curriculum that took an active learning approach to children's intellectual, social, and physical development, focusing on a plan-do-review routine (the High/Scope Curriculum is used nationwide in many early childhood initiatives, including some Head Start programs). The plan-do-review routine encourages children to plan their own learning activities. Children were offered a materials-rich environment to implement these activities and had to report on results afterwards. The role of the adult was basically that of guidance and support. The curriculum emphasized language and literacy, social relations and initiation, movement, music, classification, numbers, space, and time. Small groups were used to develop closer relationships between the teacher and the child (the teacher plans the materials but allows children to choose how to use them). Classes also held circle time where the whole class met together with an adult for about 15 minutes to play games, sing or exercise.[94]

The program included teachers trained in both special education and early childhood development and had a child-teacher ratio lower than 7:1. Most of the teachers in the Perry Preschool Project had bachelor's degrees in education. They were paid regular public school teacher salaries plus a 10% bonus for participating in this special program.[95]

Additional components of the Perry program targeted a number of the early childhood risk factors associated with later delinquency and other behavioral problems. In addition to directly reinforcing early developmental processes in the educational setting, the program strengthened positive parenting skills. The High/Scope Educational Research Foundation explains the effectiveness of the Perry model in terms of empowerment, which includes developing skills for success by enabling children to be active and independent learners, helping parents to support the development of their children, and providing teachers with effective training and support.[96]

Because an ongoing home-school relationship enhances socialization, involving parents early in the educational process was critical to the later success of participants in the Perry Program. Teachers in the program conducted weekly home visits for each student that lasted 1.5 hours each. Additional parent meetings were also held for further family support. The weekly visits involved the child and the parents in discussion and modeling of the child's activities in the classroom. Monthly group meetings helped parents to understand their children's development and abilities. The focus was on helping parents to provide the necessary supports for their child to develop intellectually, socially and physically.[97] Weekly home visits by teachers and regular parent group meetings promoted the strengthening of parent-child relationships and increased parent involvement in the educational process.[98]

Longitudinal studies of the life outcomes of the children who participated in the program show gains made with respect to IQ, educational achievement, and high school graduation. Participants had significantly higher scores on intelligence and language tests through age seven as well as higher school-achievement test scores at age 14 compared to the control group. Through their entire K-12 careers, program participants were less likely to need special education services and more likely to complete high school than the control group. At age 40, program participants were more likely to be employed and to earn significantly more than the control group. Participants were half as likely as the control group to be arrested; they had fewer arrests for violent, property, or drug crimes and were less likely to be sentenced to prison. Program participants were also less likely to be on welfare.[99] Half as many of the preschool group was receiving public assistance at age 27 compared to the control group.

The program was relatively expensive; an average of $15,166 per child or $8,540 per child per year. The program was also highly targeted, which could limit its applicability to large public programs with wide-ranging accessibility.[100] Another evaluation of the program found that for every $1 investment, $2.54-$8.74 was recouped in terms of total benefits over the life of the students.[101] The largest proportion of the benefits was obtained by society in the form of medium-term and long-term cost-savings such as reducing crime and decreasing welfare dependency. The Perry Program was the most effective program in terms of long-term adult outcomes as evaluated by the RAND Corporation. The program achieved significant child outcomes in educational attainment, employment and earnings, social services use, and crime.[102]

Educare Centers – Chicago, IL
Average annual cost per child: $13,000 (minimum)

Educare is a full-day, year-round school that serves low-income, distressed environment children from birth to five years. It is a fairly new program, with the first site opening in 2000. Building on the foundations of Early Head Start and Head Start, Educare promotes school readiness by implementing proven programming aimed at preventing the achievement gap from taking root in the early years. Central to Educare's mission is family involvement that strengthens parents' abilities to serve as champions for their child's learning from infancy through their primary and secondary school educations.[103]

The Educare model draws on a unique blend of private and public dollars, including child care, Early Head Start, Head Start, state funding streams, parent copayments, and private sector support. The funding sources come from a partnership that includes: 1) a philanthropic partner (for example, the Buffet Early Childhood Fund) that leads the privately funded Educare capital campaign, engages other funders, and hires evaluators; 2) a program partner, typically a Head Start/Early Head Start provider, that implements the core components of the Educare model; and 3) a public schools partner to provide operating dollars, land, and other support.[104] Each partner shares governance of the Educare school and signs legally binding Educare contracts and agreements to solidify their work together.

Educare centers serve between 100 and 200 children and their families by offering a full-day, year-round educational program for children birth to age five. The program emphasizes both small class sizes and high staff-child ratios. Infant-toddler rooms have a maximum of eight children and a minimum of three adults in each classroom (ratio of 8:3). Preschool rooms have a maximum of 17 children and minimum of three adults in each classroom (ratio of 17:3). Auxiliary staff (floaters/permanent substitutes) is available to maintain ratios and support participation in professional development activities.

By developing partnerships with local school districts, colleges and universities, and the state and federal government (through Head Start and Early Head Start), Educare centers hire highly qualified staff, pay them competitive wages, and support their professional development. Each classroom teacher has a bachelor's degree in early childhood education or its equivalent, while Assistant Teachers have an associate's degree in early childhood education and Teacher Aides have courses or credentials in child development or child care. Master Teachers have advanced degrees in early childhood education and teachers in Infant-Toddler classrooms have special experience/training in infancy. Other support staff, Family Support Supervisors and Family Support Specialists, has master's degrees in social work or its equivalent.

Educare's curriculum centers on: 1) language and literacy; 2) problem-solving and numeracy; and 3) social-emotional development. Educare staff provides children with rich language experiences in the classroom that develop early literacy skills and increase their vocabulary. The staff also encourages and supports parents in helping their children acquire language and literacy skills. The Educare model recognizes that children best learn language, both at school and at home, when they experience shared focus and interactions with responsive parents, teachers, and other caregivers. Intentional emphasis on problem-solving and numeracy skills is also included

curriculum through individual child strength plans, family partnership agreements, weekly lesson plans, as well as small groups and individualized interactions. In terms of social-emotional development, Educare staff receives training and consultation to help meet children's emotional needs in the classroom and parents identify and address their children's emotional and behavioral needs. The program uses age-appropriate tools to screen and assess the social-emotional development of all children from birth to age five. The results of these assessments are addressed during each family/child review, parent/staff conference, and home visit.

There is also a strong focus on providing continuity of care at Educare. Children attending Educare centers stay with the same teachers for the first three years of life and then again in the preschool classrooms. A primary caregiver is assigned to each child and small groups are assigned to each primary caregiver (no more than four infants/toddlers or nine preschoolers are assigned to each caregiver). This "continuity of care" helps children form healthy, secure attachments to adults and caregivers. Educare schools are also typically built in close proximity to public elementary schools to encourage this continuity of care.

To best address the needs of each child and family, the Educare model uses an interdisciplinary team approach in which staff members and consultants collaborate to provide early childhood care and education, health, nutritional, social, and other services to all children, including those with special needs. Support services offered vary by site, but examples include nutritious food service, a health clinic for children, and parental supports to help parents transition from welfare to work and overcome threats to health and safety. Believing a child's needs are best addressed in the context of the family, Educare centers also provide on-site family support services during program hours. The Educare model employs a child-centered and family-focused approach to services where parents are involved in all aspects of the child's education including assessment, service plan development, and service delivery. Finally, in many Educare centers, specially trained home visitors, begin working with families during pregnancy. The family support and teaching staff then continue to provide support to the children and families throughout the child's first five years of life.

Children from the areas in which Educare centers are located typically score well below the national average and are developmentally several months behind their more advantaged peers. School readiness scores of kindergarten-bound Educare children, however, average 96.7—nearing the national average of 100.[105] Evaluation data consistently show Educare children demonstrate improved vocabulary skills, improved literacy, and better school preparation on standardized tests commonly used to measure school readiness. Test scores for children who have benefited from the Educare model match national averages for all children, regardless of income level or other risk factors. At the two longest running schools, between half and almost all Educare children entering kindergarten met pre-literacy skill criteria for their age.[106]

It is important to note that children who begin the Educare program earlier in life tend to score better on measures of school readiness. For example, kindergarten-bound children who joined Educare between birth and two years exceeded the national average by 9 points. This pattern persists even after controlling for risk factors such as maternal education, race, and teen parent status.[107] In terms of social and emotional development, Educare graduates are also half as likely as other low-income children to demonstrate behavioral problems in kindergarten.

Annual budgets at Educare schools range from $2.6 to $3.6 million, with variance by geographic region and the number of children and families served. This calculates to a minimum average cost of $13,000 per child per year, making it a relatively expensive program. The higher costs likely reflect the fact that program provides targeted intervention for five years of a child's life, including infants and toddlers, and that it is a full-day, year-round program.

Example of a Local High-Quality Preschool

Granite School District's Title I Preschool Program (GSD) – Salt Lake City, UT
Average annual cost per child: $1,500

The GSD Preschool Program is a high quality educational program serving over 3,000 students in regular educational and special education settings in 43 schools across the Salt Lake Valley. Of these schools, 31 are eligible for Title I funding based on the rates of National School Lunch eligibility. Eighteen of these 31 schools receive Title I funding to help children in preschool through grade six. Overall, the preschool is funded through federal Title I and Special Education funds, sliding scale tuition co-pays, registration fees, grants, and private donations (1,100 children attend Title I classrooms and 1,200 attend tuition-based classrooms—the remaining 700 are in special education).[108] By utilizing both public and private dollars, GSD maximizes funding and minimizes the cost to participate. The GSD Title I preschool program was designated a "Center of Excellence" by the U.S. Department of Education its first year of implementation.

In the half-day GSD program, three and four year olds are provided with a full-range of age appropriate instruction in early literacy, numeracy, and social-emotional, physical, and cognitive growth. It focuses on intentional and explicit teaching in whole and small group, with the emphasis placed on language and literacy development. Teachers focus on meeting standards that are aligned with kindergarten standards. Each classroom educates approximately 18 students with two full-time instructional staff, for a child to adult ratio of 9:1. Children's progress is assessed three times yearly (both curriculum-based assessments and individual growth and development indicator assessments).[109]

Additional support is provided by special education consultants, speech-language pathologists, and other supervisors who provide specialized instruction for children with disabilities as well as other children with special needs. Staff includes 24 special education teachers, 24 speech pathologists, three school nurses, a social worker, a school psychologist, an adaptive PE specialist, occupational and physical therapists, four coordinators, six instructional coaches, five network leaders, 140 regular education lead teachers and assistant teachers, 24 classroom assistants, and seven secretaries. The program also focuses on making family/home connections by providing families with information and services to help their children progress and learn.

The GSD program significantly reduced the school readiness gap in language arts between children in schools most impacted by poverty who attended preschool and children in schools least impacted by poverty. The mean score was 14% for those attending GSD and 17% for students least impacted by poverty. This compares to a mean score of 6% for children who did not attend preschool and are most impacted by poverty. Upon exiting kindergarten, there was no

difference in the mean language arts assessment scores between GSD students and students who attended schools with low rates of poverty. Similar gains were made in math; upon exiting kindergarten, GSD students scored comparably on the math assessment (85% correct) to students in the schools least impacted by poverty (88%).

Compared to other programs, the cost per child at GSD is low—average costs per year were $800 for each three year old and $1,500 for each four year old. This is due to the fact that it is a half-day program and that it does not have a parent center. However, another reason GSD is able to keep its costs so low is because it does not provide its teachers with benefits.

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[106] Educare, "Why Educare," http://www.educarecenters.org/pages/index.php?q=node/2.

[107] N. Yazejian and D. M. Bryant.

[108] Janis Dubno.

[109] Curriculum-based assessments test oral language/vocabulary, phonological awareness, alphabet knowledge, pre-writing, book knowledge/print awareness, math/numeracy concepts, social-emotional skills, and motor skills. Individual growth and development indicators focus on picture naming, alliteration, and rhyming.

Healthy Behaviors: How can one best change a population's unhealthy behaviors related to nutrition and exercise?

Strategies

Experts have summarized the ideal obesity prevention program as being multi-faceted.[1] Therefore, programs targeting healthy behaviors and reducing childhood obesity should use many elements to achieve success. The following is a list of a components that can be used in a program or part of a larger healthy behaviors initiative.[2]

1. **Health education:** Educating individuals and families about healthy living and nutrition can be done through social marketing campaigns, schools, and/or health clinics. An analysis of current programs revealed that programs based in schools and health clinics were helpful in reducing body fat, improving fitness, and reducing chronic disease factor levels, such as blood fat and blood pressure.[3] Health education generally includes a planned, sequential K-12 curriculum taught by qualified teachers that addresses the physical, mental, emotional and social dimensions of health. The comprehensive health education curriculum includes a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.
2. **Physical activity:** Participating in physical activity is an important factor in reducing and preventing obesity. Experts generally agree that dietary treatment of obesity alone is relatively ineffective and that obesity preventative strategies should emphasize increased physical activity as well.[4] Regular physical activity during childhood and adolescence is also associated with improvements in numerous physiological and psychological variables such as improved cardiovascular functioning and decreased risk for depression and anxiety. Populations shown to be at high risk for physical inactivity, such as minorities, individuals with low socioeconomic status, and children, should be the primary target of physical activity programs.
3. **Family support:** Involving program participants in the development of health behaviors programs is important to building and sustaining acceptance by children, families, and communities. The family, especially parents or primary care providers, strongly influence the nutritional habits of children during the formative years. It has been suggested that a child's weight is directly impacted through his/her family's food preferences as well as eating and activity patterns.[5] It has also been shown that programs with unmotivated children had dropout rates up to 87%.[6]
4. **Behavior modification:** Experts have found that good dietary and physical activity habits learned during early childhood and adolescence profoundly influence the development of adult obesity and the subsequent development of chronic disease that goes along with it.[7] Behavior modification is best started at a young age and can include promoting breastfeeding and educating children, and their primary care givers, about their dietary needs.[8] Some experts suggest that by age four children's propensity to eat a variety of foods begins to decline. If variety is not introduced during this time, life-long aversions to foods may develop.[9] Evidence has shown that childhood obesity has become

a serious problem by fifth grade, again reinforcing the need to target young children. Behavior modification interventions that include the development of self-control, stimulus control, and reinforcement interventions show positive immediate and long-term changes in physical activity, BMI, and dietary habits.[10]

5. **Improving access to healthy food choices and exercise in schools:** Access to a variety of nutritious meals that accommodate the health and nutrition needs of all students should be available in every school. School nutrition programs need to reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. Reducing the amount of competitive food available to children through school lunch and vending machines as well as integrating school food with nutrition education can have a positive effect on the dietary habits of children.[11]

   Improving access to healthy food choices can be achieved through several approaches: 1) establishing nutrition standards for competitive foods; 2) influencing food and beverage contracts; 3) making more healthful foods and beverages available; 4) adopting marketing techniques to promote healthful choices; 5) limiting student access to competitive foods; and 6) using fundraising activities and rewards that support student health.[12] While implementing any change is a multiple step process, most of these approaches can be accomplished through advocacy efforts involving parents and schools.

   School physical education is the societal institution with the best success and most responsibility for promoting physical activity in youth.[13] For many children, especially minorities and lower income groups, schools provide the only safe place for regular physical activity. However, there is evidence that school-based physical education is not adequately filling this role—partly due to limited school budgets as well as priority placed on devoting school hours to class time in order to meet academic standards.[14] Less than 5% of the nation's high schools require daily physical education and less than 30% of high school youth participate in daily physical education. Even in schools that do require daily physical education, most students are inactive over 50% of the class time.[15]

   Increasing the amount of physical activity available at school not only helps change students' attitudes toward physical activity, but it has a positive effect on academic achievement as well.[16] School-based physical education should include a planned, sequential K-12 curriculum taught by qualified teachers that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills, physical fitness, dance, games, sports, tumbling, and, when possible, aquatics.[17]

6. **Rewards/incentives:** Both long-term and intermediate rewards can be used to provide program participants with the incentive to participate in a healthy behaviors program. Small rewards given for intermediate outcomes achieved provide tangible positive feedback to participants. This in turn can improve program retention, especially for participants who have multiple barriers to healthy living. A larger reward given at completion of the program can also improve retention and increase participant morale. Some examples of common rewards include water bottles, T-shirts, or money.

7. **Social marketing:** An effective way to increase community awareness and acceptance of healthy behaviors is through social marketing campaigns. Effective campaigns focus on harm caused by products or unhealthy choices, but do not stigmatize individuals.[18] Campaigns should also intentionally target specific high risk samples of the community.[19]

A multiple method recruitment strategy, targeting all high-risk groups, is needed otherwise only certain segments of the community will participate. Culturally relevant messages are also necessary to maximize effectiveness.[20]

An example of a local social marking campaign is the IHC LiVe Public Service Campaign. The LiVe public service campaign is designed to fight childhood obesity and includes an interactive website, school assemblies for 6th through 9th grades, sponsorship of events that promote physical activity, humorous educational advertisements, and informational offerings for kids, teens, and their parents. The interactive LiVe website, which is available in both English and Spanish, contains helpful materials for parents and children, posters and brochures to download, as well as games that teach kids about living a healthy lifestyle. The school assembly program, *LiVe —This is Your Life!,* is a research-driven, thought-provoking, humorous show that helps adolescents take charge of their lives to grow up healthy and fit. The show addresses adolescent obesity, eating disorders, body image, and unhealthy media messages. Finally, the LiVe campaign partners with local businesses to promote healthy living. An example of this type of partnership is the Park Farther Project, in which businesses mark certain parking stalls with the LiVe logo to encourage people to park farther from their office building.

8. **Evaluation:** Programs need to be evaluated and outcome driven to determine if the health gains are present and can be sustained over time. They should also follow program participants for more than a year to better understand what components and strategies work best in reducing obesity over time.[21]

Models

When evaluating the various models used to improve healthy behaviors and reduce childhood obesity in a particular community, two models stand out as best practices: the Ecological Approach and School Based Programs. These models are not necessarily mutually exclusive, but represent different starting points to developing healthy behaviors programs—one starting with the broader community and working inward and one starting within a school and working outward to reach the community.

Ecological Model

An ecological approach focuses on making the changes needed at the community level to support healthy eating and active living. Although a child's individual health behaviors play a major role in their propensity for obesity, multiple environments surround a child and affect a child's weight status.[22] The combined effect of society, family, and individual factors intensify the causes of obesity.[23] Research suggests that environmental change is critical to support and maintain individual change.[24] The potential to change and maintain that progress in public health issues, such as childhood obesity, can be realized only when it is implemented broadly with adequate resources.[25]

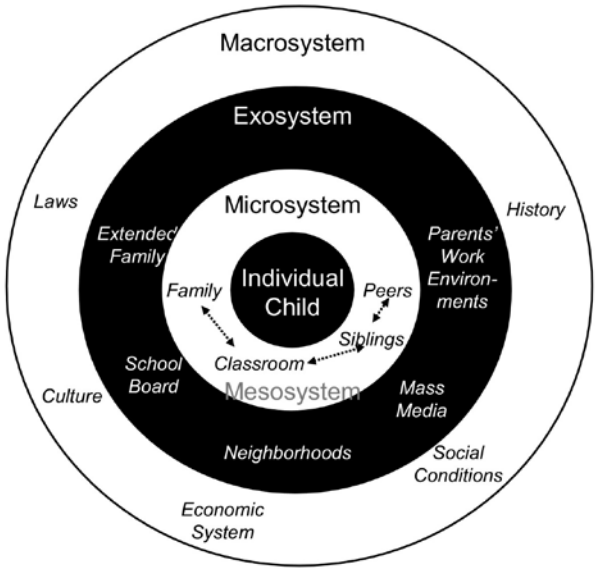
According to the Institute of Medicine's 2007 report, "Progress in Preventing Childhood Obesity: How Do We Measure Up?" greater success in reducing childhood obesity occurs when public, private, and voluntary organizations combine endeavors, share resources, and create

coordinated, sustained efforts. In the best case scenario, these efforts reach across the individual to the family and social networks, organizations, the broader community, and even government agencies.[26] Using an ecological approach to program development ensures there are community representation at all program levels by using social relationships in families, schools, neighborhoods, and communities to target intervention.

The Ecological Model is a theoretical model that focuses on both individual and social environmental factors as targets for health promotion interventions. It generally starts at the broad community level by dividing the possible sources of influence into different types of environments nested within the others. For example, the individual child is surrounded most immediately by various microsystem environments. These are the immediate environments with which a child interacts (parents, siblings, teachers, peers, etc.). The mesosystem is the relationships that exist between the various microsystems; such as the relations that parents have with a child's siblings and teachers that can affect the target child. The exosystem includes environments with which the child doesn't usually directly interact, but that can still affect the child. These include decisions made by school boards, the opportunities present at the parents' workplaces, etc. The macrosystem includes the broad societal settings under which the others function. These include shared culture, history, or customs, the system of laws, and the economic system. The mass media are often placed at the exosystem level.[27]

The model is based on the understanding that health promotion includes not only educational activities but also advocacy, organizational change, policy development, economic supports, environmental change, and multi-method strategies. Utilizing the Ecological Model requires one to look across a community to determine environments that affect a child's behavior from child care and schools to faith-based organizations and legislative bodies.[28] It also proposes that there are multiple leverage points that may be important in modifying nutrition and physical activity behavior.[29] The model suggests that change is maximized by influencing as many of these leverage points as possible.

Figure 1: Bronfenbrenner's Ecological Model describing the set of nested environmental influences on a child.



School Based Programs

As mentioned above, studies have shown that programs based in schools and health clinics were helpful in reducing body fat, improving fitness, and reducing chronic disease factor levels. The Centers for Disease Control and Prevention (CDC) has identified ten key strategies schools can use to help staff adopt healthy eating and physical activity behaviors.[30] Strategies one through four focus on building a strong foundation. These strategies will help schools develop a tailored approach that meets their specific, local needs and interests, earn the support and commitment of the school community, use the insights gained from scientific research, and emphasize teamwork and collaboration to maximize effectiveness and efficiency. Strategies five through ten focuses on taking action.

Build a Strong Foundation

1. *Address physical activity and nutrition through a Coordinated School Health Program (CSHP):* Eight components that strongly influence student health and learning are involved in a typical CSHP. These components already exist in most schools and include: 1) health education; 2) physical education; 3) counseling, psychological, and social services, 4) health services, 5) nutrition services, 6) healthy school environments, 7) parent community involvement, and 8) staff wellness.

   CSHPs focus on improving the quality of each of these components and expanding collaboration among the people responsible for them. This coordination leads to a planned, organized, and comprehensive set of courses, services, policies, and interventions that meet the health and safety needs of all students. CSHPs provide a systematic approach to promoting student health and learning that emphasizes four areas: 1) assessing programs and policies; 2) planning based on data, sound science, and analysis of gaps and redundancies in school health programming; 3) establishing goals; and 4) evaluation.

2. *Designate a school health coordinator and maintain an active school health council:* Establishing a school health council (SHC) is an effective way to achieve a permanent focus on promoting physical activity and healthy eating. SHCs can be responsible for a number of tasks, from helping schools meet federal and state health-related guidelines to establishing a local school wellness policy.

   Comprising representatives from the home, school, and community, SHCs establish goals for the school health program and facilitate health programming in the school and between the school and the community. Guided by the SHC's vision, a school health coordinator manages and coordinates all school health policies, programs, activities, and resources. SHCs have helped create lasting changes in school environments such as the adoption of nutrition standards, the establishment of student and staff walking programs, the provision of adequate class time for physical education and health education, and the opening of school facilities for after-school physical activity programs.[31]

3. *Assess the school's health policies and programs and develop a plan for improvements:* Self-assessment and planning provide structure to a coordinated school health program. The self-assessment describes where the program is now and the plan provides the destination and directions to get there. A school health plan is most likely to be effective when it is based on a systematic analysis of existing policies and practices, guided by

insights from research, and developed by a school health council that includes teachers, parents, school administrators, students, and the community.

4. *Strengthen the school's nutrition and physical activity policies:* School policies can dictate how often students attend physical education, which items go into school vending machines, which topics and skills are taught in health education, which foods are served in the cafeteria, and more. School policies directly affect students' opportunities for physical activity and healthy eating and can support the implementation of all other strategies listed above.[32]

Take Action

5. *Implement a high-quality health promotion program for school staff:* Staff wellness programs provide opportunities for school staff members to participate in health assessments, nutrition classes, physical activity programs, and other health promotion activities. These opportunities can contribute to improvements in physical and mental health outcomes, increases in morale, productivity, and positive role modeling, and decreases in absenteeism and health insurance costs.[33]
6. *Implement a high-quality course of study in health education:* Health education provides formal opportunities for students to acquire knowledge and learn essential life skills that can foster physical activity and healthy eating. Taught by qualified teachers, quality health education includes instruction on topics that protect and promote physical, social, and emotional health and safety and provides students with ample opportunities to practice health-enhancing skills. State-of-the-art health education features a sequential curriculum consistent with state or national standards and adequate instructional time.
7. *Implement a high-quality course of study in physical education:* Physical education is the cornerstone of a comprehensive approach to promoting physical activity through schools. All students, from pre-kindergarten through grade 12, should participate in quality physical education classes every school day. Physical education not only provides opportunities for students to be active during the school day, but also helps them develop the knowledge, attitudes, skills, behaviors, and confidence to be physically active for life.
8. *Increase opportunities for students to engage in physical activity:* The school setting offers multiple opportunities for all students, not just those who are athletically inclined, to enjoy physical activity outside of physical education classes; for example, walking to and from school, enjoying recess, physical activity clubs and intramural sports programs, and having classroom lessons that incorporate physical activities. These opportunities help students learn how to weave physical activity into their daily routines.
9. *Implement a quality school meals program:* Millions of students eat one or two meals that are provided as part of the federally funded school meals program each day. These meals have a substantial impact on the nutritional quality of students' overall dietary intake and provide a valuable opportunity for students to learn about good nutrition. It is imperative to ensure these meals are safe, nutritious, and balanced.
10. *Ensure that students have appealing, healthy choices in foods and beverages offered outside of the school meals program:* Most schools offer foods and beverages to students through a variety of channels outside of the federally regulated school meals program; for example, vending machines, school stores, concession stands, after-school programs,

fundraising campaigns, and class parties. These offerings have dramatically increased student access to high-fat or high-sodium snacks and non-nutritious, high-calorie beverages. Although federal regulations on these foods and beverages are limited, many states, school districts, and schools are establishing strong policies and innovative marketing practices to promote the sale of healthier foods and beverages.

There are two main drawbacks to school-based programs. First, if the program does not involve the community and the families of the children, long-term changes will be difficult to achieve. Behaviors learned at school need to be reinforced at home so they can be retained after school and during summer vacation. The results of school-based programs aimed at preventing childhood obesity demonstrated that schools may be a good setting for promoting healthy lifestyles in children, but these programs require follow-up in other social environments in order to be effective.[34] Effective school-based programs are long-lasting, multi-faceted, and sustainable. They should be developed through an ecological approach that is behaviorally focused and targets the children's family, community, and environment.

The second drawback to school-based programs is that it can be difficult for community partners to obtain the support of school administrators to implement these programs. Schools operate with limited resources and time. Because students are required to meet strict academic levels, principals and teachers may find the thought of including additional programs and curriculum in their schedules overwhelming. Navigating the bureaucracy associated with school districts can be difficult for community partners as well. Each school district operates under its own set of rules and guidelines, and therefore must be approached separately.[35]

Examples of Ecological Approaches

Switch what you Do, View, and Chew (Switch) – Minneapolis, MN
Average annual cost per student: $40

Switch what you Do, View, and Chew was designed and implemented by the National Institute on Media and the Family.[36] The program is a community, school, and family-based intervention aimed at modifying key behaviors related to childhood obesity in 3rd through 5th graders.[37] It utilizes the social ecological model, which emphasizes the fact that an individual's eating and physical behavior is determined by their social/personal interactions and the moderating environmental influences.

The primary objective of the program is to target key behaviors related to obesity—physical activity, screen time, and healthful eating by promoting a healthy lifestyle through positively influencing three types of factors: personal, behavioral, and environmental. A secondary objective is to reduce the occurrence of excessive weight gain. In order to achieve these objectives the program uses two strategies: 1) increase community awareness and knowledge about preventing childhood obesity through public education; 2) provide specific interventions to families with school support. Switch program designers decided to make families the program's main target, rather than schools, since parents serve as a gate-keeper role in influencing their children's physical activity opportunities and access to food. Because obesity runs in families,

they felt it may be unrealistic to intervene at the student level while the students' family members are modeling and supporting behaviors that counter the intervention's effectiveness.

The Switch pilot project was organized into four sequential phases. During the first phase of the program, each child and their parents established a baseline that identified their current health behavior practices and evaluated their attitudes and feelings towards making a change in the three key components (Do, View, and Chew). Once families identified their current practices they established long term and short-term goals that fit within their lifestyle.

The second phase of the program focused on making incremental changes reinforced by self-rewards. The ultimate Do, View, and Chew goals were to: 1) be active for 60 minutes or more per day; 2) limit screen time to two hours or less per day; and 3) eat five fruits/vegetables or more per day. Each change in behavior towards reaching a self-identified goal was rewarded with goal points or activity points. To receive points, children and families engaged in Switch activities; making healthy fruit and vegetable recipes, using the activity jar to increase physical activity, and utilizing the screen time box to keep track of time spent in front of the television, video games, and computers. The child recorded his or her physical activity, screen time, and fruit and vegetable consumption on a daily basis. Once the weekly tracker was completed and returned to the classroom, the child was rewarded with appropriate incentives.

The participating school teachers were provided with materials and ideas/examples on ways to include the core concepts for the three key health behaviors across existing curriculum. For example, students could graph pedometer steps in math, evaluate caloric intake in science, and create a "Top 10" list of things to do besides screen time in language arts. Supplemental worksheet activities also gave teachers tools to reinforce these concepts during the week. However, it is important to understand that 1) although teachers were provided with the opportunity to integrate some of the ideas into their classroom, it was up to them to choose whether to do so; and 2) Switch is not a school-based curriculum.

While some researchers would argue this participatory approach may limit the effectiveness of the program, those who analyzed the program found it to be beneficial. Most previous school-based interventions have utilized tight controls to ensure uniform implementation, but these require frequent staff training and ongoing support. That approach is costly and limits sustainability. The Switch approach was to standardize recommendations to communities, teachers, and parents but to allow flexibility in how the materials were used. Other studies have demonstrated that this participatory approach has advantages for long-term sustainability.[38]

The third phase of the program was designed to make it easier for families to plan meals, make healthy snacks, and include healthy fruits and vegetables in shopping by providing mealtime and shopping planners. As families made changes they became more health conscious and eager to make further changes. The fourth phase of the Switch program focused on maintenance of the health behaviors families established. To encourage changes and promote maintenance, each family received monthly packets which included new materials for both the child and the parents. The materials provided in these packets included: 1) a printed brochure describing the project and highlighting the timeline (the eight months school year); 2) a printed calendar for the month to help motivate, remind, and track progress on screen time, activity, and nutrition goals;

3) a packet of screen time tickets and a box for the child/parent to track their screen time; 4) an activity jar with tips for increasing physical activity; 5) a meal planner which the families could plan meals and make grocery lists; and 6) recipes that focused on increasing fruits and vegetables in creative and enticing ways for children. Families were also provided with *Switch trackers* which allowed families to track their Do, View, and Chew goals on a daily basis.

A total of 1,359 children were enrolled in the program. The primary outcome measures used to evaluate the effectiveness of the intervention included pedometer-assessed physical activity, self-reported screen time, and self-reported fruit and vegetable consumption. These self-reported activities were recorded in a *Switch Point Tracking Log*.

The program's *Community Awareness Strategy* consisted of a public education intervention to increase the targeted communities' overall awareness and knowledge about preventing childhood obesity. The first phase of the project established a coalition of community leaders to give the project high visibility and to advocate for and sustain the project. The leadership group included leaders and project grantors from education, health care, government, business, and the faith communities. The following is an outline of the coalition's activities:

- Launch the project with a community wide event sponsored by coalition members and organizations.
- Launch a public service advertising campaign in local newspapers and media outlets.
- Produce/distribute posters to all types of organizations in the participating school district.
- Provide printed materials in community and private family practice and pediatric clinics.
- Offer public education/training workshops for parents, teachers, healthcare providers, religious leaders, and business leaders in the community at large.
- Offer employee presentations to employers in the community.
- Add the project web page to granting organizations websites.
- Provide information to local newspapers for monthly columns and features.
- Solicit local businesses to provide incentives and supporting events throughout the project timeline.
- Sponsor "Switch Days," which provide students and families with opportunities to engage in community activities centered on the three goals. Examples of activities include swimming, scavenger hunts at local grocery stores, and roller skating.
- Provide public education to existing groups of parents, educators, school boards, etc.

Measured outcomes from the Switch program reveal its interventions have resulted in positive outcome. Switch participants had about two hours less TV time per week than non-participants, an effect that was maintained at six months post-intervention. There were significant increases in fruits and vegetable consumption, which were also maintained at six months post-intervention. Child-participants accumulated about 350 more steps per day of physical activity than non-participants. However, at both post-intervention (eight months after program inception) and six month post-intervention, the mean BMI values were not significantly different between the

treatment and control groups.[39] Positive outcomes have also been seen in terms of parental support of the program. Recent surveys from the Switch program implemented in Cedar Rapids showed that 95% of parents liked the program and wanted it to be continued by the schools. They felt it provided them with positive tools to reinforce healthy behaviors at home.

A key challenge in the Switch project was to document and track the extent to which children, parents, and teachers utilized the specific strategies that were provided. Other studies have reported challenges in getting families to maintain participation in school and/or community projects, especially low-income families. Most large-scale, prevention-based interventions targeting families have generally been ineffective because of this limitation.[40]

The cost to implement the Switch program in schools is about $40 per student. This cost includes all materials, resources, and incentives provided to teachers, students, and parents. However, the program recently moved from the Institute on Media and the Family and is now being implemented through the Search Institute based in Minneapolis, MN. The Search Institute is currently working on reducing costs by moving part of the program online.

Shape Up Somerville (SUS) – Somerville, MA
Start-up costs (over a four year period): $4,320,000

Funded by the Centers for Disease Control and Prevention, "Shape Up Somerville: Eat Smart. Play Hard" was a three-year (2002-2005), environmental change intervention designed to prevent obesity in culturally diverse, high-risk, early-elementary school children. Led by Dr. Christina Economos, the Shape Up team developed and implemented strategies designed to create energy balance for 1st through 3rd graders in Somerville, MA.[41] In before, during, and after-school environments, interventions were focused on increasing the number of physical activity options available to children throughout the day and on improving dietary choices. Below is a description of each of the interventions that comprised Shape Up Somerville, many of which still continue today.

School Food Service: Around 65% of students in the Somerville area are eligible for free/reduced meals. Because of this, Shape Up Somerville worked with the Somerville School Food Service Department to enhance the quality and quantity of healthy foods for students. The following is a list of activities that were included in this initiative:

- A fruit or vegetable was highlighted each month in all elementary schools and there were taste tests done during lunch periods at all schools. The children voted on whether or not they would like to have the featured fruits and vegetables on the monthly school menu.
- Colorful educational posters and tabletop tents were displayed around school cafeterias with nutrient and health information for all school staff to read.
- New kitchen preparation and serving equipment were purchased. Food service staff received training on nutrition education, knife skills, and food safety.
- New vegetarian recipes were developed and salads were made fresh each day.
- A la Carte items were changed to meet specific nutritional standards.

- Fresh fruit was made available everyday for breakfast and lunch.
- Ice cream was only available one day per week and sugared cereals were limited at breakfast.
- In 2005, the School Department received a federal grant that has allowed them to continue these initiatives and support a part-time nutritionist to develop new strategies within the Food Service Department.

HEAT Club in-school curriculum: Over ninety teachers were trained to implement a new, classroom-based health curriculum called The HEAT Club (Health Eating and Active Time). Each lesson focuses on one of four themes: increasing fruit, vegetable, whole grain, and low-fat dairy consumption, decreasing consumption of snacks high in saturated fat and sugar, increasing physical activity, and decreasing sedentary time (screen viewing). The curriculum also has a component called Cool Moves, which features creative ways to incorporate physical activity into the children's classroom hours. Art and Physical Education teachers and librarians received curriculum extensions, which allow teachers and children to extend the lessons and expand on the objectives in creative ways.

HEAT Club after-school curriculum: During the first intervention year, six after-school programs in Somerville were trained on cooking and nutrition education as well as how to use the HEAT Club After-School curriculum. The curriculum includes 26 lesson plans, which use crafts, cooking demonstrations, and physically active games as creative vehicles for education. Program sites received cooking and physical activity equipment and the program leaders were taught yoga, dance, and soccer skills. Each program had a field trip to Gaining Ground, an organic farm in Concord, MA where the children helped harvest crops to take home and donate to local food pantries and soup kitchens. In the second year of the intervention, all fourteen of Somerville's after-school programs were using the curriculum.

Parent and community outreach: Parents and community members were engaged in a variety of ways. Each month SUS sent home a parent newsletter to over 500 families and a community newsletter to over 200 community members. The newsletters contained updates on the project, health tips, and coupons for healthy foods. In addition to the newsletter, parents were reached out to through community events, local media outlets, and the Parent Teacher Association. Parent forums were held in English, Spanish, Portuguese, and Haitian Creole. The Shape Up team also served on several community coalitions that worked creatively toward sustaining the different interventions and sought out funding to support health initiatives. Finally, a healthy meeting guide, a physical activity guide, and a healthy snack list were posted on the School and City websites and continue to be updated annually.

Shape Up approved restaurants: Shape Up Somerville worked with restaurants across the city to enhance food options for people and families who eat out. In 2005, 21 restaurants were "Shape Up Approved," meaning they met the following criteria:

- Offered low fat dairy products and fruits and vegetables as side dishes.
- Offered some dishes in a smaller portion size.
- Had visible signs that highlighted healthier options.

Walkability/safe routes to school: A community walking committee was formed to guide the walking initiative for students. The committee submitted a grant to the Robert Wood Johnson Foundation and received funding through their Active Living by Design (ALbD) initiative in the summer of 2003. Together, the Shape Up team and the Somerville ALbD Partnership hired a Pedestrian/Bike Coordinator for the City and created Safe Routes to School (SR2S) maps using Geographic Informational System (GIS) for each school within a half-mile distance. The SR2S maps were distributed to all parents of 1st through 3rd graders and posted on the School and City's website. Other piloted initiatives included a walking school bus and a traffic calming campaign. Parents filled out walkability checklists and with that data pedestrian trainings were held to educate policy makers about the link between city planning and public health issues such as obesity. The Mayor authorized all crosswalks to be re-painted in thermoplastic material and bike racks were being installed at all elementary schools. The Somerville ALbD partnership still continues today and is working to extend the community bike path and to create open spaces and policies supporting pedestrians and bicyclists.

School Nurses/Pediatricians: All Somerville school nurses have been formally trained to collect height and weight on elementary school students each year, as well as how to approach and counsel families who have a child identified as being overweight or at-risk of being overweight. Over 50 local clinicians and the school nurses were also trained to use a new toolkit designed to assess and address obesity in children. The Somerville School Physician helped organize the 1st Annual Shape Up Somerville 5K in September of 2004.

Policy initiatives: Recognizing that childhood obesity can have serious negative health outcomes, the Somerville School Department has taken a leadership role in preventing childhood obesity. They are committed to making improvements in the areas of nutrition, physical activity, and nutrition education and have created new policies in each of these areas including the comprehensive 2006 Wellness Policy.

Other interventions/community results include:[42]

- Engaged 90 teachers in 100% of 1st through 3rd grade classrooms (N=81).
- Participated/conducted 100 community events.
- Held "Help 4 Parent" forums for non-English speakers.
- Increased walking to school by 5%.
- Reached 811 families through nine parent newsletters.
- Reached 353 partners through six community newsletters.
- Reached over 20,000 through a monthly media piece.
- Developed community-wide policies to promote and sustain change (Wellness Policy, Pedestrian Safety).

In 2003, Tufts researchers found that 46% of Somerville's 1st through 3rd grade population were at-risk of being overweight or were overweight. They used a BMI-for-age percentile score to report changes in weight gain among children who participated in the SUS intervention, as

compared to children in two socio-demographically similar communities in Massachusetts who did not receive the intervention. On average, SUS reduced approximately one pound of weight gain over eight months for an eight-year-old child. This may seem small for an individual, but on a population level this reduction in weight gain, observed through a decrease in BMI score, translates into large numbers of children moving out of the overweight category.

Assigning one cost the SUS program is difficult, because the program has benefited tremendously from "in-kind" resources, partners, and other environmental assets. For example, Tufts University, Harvard University, Boston University, and MIT all contributed significant research partners and resources, some of which came in the form of unpaid research support, interns, and use of academic research facilities. Furthermore, SUS did not start from a one time investment, but from a series of funding sources that were grant-based. Some of these grants provided "in-kind" resources and technical support systems, rather than dollars. For example, the program's five year grant from Robert Wood Johnson was for only $200,000, but the foundation provided at least that amount in training, support, and consulting services.

A snapshot of the financial support given to the SUS program in the first four years of its implementation was roughly $4.32 million. $1.5 million of this amount came from initial grants Chris Economos received to start the Shape Up Somerville work. The remaining $2.82 million was funding used to implement and maintain components of the program running year after year. Today, the operating costs associated with Shape Up Somerville are primarily related to program's coordinator and director, located within the City Health Department. There are other operating costs associated with food stamp outreach, equipment, and expenses for a grant writing team to seek outside funds. Extended partners also share project resources in the form of grants and funding support managed outside the Health Department.[43]

Tufts University recently completed a Shape Up Somerville replication study (the Balance Study). This replication study worked with three intervention communities, all of whom had a population of between 80,000 and 100,000. Overall, the cost to replicate the program at one intervention site was approximately $250,000 per year ($500,000 over a two year period). The costs broke down as follows:

- Tufts provided the communities $150,000 per year, for two years. This money supported a project manager as well as all program initiatives that the communities took on.
- Tufts provided $10,000 to the food service departments directly for equipment purchases and infrastructure improvements.
- Tufts provided the communities the opportunity to apply for an additional $10,000 "innovation" grant, which would seed some new innovative, sustainable initiatives.
- Tufts provided professional development trainings and curriculum books for 1st through 3rd grade teachers. This costs approximately $20,000 - $40,000 per year.
- The communities themselves committed $50,000 in kind donations (space, personnel time, supplies, etc.).

Examples of School Based Programs

Gold Medal Schools (GMS) – Utah Department of Health
Annual operating budget: $695,000

This multi-level program administered through the Department of Health assists elementary schools in promoting physical education, nutrition, and tobacco-use prevention. Through participation, schools can earn up to $1,500 for nutrition and physical education supplies or tobacco-use prevention resources. All public, private, or charter elementary schools in Utah are eligible to participate in this free program.

The Utah Department of Health developed the Gold Medal Schools™ (GMS) program in 2001 using the State Office of Education's core curriculum and the Centers for Disease Control's guidelines to address overweight and obesity in elementary schools. Today, GMS has reached more than 200,015 students and over 8,123 teachers in 374 elementary schools. GMS makes it possible for elementary schools to provide physical activity and healthy nutrition choices at a time when budget cuts and testing requirements overshadow physical activity and nutrition. GMS aims to improve students' academic success through policies and environmental changes that support good nutrition, physical activity, and staying tobacco-free.[44] The Department's current annual operating budget for GMS is around $695,000, which includes a mix of state and federal dollars.

Participating schools first designate a school coordinator who receives a $1,000 stipend from the Department of Health. The school coordinator, usually a school employee, works closely with the Department of Health and the school's principal to set goals that will meet GMS criteria, which are divided into five levels: Bronze, Silver, Gold, Platinum, and Platinum Focus. School coordinators also write policies, educate faculty and staff about GMS, help coordinate GMS assemblies, track the number of Gold Medal Miles walked, and increase awareness of Gold Medal School Program throughout the school. The Utah Department of Health provides multiple resources, including a non-food rewards book, a five minute energizer book, physical activity conversion charts, and tobacco-free signs to help schools reach their goals.[45]

Once a school's goals are set the school coordinator implements actions plans to achieve each goal. As the school achieves new levels, it continues to implement the criteria it completed in previous levels as well. This way by the time a school reaches the Platinum Focus level it will be implementing all GMS criteria from Bronze to Platinum Focus. This creates a comprehensive healthy school environment. Examples of criteria include establishing a Gold Medal Mile walking program on or around school grounds and setting a goal for each student to walk at least one mile each week; developing a policy for all teachers, faculty, and staff emphasizing that food is not to be used as a reward or as a punishment; and writing a comprehensive policy that mandates a tobacco-free school and offers smoking cessation support to its faculty. Complete lists of the criteria that must be met for each level are located in the Appendix.

Schools should implement Bronze through Gold levels in one to three years. The Platinum must be done by itself in a year and the Platinum Focus areas must also be completed by themselves in one year. As each school reaches each level, it will be awarded a cash prize. Bronze schools

receive $200, Silver schools receive $300, Gold schools receive $500, Platinum schools receive $300, and Platinum Focus schools can apply to receive a $200 grant, for a total of $1,500 if a school completes all the levels. This money can be used to purchase new physical education (PE) equipment, nutrition resources, or tobacco prevention materials.

Measurable success (both qualitative and quantitative) has been achieved by schools participating in the GMS program. For many schools, it is the number of subtle positive changes that have added up to make a big difference for the students and its school. For example, Academic Park Elementary in West Valley experienced test score, attendance, and behavior improvements. Attendance increased by 3.8%. Behavior improved as more grades started walking during morning recess, which meant fewer students were sent home with citations. CRT Test Scores of sixth graders also increased—Language Arts score increased from a 48% composite score to a 68% and Math scores increased from a 57% composite score to a 73%.

The drawback to the GMS program is that it is strictly a school based program. While resources are available to parents on the GMS website and one of the criteria is for the Parent Teacher Association to coordinate at least one health-related event per year that involves students, teachers, faculty, staff, and parents, the program focuses strictly on influencing children's behavior in school. While the program has had community partners in the past, there are no community partners currently involved in or contributing to the program.

Sports, Play, and Active Recreation for Kids (SPARK) – San Diego, CA
Cost per program: $2,699 (minimum cost for to purchase one program)

SPARK is a research-based, public health organization dedicated to creating, implementing, and evaluating programs that promote lifelong wellness. It strives to improve the health of children, adolescents, and adults by disseminating evidence-based Physical Education, After School, Early Childhood, and Coordinated School Health programs to teachers and recreation leaders serving Pre-K through 12th grade students. Each SPARK program fosters environmental and behavioral change by providing a coordinated package of highly active curriculum, on-site teacher training, extensive follow-up support, and content-matched equipment.[46]

SPARK offers ten research-based programs; four in physical education (grades K-2, 3-5, 6-8, and 9-12), four in Coordinated School Health (Ignite a Healthy Environment, Nutrition Services, Health Education, and Wellness for Staff), one for afterschool programs, and one for early childhood programs. These age-appropriate programs are designed target separate audiences, but they can be used together to provide a seamless sequence of information and activity for Pre-K through 12th grade. SPARK's physical education programs are aligned with national PE standards; however they are designed to be more inclusive and active than traditional PE classes.

SPARK's Coordination School Health (CSH) model is based on CDC's guidelines outlined in their Coordinated School Health Program.[47] It involves eight interactive components, including: 1) health education, 2) physical education; 3) health services; 4) nutrition services; 5) counseling and psychological services; 6) healthy school environments; 7) health promotion for staff; and 8) family/community involvement. SPARK CHC programs provide formative assessment, training,

and follow-up support of each of the eight areas listed above. Training includes information about best practices for creating an environment that supports healthy eating and physical activity, successful policies and protocols, ways to increase awareness and advocacy, ways to utilize the environment to teach/reinforce health and wellness behaviors, and skill building for making healthy choices a part of daily life.

When a school decides to implement a SPARK Program, they are provided with a coordinated package that includes a project coordinator, curriculum, on-site teacher training, content-matched equipment, assessment/evaluation, lifetime follow-up support, and SPARK teacher certifications. As soon as a school begins working with SPARK, they are assigned a Project Coordinator (PC). The SPARK PC serves as a single point of contact and manages all the daily concerns related to the project, including staffing trainers, workshop site logistics, and timely delivery of manuals, materials, and equipment. Every aspect of the program is overseen by the SPARK staff.

The SPARK program provides a coordinated package of curriculum, training, content-matched equipment, and extensive follow up. All SPARK curricula are presented in three-ring binders and are designed to be practical and effective for all physical education/activity providers. On-site teacher training are hosted by SPARK staff and are designed to meet the needs of the host school. SPARK also hosts yearly seminars for each of its programs as well as advanced training seminars for elementary educators. When a teacher completes 12 hours of SPARK training in a subject area (for example, K-2 PE) they receive a SPARK Certified Instructor Award and are eligible to receive a unit of credit at San Diego State University. In terms of providing content-matched equipment, the schools' SPARK PC direct orders any necessary equipment (either a complete set or single item) for the school from the Sportime catalog.

Extensive needs assessments, in-service evaluations, program evaluations, curricula assessments, teacher assessment tools, as well as consultation on how to use them are included in every program. Ongoing consultation is provided by the SPARK PC. SPARK is also committed to extensive follow up through phone and email consultation, a monthly webinar series, social networking opportunities, and a monthly eNewsletter that includes updates and teaching tips.[48]

SPARK has developed many materials that promote family and community involvement, some of which are provided free on their website. For example, one document is "13 Ways Parents Can Help Children Be More Physically Active." It has also developed a whole package of "Family Fun Activities for Children Ages 3-5." The SPARK curriculum also features "Homeplay" activities—physical activities that involve parents, friends, and family members. SPARK becomes integrated with each community by establishing collaborative arrangements with the school system. It also works with YMCA's, Boys and Girls Clubs, and offers programs for pre-school and after school programs.[49]

The SPARK program has proven to be very successful since its beginning in 1989.[50] Numerous publications have reported SPARK physical education (PE) program effects, including papers showing evidence of achievement in the following variables: 1) physical activity;[51] 2) physical fitness;[52] 3) lesson context and teacher behavior;[53] 4) academic achievement;[54] 5) motor skill development;[55] 6) student enjoyment of the program;[56] 7) adiposity (fatness);[57] 8) long term effects;[58] and 9) process measures (parent behavior, teacher acceptance of program).[59] In terms

of physical fitness, the greatest improvements were seen when led by properly trained teachers.[60] Research also shows that many of the effects achieved by the SPARK program were maintained at least two years after completion.

Costs to implement the SPARK program range from $2,699 (standard package[61]) to $4,699 (premium package[62]) per curriculum. Program package costs can be shared across multiple schools for up to 40 teachers. These costs do not include transportation costs for the SPARK trainer or SPARK binders and media kits, which range from $100 to $300. Costs also do not include PE equipment purchases made through the SPARK PC.

Appendix

Gold Medal Schools Criteria:[63]

Bronze School: To become a Bronze School, you must complete all six Bronze Criteria. Upon completion your school will receive $200.

1. Write a policy that requires grades K-2 to receive 45-75 minutes and grades 3-6 to receive 90-150 minutes of structured physical activity each week using the Utah State Office of Education's Physical Education Core Curriculum. Five minute energizers can be used to help your school achieve 90 minutes of structured physical activity each week (1 energizer a day = 25 minutes).
2. Teach Health Education Core Curriculum provided by Utah State Office of Education.
3. Establish a Gold Medal Mile walking program on or around school grounds and a goal for student participation.
4. Promote Safe Routes to School by requiring the development and distribution of a written Student Neighborhood Access Program (SNAP) plan, SNAP map, and safe drop-off/pick-up map.
5. Write a policy mandating a tobacco-free school.
6. Complete and submit Heart Health Surveys.

Silver School: To become a Silver School, you must continue implementing the Bronze Criteria and complete all four Silver Criteria. Upon completion your school will receive $300.

1. Parent Teacher Association/Parent Teacher Organization must coordinate at least one health-related event per year that involves students, teachers, faculty, staff, and parents.
2. Write a policy that requires a yearly teacher, faculty, and staff wellness program.
3. Offer a variety of competitive and non-competitive physical activity programs.
4. Choose and complete three criteria from Criteria Menu (see below).

Gold School: To become a Gold School, you must continue implementing the Bronze and Silver Criteria and complete all four Gold Criteria. Upon completion you will receive $500.

1. Write a policy that requires K-6 Physical Education (PE) and physical activity courses to be overseen by certified PE teacher(s) or PE specialist(s).
2. Write a policy for all teachers, faculty, and staff that food is not to be used as a reward or as a punishment.
3. Complete four of the following from the *Changing the Scene Program - Improving the School Nutrition Environment* (Gold #3A-#3I).
    a. Write a policy that requires healthy food and beverage choices to be available whenever food is available outside of school meal services.

b. Enroll school as a Team Nutrition School and conduct nutrition education activities and promotions that involve students, teachers, faculty, staff, parents/legal guardians, and community.
c. Offer nutrition education, with coordination between school food service personnel and teachers, faculty, and staff.
d. Write a policy that requires lunch to be at least twenty minutes long from the time students are seated and held between 11:00am and 1:00 pm.
e. Write a policy that bans advertising of less nutritious food choices and promotes healthy food choices.
f. Write a policy that requires food service personnel to have appropriate pre-service training and regular participation in professional development activities.
g. Require all organizations to raise funds by selling only non-food items.
h. Consider student needs in planning for a healthy school nutrition environment by asking students for input and incorporating their feedback into policy making.
i. Write a policy that requires recess to be scheduled immediately before lunch for most or all grades.

4. Choose and complete two criteria, in addition to the three options chosen for the Silver level, from the Criteria Menu.

Platinum School: To become a Platinum School, you must continue implementing the Bronze, Silver, and Gold Criteria and complete all five Platinum Criteria. Upon completion your school will receive $300.

1. Strengthen your School Community Council by holding regular meetings and including health on the agenda at each meeting.
2. Write a policy that requires healthy food and beverage choices to be available whenever food is available outside of school meal services.
3. Plan and carry out a year-long teacher, faculty, and staff wellness program.
4. Involve families and the community in completing the Gold Medal Schools criteria.
5. Write a policy that requires recess to be scheduled immediately before lunch for most or all grades –or- Write a policy that requires lunch to be at least twenty minutes long from the time students are seated and held between 11:00am and 1:00pm.

Mental Health and Wellness Focus: After completing the Platinum Criteria choose one focus area, listed below, each year until you have completed all of them. Upon completion of the Mental Health and Wellness focus criteria your school will receive $200.

- Mental Health and Wellness (must be done first)
    - Discuss your district of School Medical Recommendations Policy with teachers, faculty, and staff. If your school or district does not have a policy one must be written.
    - Identify ways your school can promote mental health and wellness by improving students' self-worth and stress management skill.

  - Provide teachers, faculty, and staff with resources about mental health and how they can recognize mental health concerns in students.

- Asthma
- Diabetes Control
- Environmental Quality
- Fruits and Vegetables Galore
- Immunizations
- Oral Health
- Sun Safety
- Violence and Injury Prevention

Criteria Menu:

1. Participate in Walk to School Day
2. Participate in the American Heart Association's physical activity and community service programs, Jump Rope for Heart or Hoops for Heart
3. Participate in the Utah Department of Health's Fruits & Veggies—More Matters® Grocery Store Tours or Albertsons *Healthy Eaters™* Field Trip
4. Participate in a health related walk
5. Participate in Truth From Youth advertising Contest
6. Teach a proven effective tobacco prevention program in the classroom
7. Utilize the National Dairy Councils Classroom - Cafeteria Connections program to market and promote the link between the cafeteria and the classroom
8. Participate in United States Department of Agriculture's Food and Nutrition Service program, HealthierUS Challenge
9. Participate in one national health campaign
10. Hold an Olympic Field Day
11. Allow students and community members to use physical activity facilities after hours
12. Establish a School Health Council that discusses ways to meet GMS criteria
13. Write a policy that discourages withholding Physical Education (PE) or recess as a punishment
14. Write a policy that provides for continuing education for PE, tobacco prevention, and nutrition
15. Write a policy that requires both lunch and breakfast programs
16. Participate in Physical Fitness Testing or Health Fitness Testing of the President's Challenge
17. Participate in Governor's Golden Sneaker Awards Program

Health: Improve child health and promote healthy behaviors.

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[62] The SPARK premium package includes 2 full-day workshops (12 hours total), project coordination, pre-, during-, and post-prep/planning by SPARK staff and trainers, needs assessments, workshops, program evaluations, handouts and teaching materials for up to 40 attendees prepared and shipped, one unit of credit at San Diego State University (per program) for eligible teachers, and 1 full year of access to SPARKfamily.org for up to 40 teachers.

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Health Coverage: How can one best help a population obtain healthcare coverage by enrolling in existing programs?

Strategies

Several approaches and strategies can and should be used to maximize the enrollment of eligible children and adults in public health insurance programs. The following is a list of strategies that can be used as part of a public health coverage initiative. While these strategies focus on increasing enrollment for children, they can be applied to adults as well.

1. **Simplify enrollment and renewal procedures:** Both research and state experiences support the idea that simplifying enrollment and renewal procedures can promote enrollment of eligible children, reduce unnecessary loss of coverage, and promote continuous coverage for children. Key strategies related to simplifying enrollment procedures include simplifying the application process, reducing income and eligibility documentation, eliminating asset tests, adopting presumptive eligibility, and coordinating Medicaid and State's Children's Health Insurance Program (SCHIP) eligibility processes. The research also provides substantial evidence that charging premiums for late applications has a negative effect on enrollment, particularly for children in lower-income families. Some evidence indicates imposing a wait period limits enrollment as well.[1]

   Key strategies related to simplifying renewal procedures include allowing annual renewals and 12-month continuous eligibility. Adopting administrative renewal policies that make it easier for children to transition between Medicaid and SCHIP can shorten the renewal process for many families as well. Simplifying renewal processes is critical to retaining enrollment of eligible children.

2. **Use community-based outreach to increase enrollment:** Community-based organizations (CBO) and institutions like schools, community health centers, and local and religious organizations can play a key role in outreach and enrollment by capitalizing on the existing relationships and trust they have established with families. For example, CBOs can help families who face language, cultural, or literacy barriers, live in remote areas, need extra assistance, or do not trust government become aware of and enroll in Medicaid and SCHIP. CBOs provide an invaluable service by helping families complete and submit applications as well. Research has shown that community-based outreach is a highly effective strategy to increase the enrollment of eligible children.

   Person-to-person contacts: Person-to-person outreach can include all stages of the enrollment process, starting from increasing awareness, continuing through the application and enrollment process, and ultimately assisting clients in accessing care.[2] More information about this strategy is provided below in the "models" section.

   Room for United Way? A baseline assessment of Utah's systems, policies, and processes for enrolling and retaining children in coverage by the National Academy for State Health Policy (NASHP)[3] found that Utah has relatively few community partners to help families with application and renewal processes.[4] While the Department of Workforce

Service's (DWS) eligibility workers play an active role in outreach and application assistance, research has shown that CBOs have a much stronger effect on increasing enrollment. As of 2009, the state had worked with Comunidades Unidas to reach eligible, but unenrolled children in the Latino community; however, there is no data on this group's effectiveness. The Department of Health (DOH) also planned to provide outreach grants to selected CBOs, but these funds were eliminated as part of the 2008 budget process. The state has had some collaboration with Native American communities and it communicates with a variety of advocacy groups through the Covering Kids and Families Coalition. These advocacy groups are primarily interested in using data collected by schools to target eligible children. While these collaborations are helpful, more community partners are necessary to advance enrollment outreach in Utah.

3. **Use technology to coordinate programs and reduce administrative burdens:** Use of information technology is an emerging and promising area of opportunity for states seeking to increase enrollment of eligible children in public programs. Information technology and exchange can support and advance state policy goals to reduce barriers to enrollment. The two types of technology changes most states are currently pursuing are online applications and data sharing with other agencies.

4. **Change agency culture to promote enrollment goals:** Reorienting the culture of state agencies is crucial to the success of state efforts to improve the enrollment of eligible children. A number of states have worked to change the culture of eligibility agencies, which traditionally focus on procedures rather than promoting enrollment. Conducting "internal marketing" to promote the goal of enrolling eligible families to agency staff, educating eligibility workers about the challenges that low-income families face, and changing the incentives and expectations that guide eligibility workers' performance are all considered vital components of changing agency culture.

5. **Engage leaders who champion the goal of covering children:** High-level leadership is necessary to successfully increase enrollment of eligible children in Medicaid and SCHIP. Governors in a number of states have made covering children a major policy priority, and having that high-level public commitment supports all other efforts to enroll eligible children. The leadership and involvement of state legislators, community leaders, and state Medicaid and SCHIP directors is also necessary.

6. **Engage partners to help achieve coverage goals:** Partnerships between states, community organizations, and institutions like schools, health plans, hospitals, foundations, and businesses play an important role in helping cover uninsured children. As mentioned above, these organizations have existing relationships with community members that facilitates the enrollment process; including contacting eligible families, educating them about the availability of programs, and helping them through the application process. These organizations are especially helpful in reaching diverse racial and ethnic groups, such as immigrants and refugees.

'No Wrong Door' Approach

This approach is based on the idea that whenever and wherever an individual attempts to access the system, they will be welcomed and provided with resources addressing issues of public health insurance eligibility, enrollment, complaints and appeals, and healthcare decision making. Any public or community-based agency serving low-income uninsured and under-enrolled individuals will have the knowledge and tools needed to guide clients through the application, enrollment, and renewal process. This approach ensures an individual will immediately have access to the full range of relevant resources, regardless of what agency the individual contacts. The No Wrong Door approach is implemented through working partnerships across community organizations, health plan providers, and state government agencies in order to connect, align, and augment their efforts.

Utah's Health Policy Project (UHPP) believes implementing this strategy will allow Utah to achieve maximum coverage of its residents as federal health reform is implemented. While facilitating a broad understanding of federal health reform around the state, UHPP plans to introduce likely partner organizations to the No Wrong Door approach and help them extend their capacity to serve. UHPP will develop an internet site with information about how to enroll individuals in public health insurance plans as well as host regular statewide satellite training sessions with Q&A sessions, webinars, conference calls, and CLAS (Culturally and Linguistically Appropriate Services) Training. CLAS Training will help partners address the needs of minority communities and immigrant families.[5]

School-Based Approach

According to research, partnerships with schools have played an important role in helping children enroll in Medicaid and SCHIP. For example, school nurses can play an active role in helping children enroll in public health insurance plans by sending home information about health coverage with sick children. Nurses can also add health insurance questions to mandatory health forms and school administrators can coordinate special health coverage "sign-up" events.[6] Schools can also identify eligible children using the information it collects to determine federal School Lunch program eligibility.

7. **Social marketing:** In some cases, marketing can help propel successful efforts to enroll eligible children in Medicaid and SCHIP. Large-scale marketing, including advertising through radio, television, print media, and promotional materials, can help build awareness of public health insurance programs and children's eligibility. Smaller, culturally-competent, consumer-driven marketing strategies can have a greater effect at the local level. Representatives from targeted communities should be involved in all aspects of designing, planning, and implementing these targeted outreach activities.[7]

   Health helpline: An effective program that could be used in conjunction with a social marking campaign is a health helpline, or a toll-free number people can call to receive information about eligibility, different coverage options, and/or assistance in applying for or renewing coverage. The helpline could also provide callers with assistance, referrals,

or advice for overcoming barriers to enrollment. The health helpline could operate in collaboration with similar helplines, like the statewide 2-1-1.[8]

Models

One-on-One Enrollment Assistance

Research has shown that person-to-person outreach may be the most effective strategy states can pursue to improve participation in public health insurance programs.[9] Such efforts are especially successful when done in partnership with public health agencies or other organizations that have a community presence, and in conjunction with events that attract both youth and adults in the target population.[10] This outreach approach uses community outreach workers, or case managers, to establish personal contact with people to discuss available public health coverage options. In addition, these workers often assist families in the application and enrollment process.

Individualized face-to-face contact allows the case manager to build a trusting relationship with the prospective client and tailor the message to their specific informational needs, situation, and language. It is seen as the best way to connect with hard-to-reach groups, such as working families with no previous experience receiving public benefits and immigrant families.[11] Caseworkers can be volunteers, employed by community organizations, or be an experienced client who has already gone through the process and knows how to navigate the system.

Person-to-person outreach often involves walking the client through each stage of the enrollment process, including increasing awareness of programs, providing information, helping clients through the application and enrollment process (including obtaining necessary documentation), addressing questions through follow-up, and ultimately assisting clients access care. It ensures a completed application is submitted to the public health insurance agency, which increases the probability of enrollment and retention in the program. Person-to-person outreach is particularly effective when supported by supplementary information such as brochures, websites, and health helplines. Individualized assistance can occur through home visits or one-on-one contact at health clinics, schools, or community centers.

Caseworkers engaged in one-on-one enrollment can also serve as care coordinators by assisting persons receive support services that mitigate barriers to accessing health coverage. These barriers include, among others, a lack of transportation, problems navigating managed care networks, long delays in getting an appointment, an inability to leave work for an appointment, and lack of child care.[12] One-on-one enrollment programs help families identify available providers, accommodate special needs, and overcome these access barriers.

An interim evaluation of the SCHIP program found that while broader mass media marketing efforts were important in raising awareness of existing public health insurance programs, more targeted community-based outreach and person-to-person strategies actually helped families overcome barriers to enrollment.[13] The broader marketing attracted families' attention, sparked initial interest, and built brand recognition over time. Community-based efforts, however, used trusted voices from the neighborhood to contact families directly, discuss details of the program, answer questions and clarify misconceptions, and assist families in completing applications.[14]

Examples of One-on-One Enrollment Assistance Programs

Clinic-Based Targeted Outreach and Family Enrollment Assistance Project – Utah
Average cost per enrolled child: $68

The Association for Utah Community Health (AUCH), Utah's federally recognized Primary Care Association, in partnership with four Federally Qualified Health Centers (FQHC), is implementing a clinic-based targeted outreach and one-to-one patient and family enrollment assistance project. The goal of the two-year project is to enroll 50% of uninsured, yet eligible pediatric FQHC patients and retain 75% of currently enrolled CHIP/Medicaid FQHC patients.[15] The goal is expected to be achieved through a combination of targeted outreach and one-to-one enrollment assistance activities. The project has hired and trained nine enrollment specialists who were placed in the four FQHCs throughout Utah. Enrollment specialists work as patient advocates and navigators, helping parents complete the application for Medicaid or CHIP and passing the completed application off to DWS. In the project's first full month of implementation, February 2010, it enrolled 149 children in the Salt Lake City area clinics.

There is an estimated 55,000 children in Utah who are eligible, but not enrolled in Medicaid/ CHIP.[16] According to the 2008 Uniform Data System, 40% (22,000) of Utah's eligible yet uninsured children are currently patients of one of Utah's 11 FQHC organizations. FQHC patients represent a diverse sampling of the population, including Hispanic children, children residing in mixed immigration status households, homeless children, and children who reside in rural areas.[17] These groups are the most "hard to reach" and have the greatest barriers to enrollment, such as language and low literacy levels, making FQHCs the ideal place for outreach and enrollment assistance activities. FQHCs can use electronic health records and patient proof of payment records to identify eligible children and families.

Because FQHCs have established and trusted relationships with the target population, the probability for outreach success is increased. In the Outreach and Family Enrollment Project, daily outreach to the target population will occur via "appointment intervention," in which the medical provider will introduce the concept of enrollment as well as discuss the assistance that is available to the patient. The enrollment specialist will then initiate the enrollment process, providing one-to-one assistance to the family and acting as an advocate/liaison between the family and state eligibility workers. Enrollment specialists will also inform patients of other public programs for which they are eligible. These specialists are representative of the communities they serve, culturally competent, and multi-lingual (where appropriate). A training curriculum for enrollment specialists has been developed in partnership with DOH and DWS. Project data will be tracked, collected, and analyzed for evaluative purposes.[18]

The total estimated project budget is $762,580 for the two-year grant period. Realization of project goals over the two-year period (enrolling 50% of uninsured, yet eligible pediatric patients and retaining 75% of currently enrolled CHIP/Medicaid patients) would yield an average cost of $68 per child enrolled/retained.[19] If proven successful, the project model will be expanded to all interested FQHC organizations in Utah and will be sustained by individual health centers through enhanced revenue streams due to newly enrolled patient revenue, and through continued collaboration with AUCH and other partner organizations.

The model used by the Clinic-Based Targeted Outreach and Family Enrollment Assistance Project is based on a study currently taking place at an urban health center in Utah. The study, which is IRB approved through the University of Utah, is under the supervision of Dr. Carole Stipelman, a practicing pediatrician at the Central City Community Health Center (CCCHC), in collaboration with two researchers from the Division of General Pediatrics at the University of Utah. The Stipelman/CCCHC study utilizes part-time, multi-lingual AmeriCorps volunteers to act as family advocates and provide one-to-one enrollment assistance with interested eligible families. Outreach is conducted solely within the clinic during scheduled appointments and assistance is provided only to interested families.

The study has demonstrated initial effectiveness and success in enrolling eligible patients. Of the 86 families that participated in the study since June 2009, 44 children from 26 families have become enrolled in either CHIP or Medicaid; while seven children from five families were denied enrollment. The process for 55 families is pending. The intervention is being compared to the enrollment statistics at a similar health center clinic that does not provide one-to-one enrollment support. Dr. Stipelman recently compared the July 2009 CHIP/Medicaid enrollment status of uninsured children attending the two clinics in May 2009. Among patients from the intervention clinic, 32% of the children uninsured in May had obtained Medicaid or SCHIP in July, compared with 3% of the uninsured children at the non-intervention clinic.[20]

Facilitated Enrollment Program (FE) – New York
Average cost per enrolled child: $119

In 1998, the Governor of New York and the state legislature significantly improved health coverage for the state's children. Program eligibility and benefits were expanded and the enrollment system was simplified.[21] However, the centerpiece of the improvements was the creation of facilitated enrollment. Using federal funding from SCHIP, community agencies and health plans are authorized to provide one-on-one assistance to people through every step of the application process.

Launched in 2000, FE uses CBOs and health plans to find and enroll "hard to reach" New Yorkers who qualify, but have not enrolled in public health insurance programs. By 2006, FE had placed more than 2,000 enrollment counselors in the community to assist families in signing up for Child Health Plus, Medicaid, and Family Health Plus.[22] Enrollers help screen families for eligibility, complete the application, gather the necessary eligibility documents, and conduct the legally mandated face-to-face interview. They can also help clients select a managed care plan. Facilitated enrollers then submit the applications on behalf of families and provide follow-up or troubleshooting to ensure that the client is enrolled and can access healthcare services.[23] Enrollers also help families with the annual renewal process.

FE counselors can be found in every county throughout the state; they are located near places where the uninsured live and work—at local clinics, schools, community centers, CBOs, and places of worship. Because nearly 80% of New York's uninsured are workers or dependents of workers, all facilitated enrollment programs provide *evening and weekend hours*. Counselors

also reflect the cultural and ethnic diversity of New York's many communities, speaking more than 40 languages.[24] Counselors can be paid employees or trained volunteers. For example, the Student Poverty Reduction OUTreach (SPROUT) project trains undergraduate and graduate students on how to complete the joint Medicaid/Child Health Plus application and New York's SCHIP application.[25] They also receive cultural sensitivity training on the appropriate screening procedures for immigrants and other low-income populations. Once trained, student volunteers are placed in CBOs to assist families with the enrollment process.[26]

The use of FE counselors helps reduce the barriers to enrollment that have prevented many of these individuals from previous enrollment. The program works well in both urban and rural settings. In many rural parts of New York, a person may have to travel as far as 60 miles to reach a Medicaid office. Many individuals do not have the time, a car, or access to public transportation to make multiple trips to the Medicaid office. Community-based facilitated enrollment brings outreach and enrollment to rural communities by making home visits or providing enrollment services in local libraries or health centers.

Because of the program's success, FE has become the backbone of New York's enrollment system for public coverage. Statewide, more than 50% of all Child Health Plus A (children's Medicaid), Medicaid, and Family Health Plus applications and 100% of Child Health Plus B (NY SCHIP) applications are completed at FE sites. In New York City, more than 80% of Family Health Plus applications come through facilitated enrollers. In 2005, New York's facilitated enrollers submitted more than 500,000 applications on behalf of uninsured families.[27] New York's local district offices have also grown reliant on the program; counties simply do not have the resources to handle the application workload and the legally mandated face-to-face interviews that are now conducted by health plan and community-based facilitated enrollers.

New York's efforts have seen measurable results. In just six years (2000-2006), the number of uninsured children in New York dropped from 729,000 to 469,000, a 36% decrease. At the same time, enrollment in Child Health Plus grew to 2 million children and teens. Nationally, the rate of uninsured children is one-third higher than New York's. The program has improved coverage rates for adults as well. For the first time in over a decade, New York's rate of uninsured adults is lower than the national average. Nearly 1.5 million low-income adults are getting the health care they need to stay healthy and working.[28]

The primary challenge the FE program has faced is securing ongoing and adequate funding. Despite its overwhelming success, the program experienced drastic budget cuts.[29] However, strong advocacy from the state's partners, including community service providers, facilitated enrollment programs, health plans, healthcare providers, healthcare advocates, and the Children's Defense Fund, helped keep the program in existence. For example, after an intense media and advocacy campaign conducted in 2006, the Center for Medicaid and Medicare Services approved the state's request to preserve the FE program. Grants from private foundations, like the New York State Health Foundation, provide additional funding for the program as well.

A study conducted by the New York Academy of Medicine and the Children's Defense Fund found community-based facilitated enrollment to be one of the most cost-effective ways to increase enrollment.[30] The study, published in 2004, found it cost approximately $280 to enroll a

child in Medicaid or SCHIP in the New York City area. However, the study also assessed the cost of enrollment by three selected CBOs funded by New York State to enroll children in high-need areas. The cost of enrollment by these organizations was significantly less, approximately $119 per enrolled child. The main reason why CBOs are able to enroll children at a lower cost is the use of inexpensive outreach strategies such as internal referrals between programs within a multiservice agency and word-of-mouth between parents who participate in other programs provided by the agency. CBOs also keep overhead costs low by providing services in existing service locations.[31]

Examples of Successful State Strategies

Multifaceted Outreach, Enrollment, and Advocacy Strategies – Texas

In the first nine months of Texas's SCHIP program, the state was able to enroll more than 212,000 children, outpacing California, New York, Florida and other states comparable in size and ethnic and geographic diversity. Unfortunately, this rate of enrollment growth was not been sustainable because of state budget cuts. However, the program's successful multifaceted outreach campaign, which included public-private partnerships and enrollment simplification, is an impressive example of how to incorporate several strategies into one initiative.

Public-private partnerships: A critical element of Texas' outreach strategy involved state contracts with local CBOs. Texas provided contracts to 50 CBOs that had strong local support and relationships with SCHIP and Medicaid-eligible populations, including county health departments, non-profit social services organizations, religious organizations, and local health clinics. Community-based outreach activities focused on publicizing health coverage programs, providing application assistance, developing localized and culturally appropriate outreach plans, and coordinating with other local organizations to minimize duplication.

Texas also developed state agency partnerships and engaged the private sector in promoting outreach.[32] HEB grocery stores printed toll-free telephone numbers on grocery bags, Reliant Energy put notices in utility bills reaching 1.5 million households, and Clear Channel Outdoor donated billboard space to promote children's health insurance. Texas also secured extensive media coverage through a kick-off media tour in 12 cities, a statewide advertising campaign, and telethons designed to collect completed applications for children's health insurance rather than donations. Telethons were held in seven major Texas cities, generating tens of thousands of applications for SCHIP and Medicaid through free media coverage.

Medicaid simplification—a streamlined eligibility process: Texas streamlined its Children's Medicaid application so that it was a simple mail-in application, similar to SCHIP's application. Documentation requirements were reduced to the same standards as SCHIP and the face-to-face interview requirement was removed. With a streamlined eligibility process, CBOs began turning their attention towards Medicaid outreach for children alongside SCHIP outreach. Local groups came together to collaborate on press, outreach, and enrollment activities in order to maximize impact. The streamlined Medicaid application, combined with outreach and community

education efforts, resulted in an almost 30% increase in enrollment of children in Medicaid (equal to 318,155 children) in a one-year period (2001-2002).

Community-based efforts: Outreach by community-based organizations also played a critical role in the enrollment of children. Examples of successful community-based efforts include the Michael & Susan Dell Foundation "insure-a-kid" Grants for School Outreach. These ten statewide grants funded 40 school districts and over 770,000 students. The goal of the grants was to increase the number of eligible children enrolled in SCHIP and Medicaid by incorporating outreach and training into routine school activities. Children's Defense Fund Texas (CDF-Texas) has been working with eight school districts and over 317,000 children to ensure that school districts go beyond outreach and enrollment to create a sustainable program and permanent school procedures that will link children with health coverage beyond the grant period.

With the support of the Robert Wood Johnson Foundation Covering Kids and Families Initiative, CDF-Texas and the Gulf Coast SCHIP Coalition partnered with Fiesta Mart, a Houston-based chain of grocery stores with a strong Spanish-speaking customer base, and Greater Houston McDonald's Restaurants to hold 13 city-wide SCHIP sign ups. These sign ups have assisted 8,313 families and 17,214 children in applying for SCHIP and Children's Medicaid. During each of the one-day campaigns, application assistance was provided at 10 to 40 restaurant and store locations throughout Houston, with sign ups being managed by CBOs.[33] CDF-Texas also partnered with faith-based organizations to hold a Texas Healthy Child Weekend to promote enrollment. CDF-Texas created bilingual toolkits that were provided to congregations which contained bulletin and pulpit announcements informing congregation members about how to apply for and renew children's health coverage.[34]

Campaign to restore SCHIP achieves partial SCHIP restoration: Despite the initial success of SCHIP, the Texas Legislature made significant cuts to SCHIP eligibility and benefits as a result of a $10 billion state budget shortfall in 2003. CDF-Texas led a 250-member statewide coalition called the "Campaign to Restore SCHIP" that successfully restored several aspects of the SCHIP program during the 2005 Texas Legislative session.[35] The Campaign used a variety of strategies which are outlined in the Appendix. Gradually, benefits were restored to SCHIP and, today, enrollment is roughly the same level as in 2003.

Simplifying Enrollment and Renewal Procedures – Utah

In February 2009, Utah was selected as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) *Maximizing Enrollment for Kids* program, with the goal of helping states to improve the enrollment and retention of eligible children in Medicaid and the CHIP. With this grant Utah has, and is continuing to try new approaches to making Medicaid and CHIP accessible for eligible families.[36] The following is a list of areas Utah is working on with the assistance of advocacy groups like Voices for Utah Children.

1. *Utah is trying new approaches to making Medicaid and CHIP accessible for eligible families:* Eligibility and renewal processes are now consolidated with DWS, which is experimenting with simplifications to the application and the local enrollment process. Families can complete a unified public benefits application which determines eligibility

for health insurance, cash assistance, and food stamps. Alternatively, families can use a new DOH joint application for all public health insurance programs. The health form is considerably shorter than the full public benefits application.

The joint application for CHIP and Medicaid benefits also has a one page tear off sheet that applicants fill out and submit at outreach events in order to begin the application process. In addition, Utah has two web-based applications that mirror the paper applications: UtahClicks can be used to apply for health insurance while UtahHelps is the unified public benefits application.

DOH and DWS workers are attending community events and going into different venues with a new CHIP van to talk with families. There are about there are 54 outstationed DWS workers who are available at provider sites, and assist people with applications. These outstationed workers and other DWS and DOH staff are available to attend community events to answer questions and assist in the application process.

Voices for Utah Children believes simplifying the enrollment and renewal procedures is critical to both increasing enrollment and retention in public health insurance programs. This is especially true given the large number of people who will be applying for public insurance under the new federal health reform. Because of this, Voices for Utah Children has pushed lawmakers to expand eligibility to 12 months for all children in order to help retain retention and simplify the renewal process. Requiring clients to constantly renew coverage (more than one per year) increases the complexity of the renewal process which increases the risk that families will fail to retain coverage.[37] In 2007, the Texas legislature eliminated the six-month renewal requirement and in the following six months enrollment increased by more than 19,000 children per month.[38]

2. *Utah has invested in new information systems to reduce paperwork and make eligibility and renewal processes more efficient:* The added information capacity will also provide data needed by state officials to monitor and improve eligibility and enrollment processes. For example, DWS launched eFind, an on-line data brokering system, in 2004. With eFind, eligibility workers are able to check 18 different data sources (Social Security, Vital Statistics, etc.) with one search in lieu of requiring families to produce physical documentation of income and U.S. citizenship. Voices for Utah Children has pushed legislative bills to expand this tool to include the Tax Commission as a source for both CHIP and Medicaid verification.

   In addition, Utah launched a new eligibility determination system, known as eREP. Like the system it is replaced, eREP is the eligibility system for many of Utah's public assistance programs, including Medicaid, CHIP, TANF, Food Stamps, and Child Care. The new system is expected to reduce errors and improve the consistency of eligibility determinations. Online applications will eventually be linked directly with the eligibility system, reducing staff time devoted to data entry. The state anticipates eREP will be able to merge information from other programs, like National School Lunch program, to identify eligible but unenrolled children.

3. *Utah is looking to partner with schools:* Utah is working closely with schools to develop partnerships to identify and enroll eligible children. This work is occurring on both the district level to connect School Lunch enrollees with health insurance as well as the statewide level through the state's new electronic student record.

Appendix

Campaign to Restore SCHIP Achieves Partial SCHIP Restoration:[39]

CDF-Texas led a 250-member statewide coalition called the "Campaign to Restore SCHIP" that successfully restored several aspects of the SCHIP program during the 2005 Texas Legislative session. CDF-Texas coordinated the following efforts as part of this effort:

- Forged partnerships with regional coordinators in ten Texas communities to create local coalitions to support SCHIP restoration. Coordinators acted in concert, speaking with a unified message and organizing activities across the state at the same time. For example, organizing a kick-off press conference on the same day in several different parts of the state; distributing press releases in unison; compiling local impact data and family testimonials; and convening public hearings and policy briefings in a coordinated way.
- With local coordinators, CDF documented the impact of high rates of uninsured people on local emergency rooms, healthcare systems, businesses and communities. Data included: budget shortfalls facing hospitals due to cuts to SCHIP and Medicaid; costs of preventive versus emergency room treatment; increases in local property taxes to fund healthcare services; the loss of SCHIP matching funds for each county; diversion rates from emergency rooms because of overcrowding; school absenteeism and loss of attendance funds due to untreated illnesses and the costs to small businesses of rising healthcare premiums.
- CDF launched a family tracking project and followed 100 families with 219 children affected by the SCHIP cuts across Texas. The study found that 75% of children who lost SCHIP remained uninsured and 89% of children who lost SCHIP delayed or missed health care, including care for serious illness. The study also found that private health insurance was either unavailable at work or was too costly for families to afford, and that SCHIP families work, but struggle to pay basic expenses. In addition, the study found that families on SCHIP were being forced to choose between paying higher premiums and using that money to pay for dental, vision, or other medical expenses no longer covered, and that many families were going into debt to pay for dental visits, medication, or critical medical tests for their children.
- CDF compiled the local impact data and family tracking project findings into a special report to the Texas Legislature called "Facing Facts: The Cost of CHIP Cuts to Texas."
- The campaign, through CDF's coordination, worked with regional coordinators to launch a statewide media campaign, featuring family testimonials and local impact data on the need for SCHIP restoration.
- CDF recruited healthcare champions to support SCHIP restoration, including businesses and chambers of commerce, faith and community leaders and local elected officials to speak out about the local impact of SCHIP cuts.
- CDF organized a CHIP Congress during the Texas Legislative session for over 100 key statewide stakeholders to educate local leaders about the local impact of SCHIP cuts.

Health: Improve child health and promote healthy behaviors.

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[14] Ibid.

[15] These percents are estimated to equal 6,079 and 5,074 persons, respectively.

[16] Utah Department of Health, "Estimated Number and Percentage of Utahns Who Lacked Health Insurance Coverage by Selected Demographic Characteristics," Utah Healthcare Access Survey, 2008, 23 March 2009.

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[32] Partnerships with several state agencies were established, including the Office of the Attorney General Child Support Division to perform outreach to custodial parents; the Texas Workforce Commission to insert promotional flyers with Unemployment Insurance Benefits applications; the Department of Criminal Justice to distribute materials to probation and parole offices; the Department of Human Services to disseminate information to Food Stamp applicants; and the Department of Public Safety to provide information to individuals who had recently applied for driver's license.

[33] Clear Channel Outdoor has promoted these events for the past three years through free billboards. Additional promotion was done through Fiesta Mart Inc. store circulars, McDonald's tray liners, and earned media.

[34] An interfaith advisory committee, including Texas Catholic Conference, the United Methodist Church, the Southwest Region of Progressive Baptist Ministers, the Presbyterian Church USA, and the American Jewish Committee, oversees the production of the toolkit and assists with statewide distribution.

[35] Dental, vision, hospice and mental health benefits have been restored to the SCHIP benefits package; premiums have been reduced and will be more convenient for families to pay; additional funds were allocated to increase enrollment; and services were maintained for legal immigrant children. Another important provision requires that the Texas Health and Human Services Commission request additional funding from the state Legislature if there is a SCHIP shortfall before imposing a wait list, enrollment cap, or cuts to eligibility or benefits.

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Healthcare Access: How can one best deliver health care to a population (including primary, dental, and mental health care)?

Strategies

Most of the strategies related to increasing access to health care focus on improving and increasing healthcare coverage. However, because the previous section discusses best practices for helping individuals obtain healthcare coverage, this section will outline strategies that can improve access to care that are not related to health insurance. The following is a list of access strategies that can be used in a program or part of a larger healthcare initiative.

1. **Provide affordable care:** Cost is the primary barrier to accessing health care for low-income, and a growing number of middle-income persons. Health care is extremely expensive and getting more expensive every year. It is currently the largest sector of the U.S. economy, and healthcare spending as a percent of GDP has risen dramatically over the last few decades.[1] Per capita health expenditures range from $100 to over $1,000 per service.[2] While costs are offset by health insurance (for those with coverage), rising premiums and copayments have made health care unaffordable for an increasing portion of the population. Many people go without seeking necessary care, even if they have coverage, because the cost is too prohibitive. Providing affordable or free health care is the first and best way to improve access.
2. **Offer accessible hours:** Another way to improve access to health care is to provide care that is accessible to the target population. A major barrier to access for many individuals, especially low-income individuals, is being able to take time off work to seek care. Health care must be available during non-work hours (evenings and weekends) in order to accommodate these people's schedules and allow them to receive the care they need.
3. **Make care available in a central location:** Besides providing accessible hours of operation, the location of care should be easily accessed by various methods of transportation. It can be intimidating and difficult for patients to travel far for care, which is why it is necessary to provide care in or near the target community.

   Two examples of local medical centers who have addressed this issue are the Mobile Clinic and the Davis Volunteer Medical Center. These clinics bring medical care to established community centers, which increases trust in and use of their services. Both of these clinics focus on providing immediate acute care to patients.
4. **Provide culturally competent care:** In order to increase accessibility, health care must be provided in a way that is culturally/socioeconomically understandable. This requires having staff or translators available who speak the languages of the population being served. It also requires understanding the religious beliefs of the population and being sensitive to how their culture views medicine and medical treatments. Finally, care must be delivered in a way that is easy to understand, both orally and in print.
5. **Utilize public/private financing strategies:** Currently, many cities across the country are experimenting with public/private enhanced financing and service strategies to incorporate the uninsured into managed care.[3] Several urban models have emerged that extend health care beyond clinic or hospital walls to integrate a community-based

mission, orientation, and strategy into urban health. For example, the Parkland Health and Hospital System community program in Dallas, TX works through a network of health centers, homeless shelters, school health settings, churches, and senior citizens' centers to provide medical care to the surrounding communities.[4]

The Parkland initiative is part of a growing recognition that healthcare organizations, policymakers, and providers must work with communities to create a healthier environment. Quality-of-care studies linking processes of care to improved outcomes support this direction, emphasizing that critical characteristics outside the health system are frequently not considered to be a part of intervention designs. Conversely, omission of these community-level effectors of medical care—environment, culture, age, literacy—can limit the effectiveness of interventions and distort measurement of effects.[5]

Models

Community Health Centers

For many uninsured individuals, the only option for medical care is costly emergency room visits. Because of this, states have recognized community health centers (CHC) for the integral role they play in the healthcare safety net.[6] CHCs are community-based and patient-directed non-profit organizations that serve individuals and families with limited access to health care. They provide high-quality, affordable primary care and preventive services, as well as on-site dental, pharmaceutical, mental health, and substance abuse services.

Often located in areas where care is needed but scarce, CHCs improve access to care for millions of Americans regardless of their insurance status or ability to pay. CHCs serve people of all ages, people with and without health insurance, special populations, and people of all races and ethnicity—including undocumented persons. Their clientele primarily includes, but is not limited to, low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, those experiencing homelessness, and those living in public housing.

Basic CHCs serve a variety of underserved populations and areas, particularly high-risk individuals with multiple barriers to medical access. Other specialty community health centers focus on specific populations. Migrant Health Centers, for example, provide services to migrant and seasonal agricultural workers. Health care for the Homeless programs reach out to homeless individuals and families and provide primary care and substance abuse services.[7]

In order to qualify as a federally-sponsored CHC, health center programs must meet the following qualifications:

1. *Serve a high need community:* The center must be located in or serve a high need community designated as a Medically Underserved Area or Population.
2. *Governed by a patient-majority board:* The center must be governed by a community board composed of a majority of health center patients who represent the population being served. Having a patient-majority board ensures quality customer-service and that the health center is sensitive and responsive to the changing needs of its patients.

3. *Provide comprehensive services:* The center must provide comprehensive primary healthcare services as well as supportive services (education, translation, transportation, etc.) that promote access to health care.
4. *Charge sliding-scale fees:* The center must provide services to all with fees adjusted based on ability to pay.
5. *Meet other federal requirements:* The center must meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

Analyses of the CHC model have shown CHCs both *improve health outcomes* and *lower the costs* of treating patients with chronic illnesses by providing care of superior quality, with exceptional cost-effectiveness and efficiency.[8] CHC's costs of care rank among the lowest because they reduce the need for more expensive inpatient and specialty care.[9] By using a medical home model (see description below), which provides patient-centered, regular, and continuous sources of care, coordinated by a team of medical professionals committed to quality improvement, CHCs are able to focus on providing low-cost primary and preventive care to patients.[10] CHCs provide less costly care for Medicare patients as well; Medicare deductible costs are waived for federally qualified health care (FQHC)-provided services.

Medical Homes

Research has shown that medical homes lead to better patient utilization and patient outcomes, including: 1) patients recognizing the need to seek care; 2) patents receiving earlier and more accurate diagnoses; 3) reduced emergency department use; 4) fewer hospitalizations; 5) lower overall costs; 6) better prevention; 7) fewer unmet needs; and 8) higher patient satisfaction.[11] Moreover, primary care characterized by enhanced accessibility, continuity, and interpersonal relationships with physicians is associated with better self-rated general and mental health, and is found to mitigate disparities and barriers related to income, race and ethnicity, and insurance inequalities.[12]

Besides providing low-cost, high-quality health care, CHCs are beneficial to the communities they serve because of the additional services they provide to their patients. For example, many CHC provide free immunization to uninsured children. They also are able to increase awareness and enrollment in public health insurance plans, such as Medicaid and CHIP, as well as other public assistance programs, such as food stamps and childcare assistance. CHC staff can connect patients to other community-based safety net programs that are available in the local area as well.

Another benefit of CHCs is that many include educational components and campaigns in their facilities. For example, some CHCs currently offer early education reading programs. Others are developing healthy behavior initiatives to help teach patients about healthy decisions and motivate them to make healthy changes in their lives. The trusting relationship that is built between patients and medical providers through the CHC model enhances the effectiveness of educational programs and makes CHCs a valuable community partner. Connecting CHCs to other service providers and community organizations can increase the number of educational programs and initiatives CHCs are able to provide and promote.

Both the Institute of Medicine and the General Accountability Office have recognized CHCs as effective models for reducing health disparities and for managing the care of people with chronic conditions such as diabetes, cardiovascular disease, and HIV. The White House Office of Management and Budget has ranked CHCs as one of the ten most effective government programs. The American Academy of Family Physicians' Robert Graham Center recently found that the total cost of care for community health center patients is 41% lower than the total cost of care for individuals served by other providers.

The primary challenge CHCs face is securing adequate funding. Funding for CHCs come from a combination of federal, state, and private grants, revenue from services provided to patients, and third-party reimbursements from Medicaid, Medicare, and other public and private insurers. However, future and existing health centers require support for capital and construction projects. Without this investment, health centers cannot achieve the technological improvements and quality measurements that ensure high quality care. Previous assessments of CHCs reveal that one in three health centers currently operates in buildings that are over 30 years old, while one in five are in buildings at least 40 years old. Additionally, about two-thirds of health centers nationally need to modernize or expand their buildings or construct new facilities. This construction, modernization, or expansion cannot be paid for with federal grant dollars.[13]

Community health centers have launched a plan, "ACCESS for All America," to nearly double their current capacity by the year 2015 in order to accommodate the growing number of uninsured and underinsured individuals. To accomplish this Health Centers need to expand grants, state reimbursements, and revenue by leveraging purchasing power and business opportunities.[14] It is estimated that if everyone in America had access to a healthcare center, then the healthcare system would save $67 billion annually.[15]

Examples of Community Health Centers

Midtown Community Health Center – Ogden, UT
Total costs: $7.6 million
Total cost per patient: $297.49

While the Midtown Community Health Center is highlighted in this report, it is just one of 11 CHCs located around the state of Utah. Some of the details mentioned in this section are specific to the Midtown Community Health Center, while other numbers reflect Utah's CHC community as a whole. Another CHC that will specifically be mentioned in this section is the Wayne Community Health Center because of its rural location.[16]

Like all other CHCs, Midtown is a federally and privately funded, non-profit CHC made up of six clinics located within the northern Wasatch Front area. It provides comprehensive medical, oral health, pharmaceutical, and mental healthcare services. It is a medical home with full-time employed family practice physicians, mid-level providers, mental health therapists, and dentists.[17] Ultrasound and basic radiology equipment are also available on site. The Midtown clinic has established a reading program for early learners as well.

About 34% of Midtown's funding comes from federal grants. An additional 8% comes from state and local grants/contracts or private and foundation funding. The majority of funding, 56% comes from revenue earned from providing services to patients. This includes fees collected from patients, as well as reimbursement from third-party payers.[18] The remaining 2% primarily comes from revenue collected from the Indigent Care Program. Per federal regulation, CHCs cannot operate as a free clinic and therefore use a sliding-fee scale based on income to determine cost of care. CHCs have found this strategy to be useful in engaging patients as well; patients tend value their care more when they are required to participate in the payment process, even if the contribution is small. The average fee paid by patients is $28 per visit.

While a substantial amount of funding comes from federal grants, the downside to this revenue source is that the growth in the number of patients CHCs serve is much faster than the growth in money that comes from the federal grants. For example, the number patients Midtown serves has increased by almost 8,000 in the last two years. The majority of this growth came from Davis County, which has a high percent of small business owners. These businesses were hit hard by the recession, leaving many residents uninsured or underinsured. In 2009, Midtown served 26,000 patients through 60,000 visits.

Midtown serves the typical CHC patient population, including a high percent of non-English speakers. Close to 99% of Midtown's patients are 200% below federal poverty level. Unlike national CHCs, however, Utah's CHCs tend to serve a higher proportion of uninsured patients. More than 66% of Midtowns patients are uninsured, compared to the national average of 38%. Federal guidelines recommend that a CHC's uninsured patient population not exceed 40% because becomes cost prohibitive at this point. However, because both IHC and the University of Utah provide medical care to Medicaid patients, Utah CHCs see less Medicaid patients, which results in a higher percent of uninsured patients.

In 2009, Midtown's total costs came to $7.6 million. The total cost per patient was $297.49. Total costs for other Utah CHCs range from $0.7 million to $14 million, depending on the needs of the population and the services the CHC provides. Cost per patient range from $266.78 to $868.90. Wayne Community Health Center had the highest total cost per patient, most likely due to its rural location.

In terms of best practices, Midtown and other Utah CHCs work well because of the following:

1. *It utilizes volunteer provider networks:* Volunteer provider networks allow CHCs to focus on providing quality primary care to patients while outsourcing specialty care to other doctors in the community. Midtown's volunteer provider network consists of local specialty doctor who are willing to take one or two charity cases per month. Volunteer provider networks lead to good coordination of services which increases efficiency.
2. *It incorporates a medical home model:* As mentioned above, medical home models are considered "best practice" for providing continuous and coordinated care for patients. This leads to better regulation of chronic diseases and ensures patients are getting proper medical attention at the appropriate times. The medical home model also promotes good prenatal care for at-risk individuals. The percent of low-birth weight babies born through CHC care is significantly lower than the national average.[19] This is partly because

utilizing a medical home model allows medical providers to complete risk assessments for domestic violence and poor nutrition of expectant mothers.

3. *It provides culturally competent care:* Midtown believes providing language-appropriate and culturally-competent care is critical to its success. Providing culturally-competent care not only limits the number of medical errors caused by language barriers, but it increases patients' understanding of medical terms. In turn, patients are more responsive to treatments and take more responsibility for their own care.
4. *It provides patients with case managers:* Case managers work one-on-one with clients to coordinate all aspects of the client's care, including finding and following up with specialists. For example, Midtown's mental health case manager follows up with clients to make sure they are receiving and taking the proper medications. Case managers can also help patients sign up for public health insurance plans and other social benefits.
5. *It offers accessible hours of operation:* Midtown clinics are open on Saturdays and some evenings, which provides working adults with the opportunity to seek care without having to take time off work. Most clinics have a doctor on call during off hours as well.
6. *It uses electronic medical records:* Electronic medical records (EMR) provide an efficient way to track and coordinate care for patients as EMRs can be easily and continuously updated. The ability to exchange records between different EMR systems also facilitates the coordination of healthcare delivery provided by CHC's volunteer provider networks. In addition, data from an electronic system can be used anonymously for statistical reporting in matters such as quality improvement, resource management and public health communicable disease surveillance.
7. *It uses telemedicine:* Telemedicine is where medical information is transferred through interactive audiovisual media for the purpose of consulting and sometimes performing remote medical procedures or examinations. This works extremely well for rural CHCs, like Wayne Community Health Center, because it allows medical providers to digitally transfer x-rays to remote radiologists for examination. Telemedicine has also been used to transfer digital images of irregular skin blemishes to dermatologists. This eliminates the need for onsite specialists, reducing overall costs.
8. *Its medical providers are paid by salary, not by procedure:* Paying medical staff a set salary reduces the incentive to run extraneous, costly, and potentially unnecessary procedures. This in turn reduces overall costs to patients.
9. *It uses open access scheduling:* Instead of setting prescheduled appointments, some CHCs have moved to open access scheduling. Patients come or call at the beginning of each day and are received on a first come, first served basis. This reduces the number of no-shows many CHCs experience. However, follow-ups and prenatal appointments are still scheduled days in advance.

As mentioned above, the primary challenge Utah CHCs face is finding and securing adequate funding. The number of patients using CHCs has grown tremendously in the past two years, but physical restrictions limit the number of patients any CHC can see. However, Utah is following the national goal of increasing capacity by implementing a statewide strategic plan for growth. Other barriers CHCs face are associated with the populations they serve. Because CHC patients

typically have heightened social and emotional needs, visits can take longer than normal because it takes time to help them understand all the details of their care.

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[14] For more information about "ACCESS for All America" go to http://www.nachc.org/access-plan-overview.cfm.

[15] S. J. Spann, "Task Force 6: Report on Financing the New Model of Family Medicine," *Annals of Family Medicine* 2, Supplement 3 (2004): S1-S21.

[16] Wayne Community Health Center is the only primary or emergency care provider within 60-120 miles of its location. Many of its patients are people who have been in car accidents along I-70.

[17] Not all clinics offer dental and pharmacy services on site; some CHCs contract these services out to local dentists and pharmacists.

[18] Third-party payers include Medicaid, Medicare, and other public and private insurers.

[19] In 2009, the percent of low-birth weight babies born at Midtown was 4.4%, while the national average was 7.3%.

Economic, Social, and Demographic Data by County and Select Cities: 2006-2008 Average Estimates

	Tooele County	Tooele City	Salt Lake County	Salt Lake City	West Valley City	West Jordan City	Davis County	Layton City	Bountiful City	Summit County
Population	56,941	30,120	1,022,651	181,698	123,447	104,447	295,332	65,514	44,473	36,100
Median Household Income	$61,552	$55,995	$58,000	$44,552	$51,629	$66,463	$66,856	$63,953	$64,544	$85,258
Poverty Status										
Percent with income below the poverty level in the past 12 months by…										
Families	5.7%	7.6%	6.6%	11.6%	8.1%	4.3%	4.6%	5.0%	3.7%	9.6%
Individuals	7.1%	8.4%	9.3%	16.8%	10.4%	5.6%	5.9%	6.5%	4.2%	13.2%
Children (under 18)	8.4%	8.9%	11.8%	21.5%	14.1%	6.6%	7.8%	8.3%	5.5%	4.9%
Education										
Percent of population 25 years and over with…										
Associate's degree	10.2%	9.9%	8.5%	6.5%	7.9%	13.2%	9.6%	10.0%	7.6%	8.2%
Bachelor's degree	13.6%	12.2%	19.3%	21.8%	9.5%	15.8%	23.1%	22.8%	24.3%	33.0%
Graduate or professional degree	5.1%	4.5%	10.4%	17.0%	3.0%	6.2%	9.3%	8.7%	14.4%	18.0%
Transportation										
Percent of housing units with…										
No vehicle available	3.8%	5.3%	5.3%	11.3%	5.6%	1.9%	2.5%	3.0%	3.5%	3.9%
One vehicle available	21.8%	24.3%	29.3%	40.1%	28.0%	21.8%	20.4%	22.4%	26.3%	16.6%

Economic, social, and demographic data.

	Tooele County	Tooele City	Salt Lake County	Salt Lake City	West Valley City	West Jordan City	Davis County	Layton City	Bountiful City	Summit County
Demographics										
Percent of population…										
Under 5 years of age	9.9%	10.3%	9.1%	8.6%	10.2%	11.8%	10.1%	9.5%	7.0%	7.3%
Race										
Percent of population who is…										
White	92.7%	91.6%	87.1%	80.7%	81.2%	88.6%	92.2%	91.1%	94.9%	95.4%
Black or African American	1.3%	1.4%	1.4%	3.6%	1.1%	0.4%	1.1%	1.4%	0.1%	0.8%
American Indian and Alaska Native	0.9%	1.1%	0.8%	1.0%	1.4%	0.5%	0.6%	0.4%	1.0%	0.1%
Asian	0.8%	0.6%	3.1%	4.3%	4.1%	2.6%	1.6%	2.1%	1.5%	1.6%
Native Hawaiian and Pacific Islander	0.3%	0.2%	1.4%	1.9%	3.3%	2.4%	0.4%	0.5%	0.0%	0.0%
Some other race	1.3%	1.6%	4.0%	6.2%	6.7%	3.8%	1.7%	2.4%	1.1%	1.9%
Two or more races	2.7%	3.4%	2.2%	2.3%	2.1%	1.6%	2.4%	2.1%	1.3%	0.2%
Hispanic or Latino	10.0%	10.9%	15.6%	21.9%	29.5%	15.6%	7.3%	9.3%	4.5%	6.5%
Language Spoken at Home										
Population 5 years and over whom…										
Speak a language other than English	n/a	n/a	19.0%	29.2%	30.2%	17.6%	8.5%	9.8%	n/a	n/a
Speak English less than "very well"	n/a	n/a	8.6%	14.1%	15.6%	7.9%	2.5%	2.4%	n/a	n/a

People who classify themselves as "Hispanic or Latino" are from Hispanic or Latino origin. Origin can be viewed as heritage, nationality group, lineage, or country of birth. People from Hispanic or Latino origin may be of any race, therefore the "Hispanic or Latino" category is not counted as part of the "race" total.

Source: U.S. Census Bureau, American Community Survey and Population Estimates Program.