The Healthy Start Initiative in California

Final Report

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Contents

List of Tables/Figures ................................................................. 4

Executive Summary ............................................................... 5

I. Introduction ........................................................................ 23

II. Background ......................................................................... 24

III. Data and Methods .......................................................... 27

IV. Findings

    Section 1: Grantee Characteristics .................................... 33

    Section 2: Coordinator Characteristics ............................. 40

    Section 3: The Collaboration Process ............................... 43

    Section 4: The Case Management Process ....................... 46

    Section 5: The Integration Process .................................. 49

    Section 6: The Evaluation Process .................................. 50

    Section 7: LEA Medi-Cal Funds ...................................... 52

    Section 8: Sustainability .................................................. 57
Tables and Figures

Figures

1A: Response Rates for the year 2000 Healthy Start Sustainability Survey 28
1C: Distribution of responding grantees by cohort 29

1-1: Number of Services provided by currently funded and post-funding grantees 35
1-2: Service Provision Bar Graph 36
1-3: Grantee Site Space Ratings 38
1-4: Grantee Site Comfort Ratings 39
1-5: Grantee Site Accessibility Ratings 39

2-1: Maximum Level of Education – All Coordinators 41

4-1: Percentage of Healthy Start Grantees Case Managing Clients 47
4-2: Computerization of case management data 48

6-1: Participation in additional evaluations 51

7-1: Distribution of LEA monies across Cohorts (Median) 55
7-2: Distribution of grantees receiving LEA money by Cohort 55

8-1: Distribution of Funds across Cohorts (Median) 62
8-2: Funding Amounts by trajectories 66

Tables

1A: Distribution of survey sections in the two versions of the survey 27
1C: Response rates by cohort 28
1D: Response rates by region 29

1-1: Service Provision Table 37

3-1: Percent of Grantees Reporting Collaborative Meeting Attendance by Each Group 44

8-1: Comparing Facilitating Factors and Barriers to Providing and Sustaining School-based Integrated Services 62
EXECUTIVE SUMMARY

INTRODUCTION

Senate Bill 620, the 1991 Healthy Start Support Services for Children Act, established California's Healthy Start Initiative\(^1\). The Initiative was originally authored by Senator Presley. The California Department of Education (CDE) administers Healthy Start and awards planning and operational grants to local education agencies.

The Healthy Start initiative is funded by Proposition 98, the "Classroom Instructional Improvement and Accountability Act". Healthy Start was launched in order to allow schools to provide a range of health and social services, and to support the learning process in order to improve academic achievement for all students. Three general goals of this Initiative are: 1) To ensure each child receives the necessary physical, emotional and education support for optimal learning; 2) To stimulate the reorganization of schools and the local agencies toward more integrated and effective strategies for service delivery to children and families; and 3) To get students and parents to become active participants, leaders, and decision-makers in their communities. To better meet the needs of the school learning community, Healthy Start provides an opportunity for schools and their collaborating community partners to develop new service delivery capacities in order to provide essential learning support services for students and families. These learning support services may include health and mental health services, family support and social services, case management and other social as well as academic support.

Grants are awarded to schools with large populations of low-income or limited-English-proficient students for a period up to five years. Healthy Start legislation dictates that to qualify for funding, at least 50% of students enrolled at the elementary school and at least 35% of students enrolled at the middle or high school are either from families that receive TANF/CalWORKs or have English Learners or the students are eligible to receive free or reduced-priced meals. If applying schools do not meet the above criteria, they must demonstrate the existence of special factors (special factors award provision) that warrant consideration\(^2\). In addition, applicants for Healthy Start grants must show how they will link with education reform initiatives and support educational success for all participating students.

An evaluation of Healthy Start conducted during the first three years of the initiative (1992-1995) by SRI International\(^3\) found that the program successfully affected several key outcome measures such as reductions in unmet needs for goods and services (such as food, clothing and other basic needs), childcare, and health and dental care, as well as a decrease in incidences of family violence. These outcome measures exhibited marked improvement over the three-year span of the evaluation.

In terms of meeting children's basic needs, children in the evaluated Healthy Start sites showed a significant movement from being in a "crisis" stage to one that was more stable. Moreover, families were able to increasingly eliminate major impediments to supporting their children's overall development, such as housing problems, inadequate food and clothing, transportation, finances, and employment. Family violence appeared to be on a decline and, through educational efforts, parents seem to better understand the effect of violent events on their children's development.

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\(^2\) From the Healthy Start "Request for Applications".

The evaluation found that the health of the targeted group also improved. The majority of the health services provided by Healthy Start are preventative in nature, including immunizations and vision and auditory screenings. At baseline, 40% of the children in the evaluated schools were overdue for physical examinations. However, at follow-up, only 17% of the children were still in need of examinations. Furthermore, 80% of those with uncorrected vision or hearing impairments had their problems corrected by the end of the evaluation period.

Academic test scores improved as well. There was a significant increase in reading aptitude scores (by 25%) as well as math scores (by 50%) for the lowest performing elementary schools taking part in the Healthy Start program. Additionally, absenteeism and grade point averages showed positive changes over the three-year period. Based on the findings of this evaluation, the important impact of the Healthy Start program was confirmed and in turn support was bolstered.

Given the demonstrated positive impact of Healthy Start programs, a crucial focus of overall Healthy Start program goals has shifted from effectiveness to sustainability. This is especially important for Healthy Start. By design and legislative intent, Healthy Start programs are meant to be self-sustaining after the initial grant period. Thus funding from CDE is provided to schools as seed money, with the assumption that each grantee must develop an infrastructure that will support the continued integration and delivery of services to families after grant funding ends. Successful Healthy Start programs must not only improve academic achievement and reducing barriers to learning, they must also become self-sufficient and sustainable.

Since no additional funds are allocated to Healthy Start grantees that have completed their operational grant periods, it is important to understand the factors and conditions that allow some Healthy Start grantees to sustain and continue to provide their services once initial operational grant funds have ended. How sustainability was achieved by these grantees may provide important lessons to current and future grantees developing sustainability strategies, and provide insights into policy changes, additional resources, and technical assistance needed to maintain and build on the collaborative family-school-community infrastructure developed by Healthy Start.

In order to ensure long-term sustainability, the California Department of Education (CDE) commissioned a survey of all currently funded and post-funding Healthy Start grantees in California to examine the determinants of sustainability. The survey was sent to all 470 Healthy Start funded operational grantees in the state of California in the Spring of 2000. These grants support sites serving 1,122 schools and 865,205 students. The purpose of the survey was to analyze the extent to which Healthy Start grantees have achieved sustainability and to define critical determinants of sustainability including management, organizational, and funding issues.

The following research questions guided this study:
1. What services are Healthy Start grantees currently providing to school-aged children and their parents?
2. How have collaborative partnerships and different funding mechanisms been used by Healthy Start grantees?
3. How have local service delivery systems changed as a result of Healthy Start?
4. Is Healthy Start sustainability associated with grantee characteristics and design features including resources, level of service integration, availability of LEA Medi-Cal billing, types of case management, levels of collaboration, and ongoing evaluation?

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*Both the SRI evaluation as well as the Healthy Start statewide evaluations have showed improved academic scores in districts with Healthy Start initiatives.
*California Department of Education.
DATA AND METHODS

DATA:
Survey Development and Administration
The data source for this study was a survey of all 470 Healthy Start funded operational grantees funded by the CDE from 1991 to 1999. The survey was conducted by the Center for Healthier Children, Families, and Communities (CHCFC), for the CDE, in the Spring of 2000.

Given the large number of potential questions, two different and complementary versions of the survey were created to decrease respondent burden. Surveys versions were randomly mailed to different grantees. Each version had a common core set of questions and one of two sets of additional sections. The core group of questions focused on the coordinator and grantee characteristics, types of services offered/coordinated by the grantees, funding sources, partnerships and sustainability. Version 1 also included questions about case management, site integration, and the facilitating factors for providing integrated services. Version 2 contained a series of more in depth questions on collaboration and evaluation.

A response rate of 61.3% (N=286) was obtained. The sample of 286 Healthy Start funded operational grantees responding to the survey varied to some degree by cohort and region. Grantees who had recently received grants (recent cohorts) were more likely to respond than grantees that were several years past their grant period (early cohorts). Regional response rates varied from 48% of region 7 to 82% of region 1.

Case Studies
In addition to the survey, the CHCFC examined six exemplary Healthy Start grantees in the Spring of 2000. Grantees included urban, rural and suburban school sites and were selected based on their demonstrated ability to sustain services past their grant period, and on their unique program strengths. The review included a site visit with structured interviews of representatives from major stakeholder groups such as grantee coordinators, grantee staff, partner agencies, parents, school administrators and teachers. The site visits also included a review of site sustainability surveys and their financial information. The specific grantees visited included Folsom Cordova USD, Pomo Elementary-Lake County, Pixley Elementary School- Tulare County, Long Beach USD, Robertson Road- Modesto, and O'Farrell Community School- San Diego. These case studies have been summarized in a separate report.

METHODS:
Funding Status Categorizations
The operational grant period for which Healthy Start funding is available to grantees ranges from 3 to 5 years. From 1992 to 1994, funding was available to all Healthy Start grantees for an operational grant period of 3 years. Starting in 1995, grantees have been given an option to extend their grant periods from 3 years to 5 years. For analytical purposes, grantees in Cohort 1 (1991-92), Cohort 2 (1992-93), and Cohort 3 (1993-94) were categorized as post-funding grantees. Grantees in Cohort 6 (1996-1997), Cohort 7 (1997-98), and Cohort 8 (1998-99) were categorized as currently funded grantees. Grantees in the intermediate cohorts, Cohort 4 (1994-95) and Cohort 5 (1995-96) were classified as either currently funded or post funding depending on whether they extended their operational period from 3 to 5 years or not. Grantees who took the grant extension were categorized as currently funded. Those that did not take the extension were categorized
as post-funding. Of a total of 286 grantees responding, 69% (197) were categorized as currently funded grantees and 31% (89) were categorized as post-funding grantees.

To estimate how non-responding post-funding grantees differed from responding post-funding grantees, an attempt was made to contact all of the post-funding grantees (N=81) among the 157 non-responders to determine closure rates. Twenty-two of the 81 non-responding post-funding grantees were found to have closed; 51 were found to be open and functional; and the status of approximately 8 of these grantees was undetermined. Overall, approximately 16-20 percent of the total number of post funding grantees (N=186) are known to have closed. Therefore, between 80-84 percent of grantees continue to operate and provide services post funding.

**Measurement of Sustainability**

The survey data was analyzed to obtain descriptive grantee information and identify characteristics significantly related to sustainability. For the purpose of this study, sustainability was conceptually defined as "the ability to continue providing an appropriate level of services when operational grant funding expires". Several different strategies were used to operationalize indicators of sustainability. Sustainability is a characteristic of a program that is manifested over time. The optimal approach to measuring sustainability is collecting longitudinal data, to document the "natural history" of program activities across the funded and post-funding periods. In this way it is possible to identify whether a grantee is continuing to provide services, the level and intensity of those services, and any changes in relationship to the elimination of state/CDE funding. The cross sectional nature of this study precludes the use of direct measures of sustainability, other than those sites that are still operational after grant funding ended. As a result, several indirect measures were used as indicators of sustainability. The amount of funding, number of services provided, and the number of partners per grantee were used as indicators of sustainability because each of these factors contribute to the likelihood of continued service provision. Self-reported ratings of service capacity changes were also used to suggest whether service capacity had increased, remained stable, or declined in the post-funding era.

The following strategies were used to identify characteristics related to sustainability:

**a. Assessment of self-reported plans for sustainability and post-operational program changes:** Currently funded grantees were asked if they had developed and implemented long-term sustainability plans, and to identify the collaborative partners named in those plans. Post-funding grantees were asked to report changes in services and staff (numbers and qualifications) after the operational grant period, and to identify collaborative partners who played a key role in the post-funding period.

**b. Comparing post-funding grantees to currently funded grantees:** Those grantees who have continued to operate in the post-funding period have (by definition) sustained at least some functions. Their characteristics (such as collaborative partners and funding sources) provide insight into what program features have successfully continued functioning, and the level at which they are operating. It is likely that some but not all of the currently funded grantees will sustain current levels of service delivery after Healthy Start funding ends. Finding significant differences between the currently funded and post funded sites is one way to potentially identify factors associated with future sustainability based on the assumption that the currently funded group is a mix of both sustainable and not sustainable grantees. To make these

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8Out of the 470 sites/grantees surveyed, 286 responded and were included in the analyses. Excluded from the analyses were 7 grantees reporting closures, 4 grantees under four grants who turned in one survey, 16 grantees who returned the survey after the study period was complete and 157 grantees who did not return the survey.

186 is the sum of all grantees in cohorts 1-5 not including survey respondents who reported taking the grant extension and classified as currently funded (N=35).

9The exact percentage depends on the assumption that the 8 grantees with undetermined status are either open, resulting in a closure rate of 16%, or closed resulting in a closure rate of 20%.

Some key indicators of sustainability may not be easy to measure. Literature and experience would suggest that factors such as leadership, vision, and quality of partnerships would be at least as important, if not more so, than other easier to measure indicators such as the number of people served.
comparisons we used proxy measures of sustainability such as amount of funding\textsuperscript{10}, number of service types offered and number of collaborating partners. Hypothesized predictors of sustainability include total funding, number of service types offered and number of collaborating partners. Each is related to sustainability or "the ability to continue providing an appropriate level of services when operational grant funding expires_.

c. **Trajectories in the post-funding period:** Knowing which programs are struggling to survive, which are able to maintain their mix of services provided when funded by Healthy Start, and which are expanding in the post grant period, provides a better picture of sustainability than simply looking at survival. Post-funded grantees were asked to self-assess their service capacity in the post-funding period—specifically whether funding had increased, stayed the same or decreased. To analyze this self-assessed measure of service capacity, grantees were grouped into three trajectories\textsuperscript{11}: those grantees who reported an increase in service capacity (upward trajectory), those with the same service capacity (same level trajectory), and those who reported a decrease in service capacity in the post-funding period (downward trajectory).

**Potential Limitations:**
This cross-sectional data collection permits a limited analysis of sustainability based on data collected at one point in time. Further inference about sustainability was derived by indirect measures.

In addition, a policy change in 1995 allowed grantees to extend their grant period from three to five years. The total amount of funding allotted to grantees opting for the extension remains the same. If this "no cost" grant extension has contributed to the sustainability or viability of grantees, it could make the comparisons between currently funded and post-funding grantees less clear. This is because the currently funded group includes two different types of grantees: 1) currently funded grantees who extended their operational period from 3 to 5 years; and 2) currently funded grantees who did not take the extension and are in the first 3 years of the operational period. Some of the currently funded grantees who opted for the extension are in effect more like post funding grantees because they have been functional for more than 3 years and have had more time to develop partnerships and cultivate funding streams to support and sustain their sites.

The reported findings may also be affected by the absence of a standardizing variable, such as school size, which would make the amount of funding the grantees receive more meaningful. Ideally we would have included a measure for the amount of funding per child in need of service. A large school that is struggling to maintain services and serving only a fraction of the students in need (and potentially not sustainable) could actually have a larger budget (thus appearing sustainable on one of the measures used) than a smaller school that meets the needs of most of their children and is expanding services. Unfortunately, these data were not available, and this limits the utility of the measure of total funding that was used.

Further, as mentioned in the Methods, this study is subject to non-response bias. If non-responding grantees are in some way different from those responding, the ability to generalize our findings to all Healthy Start grantees is somewhat limited. For example, if non-responding grantees were from programs that were struggling or closed completely, the study findings will be overly optimistic. It is likely that the post-funding grantees that responded (N=89) are not representative of the overall post-funding grantee population (N=186).

\textsuperscript{10}The "amount of funding" variable was created from the CDE's Partnerships Supporting Sustainability Chart. The total amount of funding for post-funding grantees includes Medi-Cal reimbursements, grants received from non-Healthy Start sources such as foundations or government agencies, and school or district funds that have been redirected to support qualifying Healthy Start activities. In addition, grantees were asked to give a monetary value to in-kind services provided by partners and for equipment and space donations. These sources were combined to create a total amount of funding (support) received by the grantees.

\textsuperscript{11}The word "trajectory" has been used to depict the path or progress of the Healthy Start initiative based on change in post-funding service capacity. It is possible to use a variety of measures to determine sustainability trajectories, such as funding, number of collaborative partners, types of services among others. However, given the data collected, a service-capacity trajectory was used as a proxy measure for level of sustainability.
No closure data was available when this study was initiated. The evaluation team made follow-up calls to all non-responding post-funding grantees to determine closure rates.

**FINDINGS**

Multiple factors may play a role in the functionality and sustainability of grantees. This study of Healthy Start sustainability found that most grantees (80-84 percent) continue to operate in the post-funding period. Post funded grantees often had different characteristics than currently funded grantees. These differences are likely due to a combination of a historical or cohort effect and practices that may have affected sustainability. They also might represent a "maturational effect" that result from solidifying relationships and funding commitments. Survey findings highlighted the following characteristics of Healthy Start grantees:

**Grantee Characteristics**

A profile of Healthy Start grantees in California shows what services have been provided and how the types of services currently offered varies by funding status. Questions about grantee characteristics were included in both versions of the survey (N=286).

- Most grantees reported providing an average 12 of the 15 different service types, with a minimum of 4 and a maximum of 15 service types.
- The most frequently offered services were Family Support and Functioning Services, Case Management Services, Parenting Education, Basic Needs Services, and Mental Health Services.
- On-site Medi-Cal enrollment was the only service showing much difference between current and post grantees. Approximately 83% of currently funded grantees offered on-site Medi-Cal enrollment compared to 74% of post-funding grantees.
- The most frequently reported offered services using shared staff were Youth Academic Services, After School Programs, Mental Health Services, Health Education Services, and Parenting Education.
- Reported use of shared or blended funding was highest for service types of Youth Academic Services, Youth Development Services, Family Support and Functioning Services, and Parenting Education.

**Coordinator Characteristics**

Healthy Start Coordinators play a central role in Healthy Start programs by a) coordinating services for families and b) administratively coordinating the activities of the direct service providers and partners. Thus coordinator skills may be associated with program success. Proxy measures for management abilities include educational background, and experience measured as tenure with the Healthy Start site. The amount of coordinator time dedicated to specific Healthy Start activities could differ with site maturation. Questions on coordinator characteristics were included in both versions of the survey (N=286).

- Coordinators spent 1-2 years (the standard deviation was 2.4 years) as coordinators of the Healthy Start site/initiative.
- Currently funded grantee coordinators spend an average of 90% time coordinating Healthy Start activities whereas post funded coordinators spend an average of 75% coordinating these activities.
- 61% of coordinators reported having a Master's degree and 28% reported having a four-year degree.

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12 The findings presented are primarily descriptive in nature. Statistically significant associations have been presented in the "Sustainability" section.
13 Shared staff is defined as the use of staff funded by one agency and providing services to multiple partners, or staff that serve one agency or school but are funded by more than one entity.
14 Shared funding is defined as the use of combined funding resources to provide a service or a set of services.
The Collaboration Process
One of the primary responsibilities of the coordinator is to build relationships with outside agencies and groups. These collaborators either directly provide services to children, or fund the services. Local Healthy Start collaborators can play many important roles. The collaborative process can help local agencies plan more efficient service delivery, eliminate duplication of services, and identify and fill gaps in service to families. For long-term sustainability of Healthy Start grantees, relationships must be built with the decision-makers in collaborating local agencies who can assign staff, or direct funds to fulfill the Healthy Start collaborative service needs. These relationships are considered as the foundation for future commitments to service at the Healthy Start initiatives. Questions on collaboration were included in Version 2 of the survey (N=144).

- The four most common groups reported to participate in collaborative meetings were public and private agencies (88%), CBO’s (83%), schools (79%) and families (60%).
- 60% of grantees with agencies involved in their collaborative meetings reported that the agency representatives had decision-making power for the agencies.
- Most of the grantees reported active collaborative participation by local school districts, city and county agencies, with school districts (or county office of education) having the most frequent involvement (92%), followed by counties (76%) and cities (73%). More than half of the grantees reported that the school district provided facilities (71%), policies (67%), governance (56%), funding (55%), or staff (51%). The top two areas of involvement for cities and counties were staffing (42% and 51%) and funding (31% and 34%).
- Nineteen percent of grantees reported no county involvement and 24% reported no city involvement.
- Grantees reported that successful collaborations resulted in: improved services to families, better coordination between service providers, easier access to services for families, less duplication of services, and improvements in school attendance and academic outcomes.
- The most frequently reported barriers to collaboration were finding time for multiple agencies to meet (63%) and communication problems (32%). Overall, grantees were more likely to report benefits of collaboration than difficulties with the collaborative process.

The Case Management Process
Case management is an integral component of service coordination. Case managers can link families with multiple needs to the services they need. Case management has been defined as "a system in which individuals were responsible for coordinating student or family care across agencies". Questions on case management were included in Version 1 of the survey (N=142).

- Most grantees (96%) reported the provision of case management services.
- 54% of the grantees providing case management used Healthy Start Staff. About 44% provided case management through a combination of both Healthy Start and partner agency staff. Post-funding grantees were more likely to share case management responsibilities with agency staff than currently funded grantees (51% vs. 40%) or to rely on the case management systems of other agencies entirely (5% vs. 1%) although this was rare.
- For follow-up of cases (case managing) by grantees, 80% reported conducting follow-up by contacting service agencies. 93% reported following up by directly contacting students and families. More than half of the grantees reported the use of computer software for the case management process.

The School-Healthy Start Site Integration Process
Having a positive relationship with the school site and district can result in significant benefits for Healthy Start grantees, especially in the post-funding period. The school has control over space allocated to the Healthy Start program. Both schools and districts have funding streams that could help to support Healthy Start
By enrolling as LEA Medi-Cal Billing Option providers with the DHS, school districts can claim reimbursement for covered services\(^5\) to students enrolled in Medi-Cal, provided that licensed or credentialed providers, such as school nurses, and/or specialized special education staff, deliver services\(^6\). School districts must also be willing to reinvest reimbursed Medi-Cal funds in services for school children and their families and have school-linked services collaborative group set priorities for reinvestment\(^7\) of funds made available through the LEA Medi-Cal Billing Option.

The California Department of Education (CDE) has actively promoted the use of LEA Medi-Cal funds as a key strategy for sustaining Healthy Start initiatives, since the inception of the program\(^8\). However, the use or potential use of these funds is complicated. The extent to which Healthy Start initiatives are able to access or compete for these funds is dependent upon many factors\(^9\), including district strategy and leadership regarding school-linked services, composition of the collaborative, and effectiveness of the Healthy Start site supporters at developing relationships and mobilizing support\(^20\). Many Healthy Start grantees seem to be depending on LEA Medi-Cal funds and there seems to be an association between LEA Medi-Cal funds and site/grantee sustainability. However, there are a group of grantees billing (through their districts) but not receiving funding/reimbursement directly — even though their districts are. Reimbursement of LEA Medi-Cal funds to Healthy Start grantees varies by district and represents a potential problem.

- Contrary to concern about low levels of awareness of the potential use of LEA Medi-Cal funds for grantee sustainability, the findings suggest both, a high level of awareness of the potential availability of LEA funds as well as high rates of district billing and procurement of funds.
- Approximately 86% (N=237) of grantees reported that their districts currently billed for LEA Medi-Cal money. Approximately 7% (N=18) reported that their districts were not billing for LEA Medi-Cal funds. Most grantees reported that their districts were either billing, or planning to bill for LEA Medi-Cal funds (93% of currently funded grantees and 90% of post-funding grantees).
- Not all grantees bill for LEA Medi-Cal funds, and not all that bill necessarily receive funding. Moreover, there may be differences between current and post-grantee success in procuring LEA funds. Descriptive analyses indicated that the average LEA sum promised or awarded to grantees was reported to be

\(^5\)Covered services include, but are not limited to, health services provided to students as part of an Individualized Education Plan (IEP), Individualized Family Support Plan (IFSP), of Individualized Health Services Plan (IHSP).

\(^6\)Recent Changes in the LEA Medi-Cal Billing Option: 1) Reduction in Targeted Case Management Reimbursable Services. As of July 1, 2001, the DHSS eliminated reimbursement for Targeted Case Management (TCM) services to students who have an Individual Health Service Plan (IHSP) and limited TCM reimbursement to students enrolled in Special Education Programs. This will severely limit the ability of Healthy Start grantees to claim reimbursement for TCM, which is the cornerstone of Healthy Start; and 2) Expansion of Covered Practitioners - More Revenue for Reinvestment. DHSS is developing new regulations, which will significantly increase the number of school psychologists and speech-language pathologists to the list of eligible providers. Billing for these services has previously been limited to licensed practitioners only. Because most of these services in California are provided by credentialed, rather than licensed providers, this is expected to result in a significant increase in overall LEA reimbursement revenue which can be used to sustain Healthy Starts depending upon the decisions of the interagency collaborative.

\(^7\)California Department of Education web page on the Medi-Cal billing option. http://www.cde.ca.gov/healthystart/medi-cal


\(^9\)Some of the factors that influence LEA Medi-Cal reimbursement priorities and Healthy Start's access to these funds include the following: 1) The LEA Medi-Cal reimbursement provision does not specify or require collaborations and/or districts to allocate any reimbursed funds to Healthy Start initiatives; 2) Only districts or county offices of education can enroll as LEA providers. Schools cannot enroll as providers. This is in contrast to Healthy Start - which is school or school cluster specific. Healthy Start grantees may be actually providing covered services as well as billing - but the overall billing is done by the district or service provider by district employees; 3) There may be multiple district stakeholders competing for these funds. There is significant pressure to return all or a portion of the LEA Medi-Cal Billing Option revenue to the district departments/staff units responsible for generating the funds. School nurses and special education specialists are usually responsible for generating most of the LEA Medi-Cal revenue for districts; 4) Once a school district has fully established a LEA Medi-Cal billing program, revenue will likely be relatively stable/flat. However, the number of Healthy Start sites may increase over the years as districts continue to respond to the annual availability of new Healthy Start funds. This may lead to increased competition between local Healthy Start grantees/sites and other stakeholders within the district (i.e., special education, health services) for LEA Medi-Cal funds; 5) The LEA Medi-Cal Billing Option provides partial reimbursement to local education agencies for the provision of certain school-based services delivered by staff who meet DHSS qualification standards (primarily licensed or credentialed specialists) to students enrolled in Medi-Cal. Because the strict staff/practitioner qualification standards, most Healthy Start grantees/staff are limited in their capacity to provide billable services or generate LEA Medi-Cal reimbursement. For this reason, Healthy Start grantees are more likely to be consumers of LEA Medi-Cal revenue than producers; and 6) Some districts began participating in the LEA Medi-Cal Billing Option before they had any Healthy Start grantees/sites. In some cases, this has resulted in no Healthy Start representation in the interagency collaborative decision-making body - and the reinvestment priorities and mechanisms reflect the needs of the then existing stakeholders (Don Boloe).

\(^{10}\)Personal communication with Don Boloe, Director, LEA Medi-Cal Technical Assistance Project, Santa Clara County Office of Education, San Jose, http://www.leanesi-cal.org.
$20,000, with post-funding grantees (Cohorts 1, 2 and 3) reporting higher amounts of money (median $25,000) than currently funded grantees (median $15,000).

- However, while approximately 86% of grantees (N=237) reported that their districts billed for LEA Medi-Cal money, 59% (N=140) of these grantees reported receiving LEA monies. The remaining 41% (N=97) reported not receiving any LEA money even though their districts billed for LEA monies.
- Fifty-three percent of currently funded grantees reported that the Healthy Start Collaboratives21 made spending decisions. Other decision-makers on LEA funding were LEA Medi-Cal collaboratives and school districts.

**Sustainability**

Different measures of Healthy Start grantee sustainability (all measures of the ability to continue providing services at an appropriate level when funding expires) produced several findings.

First measure of Sustainability:
The first measure used predictors of sustainability for currently funded grantees (presence and content of a sustainability plan), and for post-funding grantees, any post-funding changes as measured by an assessment of grantee self-reported changes in service and staff (numbers and qualifications) to measure sustainability.

Currently funded grantees

- Grantees may not be beginning the process of developing and implementing sustainability plans in sufficient time to preclude long-term sustainability difficulties. Approximately 66% of currently funded grantees reported having developed a long-term sustainability plan, and 75% of these reported that they had begun implementing their plans. Grantees in more recent cohorts (cohort 8 (1998-99), cohort 7 (1997-98) and cohort 6 (1996-97)) were more likely to report not having or not yet implementing a sustainability plan.
- The most frequently reported collaborative partners reported in sustainability plans were school districts, community-based organizations, and county and city agencies.

Post-funding grantees

- As with currently funded grantees, primary collaborative partners reported by post-funding grantees after the operational grant period were schools, county agencies, and nonprofit agencies.
- A significant proportion of post-funding grantees reported offering a combination of services following the Healthy Start operational grant period. Few grantees reported that the quality of services declined after the operational grant period.
- Post-funding grantees frequently reported a decline in staff numbers after the operational grant period (47%), and very infrequently reported an increase in staff numbers after the operational period (24%).
- Post-funding grantees generally reported that staff qualifications did not decline or improve after the operational grant period.

*Cohort analysis:* A cohort analysis of the post funding grantees indicated that a substantial number of grantees within each cohort (more than 20%) reported a decline in the number of services offered after the operational grant. Grantees in the earlier cohorts (Cohort 1 (1991-92) and Cohort 2 (1992-93)) were more likely to report a decrease in staff numbers after the operational grant than grantees in later cohorts (Cohort 4 (1994-95) and Cohort 5 (1995-96)). No significant differences were found in the number of service areas offered or the number of collaborative partners reported by grantees in the 5 cohorts. Overall, grantees in earlier cohorts reported lower funding amounts than grantees in later cohorts. This potentially indicates that an erosion of funding is taking place over time, and suggests that problems with

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21DHS requires that decisions about the reinvestment of LEA Medi-Cal revenue be made by an interagency collaborative – which could either be a Healthy Start collaborative or other existing interagency collaborative (Don Bolce).
sustainability may not necessarily manifest themselves immediately after state Healthy Start grants are terminated.

Second Measure of Sustainability:
A measure of sustainability was also used. This measure of sustainability was based on more money, number of services and number of collaborating partners in the post-funding period.

- When considering factors for sustaining services, funding (82%) followed by collaboration (40%) and administrative support (39%) were ranked as the important factors for sustaining services by grantees overall.
- Funding was reported as the most important factor for sustaining services by 82% of the grantees. Funding is paramount for grantees trying to maintain services.
- The average amount of funding reported by grantees was approximately $220,400 (median value). Post funding grantees reported higher amounts of both LEA and overall funding amounts than currently funded grantees. Grantees in the earlier cohorts were more likely to report higher LEA and higher overall funding amounts than those in more recent cohorts.

Grantees that have higher funding amounts may have other characteristics associated with sustainability:
- Grantees reporting higher funding amounts were also more likely to report receiving more LEA Medi-Cal funds. This finding implies that higher (total) amounts of LEA funds are associated with higher total funding amounts. This also highlights the important role of LEA funds in determining the total funding obtained by grantees and in turn their odds for sustainability. Post-funding grantees were more likely to report that their districts were billing for LEA funds, as well as receiving more LEA funds than currently funded grantees. This finding may be associated with the increased likelihood of post-funding grantees using LEA monies as funds for the continued provision of services than currently funded grantees. It also may mean that it takes time to organize how to bill and receive LEA Medi-Cal funds.
- Recent cohorts reported lower funding totals.
- Funding amounts reported by grantees were also associated with the number of collaborative partners reported by them. Grantees with more money were more likely to report more collaborative partners than grantees with less money.
- Post-funding grantees were more likely to report that their sites had conducted additional evaluations (other than the HS evaluation) than currently funded grantees. Currently funded programs tend to only take part in the California Department of Education evaluation, as they are not in the process of seeking funding. It is likely that post-funding grantees have had greater need, opportunity and time for additional evaluations and that evaluation data were used to justify further funding. Both currently funded and post-funding grantees reported evaluation findings to have been helpful in sustaining the commitment of collaborative partners.
- Currently funded grantees (97%) were more likely to report the use of a case management system than post-funding grantees (87%). This suggests that grantees may have difficulty maintaining case management services in the transition from Healthy Start funding.

Third Measure of Sustainability:
The third measure used grantee self-assessment of changes in their post funding service capacity to distinguish between different levels of sustainability in the post-funding period. Using a self-assessed measure of service capacity, a "service trajectory" was created for all post-funding grantees. Three levels of sustainability were developed to represent the ongoing (post funding) service delivery capacity: 1) Post funding grantees who reported an increase in service capacity after Healthy Start funding ceased - were designated as being on an upward service trajectory (30%); 2) Post funding grantees with no change in service capacity (or
reporting different services) - on a “same level” functional trajectory (33%); and 3) Post funding grantees reporting a decrease in service capacity - on a “decreasing” functional trajectory (37%). Evaluating the sustainability of Healthy Start initiatives based upon self-assessed service capacity of the collaboratives is only one potential indicator of sustainability\(^22\). In order to do a more comprehensive examination of factors relating to sustainability, longitudinal data should be collected.

- Post-funding grantees in the upward sustainability trajectories (who reported an increase in service capacity after the operational period) reported the highest rate of participation in additional evaluations (other than those required by the CDE).
- Higher amounts of funding were found for grantees in the upward trajectories (mean value $761,300); lower amounts were found for those in the no change trajectory (mean value $380,852); and the lowest amounts were found for those in the downward trajectory (mean value $281,090).
- No significant associations were found between the sustainability trajectory measure and LEA funds or the number of collaborative partners reported.

This self-assessed trajectory analysis was based on reported provision of services in the post-funding period. Some grantees were maintaining their level of services or expanding their service capacity, indicating a long term sustainability path, while others appeared to be declining due to down sizing or a slow and eventual phase out. Those grantees in the most positive service trajectories also report more money, more LEA funds, a more use of evaluations during their tenure.

Because these measures of sustainability are taken at a specific point in time their usefulness is limited for showing whether the grantees are increasing, decreasing or maintaining a constant level of service. For example, grantees currently on a “same-level” trajectory may progress to a more positive trajectory or conversely may decline and follow a downward trajectory (and head for possible closure) next year. Therefore, the ideal method for operationalizing this concept of sustainability would be to follow individual grantee service trajectories over time. Comparisons could then be made to determine factors that differentiate grantees in a state of decline from those maintaining or expanding programs.

**CONCLUSIONS**

Healthy Start has been recognized for playing a crucial role in improving student academic achievement and family functioning, as well as integrating effective services that foster school success, and connecting community agencies with the children and families they serve.

However, the success of Healthy Start initiatives depends on several factors, including sources of funding and types and numbers of collaborative partners, which impact the overall sustainability of these efforts. Addressing the various determinants of sustainability will enable the continued use of core state investments, student and family successes to be maintained and maximized, and the Healthy Start “service platform” to be used by complementary initiatives such as Proposition 10 in California\(^23\).

This analysis of the sustainability of Healthy Start grantees in California found that a majority of the grantees (80-84% of the post-funding grantees) were still in operation. In order to develop a more sensitive set of

\(^{22}\)It should be noted that there are potentially several measures as well as techniques that can be used to measure sustainability. Service capacity was used as a measure in this study because of the nature of data collected. However, the use of service capacity as a measure of sustainability is somewhat limited. A more reliable measure could result by the inclusion of different measures in the designation of trajectories, such as funding and staff, in addition to service capacity.

\(^{23}\)Personal communication with Roberta Peck, California Children and Families Commission.
indicators of longer term viability, responding post-funding grantees were divided into three service trajectories, using indirect measures based on self-assessments of service capacity after Healthy Start funding ceased. The service trajectory analyses revealed that almost two-thirds of the post-funding grantees still in operation were either maintaining their level of services or expanding their service capacity, thereby indicating a long-term sustainability path.

A stratified analysis of the grantees by cohort also revealed important differences based on length of time in operation. The findings indicated that a large proportion of the grantees were on a positive trajectory. The cohort analysis also indicated that certain strategies actively promoted by the CDE, such as the use of LEA Medi-Cal funds as a key strategy for sustaining Healthy Start initiatives, have had an important impact on program sustainability. Grantees with the most positive service trajectories were programs with larger amounts of funding, especially LEA Medi-Cal funds. Although most Healthy Start grantees reported large numbers of collaborative partnerships, partnerships that helped to obtain LEA Medi-Cal funds were clearly important.

The results also indicated the utilization of supplementary evaluations and program monitoring as a potential determinant of sustainability. While the survey did not examine in detail the purpose and use of the additional evaluations, the results suggest that the collection of additional program evaluation data was used to justify ongoing funding and support. Requiring and supporting a greater reliance on results based accountability (RBA) as a condition for Healthy Start funding could potentially be an additional mechanism to improve outcomes and sustainability. This would require that the state Healthy Start program provides additional technical assistance to grantees about the importance of and need for an RBA framework, and develop a tool kit that grantees could use to meet these new requirements.

Some potential concerns related to sustainability emerged from the findings. For example, while two-thirds of the post-funding grantees were either maintaining or expanding their service capacity, the remaining one-third of grantees reported a diminishing service trajectory that would indicate decreasing ability to provide services and, in turn, low future sustainability. In addition, the largest proportion of those that were not on an improving service trajectory came from earlier cohorts, suggesting not only that some earlier/older cohorts were dying off, but that problems with sustainability may not manifest immediately.

The cross-sectional nature of the data collected posed certain limitations and did not allow for drawing more concrete conclusions, especially for those grantees on an improving or same level trajectory. In order to get such information, in-depth case studies of grantees (both improving and not improving) would have to be conducted, in addition to the collection of longitudinal grantee data to find causal relationships.

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24 Grantees were asked whether they had had any evaluations in addition to the annual Healthy Start evaluation.
RECOMMENDATIONS

While there might be other strategies that would assist grantees achieve long-term sustainability, these were the ones that emerged most directly from our analyses.

Recommendations based on survey findings:

1. Increased Funding

Funding was the most important factor, identified by grantees, for maintaining and sustaining services. Approximately 81% of currently funded grantees and 85% of post funded grantees reported funding as the number one facilitating factor for sustaining integrated services to school age. Similarly, the majority of grantees reported funding as the major barrier to providing and sustaining integrated services to school age children.

2. LEA MEDI-CAL – Increased Billing, Reimbursement, and Capture of Funds

This study indicates that LEA funding is significantly associated with grantee sustainability. Grantees on the most positive service trajectory generally reported more LEA funds (including overall funding). Therefore, taking steps to facilitate a connection between Healthy Start grantees and LEA Medi-Cal billing should be an ongoing priority. An LEA Medi-Cal assistance project in Santa Clara has provided technical assistance to school districts and Healthy Start sites25. While the survey found that approximately 86% (N=237) of grantees reported that their districts billed for LEA Medi-Cal money, only 59% (N=140) of these grantees reported directly receiving LEA monies that were billed for. This indicates a potential disconnection between Healthy Start grantee billing for LEA monies and the allocation of the actual reimbursed funds by the school districts. This finding suggests that over the long term there might be little incentive for school sites/grantees to bill for LEA monies if they do not receive reimbursement at the school for support of the Healthy Start program. A remedy for this disconnect should be sought at the school district level, and could be part of state Healthy Start program requirements.

3. Increased Participation by School Districts

While there is little doubt about the roles that the school site plays in grantee sustainability (such as the provision of space and/or funds), there is less clear evidence that school districts are doing all that they could do to provide fiscal and administrative support to local school sites/grantees. One potential strategy would be to consider mechanisms that could be used to actively engage school districts in the Healthy Start programs in their district, with guidance and pre-funding agreements about providing support, in soliciting funds, and serving as fiscal intermediaries. It should be noted that in certain counties, county offices of education play a critical role for districts, and in others, especially large districts, they play a minimal role.

25Personal communication with Don Bolce, Director, LEA Medi-Cal Technical Assistance Project, Santa Clara County Office of Education, San Jose, http://www.lesmedi-calca.org
4. Increased Participation by Counties

The results of this survey indicated a potentially important yet unfulfilled role of county agencies (health, mental health, social and children services) in the sustainability planning process and in the ongoing funding of collaboratives that developed at sustainable sites/grantees. The data, while incomplete, suggest that partnerships with county agencies were important in many cases. Most grantees reported some level of county involvement but the level and intensity of that involvement was not quantifiable. However, by examining the major sources of funding, and other sources of staffing and service support, it appears that county Departments of Health, Mental Health, and Social Services could be playing a much more active, engaged and supportive role with Healthy Start sites. Nineteen percent of Healthy Start grantees reported no county involvement at all.

County agency partners may be untapped resources for many initiatives/grantees. Potential areas of county assistance include program integration, co-location of staff from county agencies, billing, staffing, evaluation and provision of funds. The current Healthy Start initiative makes no provision for encouraging or mandating local government involvement, nor do they provide incentives for county involvement. As such, grantees are left with the task of soliciting aid on their own. Coordinated efforts must be initiated to ensure long-lasting service ties with county agencies that will make it easier for grantees to continue functioning after grant funding has ended.

These findings would suggest that the Healthy Start Program should take steps to include incentives for increased participation by relevant county agencies, such as county departments of Health, Mental Health, Public Social Services, Children and Family Services in the planning and implementation phases of their local grantees. This too might be facilitated by appropriate guidance and a requirement of a pre-implementation grant agreement between the local school district and the county agencies. In addition, in order to facilitate county participation, the relevant state agencies must also be involved. State Departments of Health and Mental Health should encourage their local county agencies to support Healthy Start Collaboratives "systemically" which would mean a more systemic, comprehensive, and cooperative delivery of services across county agencies.

As Healthy Start moves forward, each local Healthy Start collaborative should consider mechanisms that could be used to engage and connect county agencies to the Healthy Start initiatives in their county. This might be done through the County Office of Education or through direct requirements that CDE places on counties to participate in their local Healthy Start programs. This might require counties to demonstrate their ability to commit resources and in-kind support to the Healthy Start programs.

5. Increased Evaluation Efforts/Program Monitoring and Quality Improvement

Survey findings indicate that conducting additional evaluations may play a role in grantee sustainability. Post-funding grantees, that reported the most positive service trajectories, along were more likely to report additional use of evaluations compared to other grantees. While the questions in this survey were of a general nature, the association that was found between greater sustainability and additional evaluations raises several issues about the need for ongoing evaluation, especially evaluations designed to lead to program improvement as well as those that can be used for accountability purposes with a funding agency.

The current cross-sectional survey, while important in filling in a number of data gaps, is not sufficient to answer many important questions related to program impact and accountability. The statewide evaluation

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\[28\] It should be noted that in certain counties, county offices of education play a critical role for districts, and in others, especially large districts, they play a minimal role.
process should be augmented to examine process and outcome data in order to have clearer standards for accountability common to all Healthy Start grantees. Consideration should be given to creating an ongoing evaluation structure to permit on going performance-based evaluation designed to demonstrate whether programs are improving over time.

6. Early Planning for Sustainability

Survey findings also suggest other factors that are related to sustainability such as the need to plan ahead for ongoing financing and continued program development. The early development of sustainability plans, during the first or second year of the grant, and strategic development of collaborative partnerships, appear to be important ingredients in a sustainable strategy.

7. Case Studies and Collection of Longitudinal Data

Another approach that could be taken by the CDE to further understand the determinants of sustainability would be to conduct in-depth case studies of grantees that have obviously achieved a positive long-term sustainability trajectory versus those who have failed. Although additional funding would be needed, this type of in-depth analysis may reveal additional determinants of sustainability that might be applicable across all sites/grantees and could be built into the program administration and guidance. An additional approach, to better understand the determinants of sustainability, would be to collect longitudinal site/grantee data to understand the causal relationships between different determining factors and sustainability outcomes.

Additional recommendations to consider:

The following recommendations, though relevant, do not necessarily come from survey data. They come from related academic and scientific sources.

1. Increase Overall LEA Medi-Cal Funds

To increase revenue available to Healthy Start several strategies could also be proposed. These include: a) Working with the California Department of Health Services to raise reimbursement rates for services provided by Healthy Start grantees; b) Expanding the number of school personnel who can bill for services beyond the licensed and/or credentialed health care practitioners; and c) Enabling para-professional staff under the supervision of credentialed professional staff to bill for Targeted Case Management. This is currently permissible under the auspices of county governments but not allowable by school districts. Developing a sustainable revenue stream for the case managed and care coordination functions of Healthy Start is perhaps the most important strategic policy change to be considered since so much of the coordination function of the collaborative service model depends on case management and coordination.

2. Service Coordination: Dedicated Effort and Division of Responsibility

Personal communication with grantee coordinators during case study interviews identified the need for a full time coordinator as one of the most necessary components for running a successful program. The presence

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27Currently most treatment services can only be billed for by licensed practitioners. Most schools have credentialed practitioners — who cannot bill for treatment services (Don Bolce).
of a full-time coordinator at a single site could directly influence sustainability. When coordinators coordinate single (as opposed to multiple) sites, they can dedicate more of their efforts to program development, service coordination and collaboration. Moreover, currently coordinators must fulfill multiple roles of program developers and systems change agents. It may be more efficient and effective to separate these responsibilities into two different positions. This might involve maintaining a coordination position to deal with day-to-day operations, needs assessments, program development and planning. Another approach is to create a new position (or increasing the involvement of CDE regional technical assistance and support personnel) to serve on behalf of clusters of grantees in the areas of financing and contract negotiations.

3. Provision and distribution of additional or sustainability funds

The need and potential utility of additional funding for the Healthy Start should also be considered. As determined by survey questions regarding the investment priorities for potential sustainability funds, additional state funds could play an important role in the ongoing provision of services by some grantees that have not been able to organize a viable sustainability strategy by the time that the operational grant period has ended. At present, currently funded grantees are given the option to extend their 3-year operational period to 5 years with the same amount of funds. While expanding the number of years definitely provides grantees with additional time to focus on operational and long-term sustainability objectives, it is not clear whether additional funds are needed for the extended time period. Strategic planning for the long term might decrease the need for post operational funding, and could ease the transition from current to post-funding status. Currently the California legislature is considering AB 892 that would offer one-time funds to partnerships to boost efforts toward locally maintained Healthy Start initiatives28.

4. Moving From Program Sites to Macro Level Policy

"Although valuable in its own right, Healthy Start was intended as a catalyst for broader and more comprehensive system development"29.

Moving toward a comprehensive, multifaceted, and integrated approach to addressing barriers to learning and enhancing healthy development of children – necessitates a shift in focus from the sustainability of specific programs to more comprehensive service systems reform and improvement. State leadership can play a critical role in the facilitation of systematic change. Given 10 years of Healthy Start experience within individual schools and school districts, a number of innovative methods for organizing, delivering and financing services have emerged at the local level. Similarly, this 10-year experience has also demonstrated clear and systematic barriers to success. There is a great deal that can be learned from this experience, to develop a set of crosscutting "change concepts" for system reform and improvement. Since the relationship between Healthy Start grantees and the health service delivery sector (medical, dental, preventive, developmental,

28AB 892 - Healthy Start Support Services (introduced on February 23, 2001). This legislation recognizes the success of the Healthy Start in improving academic results for students and functioning for families, integrating well researched services that foster school success, and connecting community agencies with the children and families they serve. It also recognizes that the coordination of these strategies and programs that support these successes require a minimal base of financial support so that the maximizing and leveraging of core state investments can continue; student and family successes can grow; and the Healthy Start "service platform" can be used by complementary initiatives such as Proposition 10 in California. Focus of the bill AB892This bill would require the Superintendent of Public Instruction to develop an equitable process for the awarding of $25,600 one-time strategic planning grants to local educational agencies or consortia after a program's 3- to 5-year operational grant period. There would be no additional funding. To be eligible to receive a grant, a local educational agency or consortium would be required to submit a plan demonstrating that the program meets certain criteria. The bill would require each program site, on an annual basis, to submit a report to the state and its regional network that updates the status of the local program in fulfilling the criteria and includes input, process, and outcome indicators and quality assessment. The bill would authorize $100,000 a year for four years for an evaluation of the strategic planning grants and would increase the amount allocated to regional grants to $1,100,000.
29Personal communication with Howard Adsman, professor of psychology at the University of California, Los Angeles, and Roberta Pek, California Children and Families Commission.
mental health services) is so crucial, steps should be taken to consider ways to facilitate the delivery of these services in a more systematic fashion. The California Department of Health Services could play an important role in facilitating the mission and goals of Healthy Start by working to diminish existing administrative, organizational and financial barriers that hamper service delivery at the local level.

Simply sustaining Healthy Start projects in the short run will not generate the systems reform and improvement that is necessary nor build the kind of infrastructure that schools need for learning supports and for full-scale school-community partnerships that potentially marshal the full range of resources in a neighborhood or community. There is an opportunity to utilize Healthy Start from not only as a set of demonstration sites but as the catalyst for state policy changes that will allow communities to better support schools as they address barriers to learning and enhance healthy development. An important first step would include attending to financial sustainability issues and consideration of how to bring together (and eventually blend) existing funds not only to underwrite but also to sustain the important work of Healthy Start.
INTRODUCTION

Local education agencies such as schools and school districts have been implementing Healthy Start programs across the state of California since 1991. These programs are intended to provide families with better access to health and social services, with the ultimate goal to support the learning process for their children. The direct motive of the Healthy Start Initiative is to use learning support techniques to improve academic achievement for all children. Healthy Start grantees receive funding support over a period of three to five years. By design and legislative intent, Healthy Start programs are meant to be self-sustaining, so each grantee must develop an infrastructure that will support the continued integration and delivery of services to families after grant funding ends. Therefore, in addition to the key program outcome of reducing barriers to learning, successful Healthy Start programs must also become sustainable. The purpose of this report is to analyze the extent to which Healthy Start grantees have achieved sustainability and to examine those factors that serve as key determinants of sustainability.

The following research questions guided this study:

1. What services are Healthy Start grantees currently providing to school-aged children and their parents?
2. How have collaborative partnerships and different funding mechanisms been used by Healthy Start grantees?
3. How have local service delivery systems changed as a result of Healthy Start?
4. Is Healthy Start sustainability associated with grantee characteristics and design features including resources, level of service integration, availability of LEA Medi-Cal billing, types of case management, levels of collaboration, and ongoing evaluation.

This report provides background information on the Healthy Start Initiative and describes the methodologies used to gather information on Healthy Start grantees (survey development and administration). The report also offers descriptive information on the grantees, identifies characteristics significantly associated with sustainability, and offers conclusions from the findings.
BACKGROUND

Senate Bill 620, the 1991 Healthy Start Support Services for Children Act, established California’s Healthy Start Initiative\(^3\). The Initiative was originally authored by Senator Presley of Riverside in 1991. It is administered by the California Department of Education (CDE), which awards planning and operational grants to local education agencies to work in collaboration with public and private community organizations to develop or expand comprehensive, integrated school-linked services.

The Healthy Start initiative is funded by Proposition 98, the "Classroom Instructional Improvement and Accountability Act". Healthy Start was launched in order to allow schools to provide a range of health and social services, and to support the learning process in order to improve academic achievement for all students. Three general goals of this Initiative are: 1) To ensure each child receives the necessary physical, emotional and education support for optimal learning; 2) To stimulate the reorganization of schools and the local agencies toward more integrated and effective strategies for service delivery to children and families; and 3) To get students and parents to become active participants, leaders, and decision-makers in their communities. To better meet the needs of the school learning community, Healthy Start provides an opportunity for schools and their collaborating community partners to develop new service delivery capacities in order to provide essential learning support services for students and families. These learning support services may include health and mental health services, family support and social services, case management and other social as well as academic support.

Grants are awarded to schools with large populations of low-income or limited-English-proficient students for a period up to five years. Healthy Start legislation dictates that to qualify for funding, at least 50% of students enrolled at the elementary school and at least 35% of students enrolled at the middle or high school are either from families that receive TANF/CalWORKs or have English Learners or the students are eligible to receive free or reduced-priced meals. If applying schools do not meet the above criteria, they must demonstrate the existence of special factors (special factors award provision) that warrant consideration\(^2\). In addition, applicants for Healthy Start grants must show how they will link with education reform initiatives and support educational success for all participating students.

Funds are provided to coordinate an integrated service approach through establishing a strong foundation for systems change. Over the course of the Healthy Start Initiative, from 1992 to 2000, nine cohorts have received funding, resulting in 549 operational grants. These grants support sites serving 1,244 schools and 949,430 students\(^3\). Our study includes sites through Cohort 8. These Healthy Start sites have already implemented services and served 865,205 students in 1122 schools. The program began with more modest funding but has remained at $39 million annually since 1996.

The Healthy Start Initiative is particularly important for the State’s low-income children and families. California’s population was 32,667,000 in 1998\(^4\). Of that number, 18% are living at or below the State Poverty Rate. This figure includes 26% all school age children between the ages of 5 and 17 who live in families with incomes below the poverty level. Accessing healthcare is a great challenge to these families. According to a

\(^3\) Healthy Start Request for Proposals (RFP)
recent study by the American Academy of Pediatrics, 2,026,688 California children are not covered by health insurance. Most are in families with incomes below 200% of the federal poverty level. Uninsured children face a number of predictable access barriers. The majority of uninsured children with asthma never see a doctor during the year\textsuperscript{35}. One in 3 uninsured children with recurring ear infections never see a doctor during the year\textsuperscript{36}.

An evaluation of Healthy Start conducted during the first three years of the initiative (1992-1995) by SRI International\textsuperscript{37} found that the program successfully affected several key outcome measures such as reductions in unmet needs for goods and services (such as food, clothing and other basic needs), childcare, and health and dental care, as well as a decrease in incidences of family violence. These outcome measures exhibited marked improvement over the three-year span of the evaluation.

In terms of meeting children's basic needs, children in the evaluated Healthy Start sites showed a significant movement from being in a "crisis" stage to one that was more stable. Moreover, families were able to increasingly eliminate major impediments to supporting their children's overall development, such as housing problems, inadequate food and clothing, transportation, finances, and employment. Family violence appeared to be on a decline and, through educational efforts, parents seem to better understand the effect of violent events on their children's development.

The evaluation found that the health of the targeted group also improved. The majority of the health services provided by Healthy Start are preventative in nature, including immunizations and vision and auditory screenings. At baseline, 40% of the children in the evaluated schools were overdue for physical examinations. However, at follow-up, only 17% of the children were still in need of examinations. Furthermore, 80% of those with uncorrected vision or hearing impairments had their problems corrected by the end of the evaluation period.

Academic test scores improved as well\textsuperscript{38}. There was a significant increase in reading aptitude scores (by 25%) as well as math scores (by 50%) for the lowest performing elementary schools taking part in the Healthy Start program. Additionally, absenteeism and grade point averages showed positive changes over the three-year period. Based on the findings of this evaluation, the important impact of the Healthy Start program was confirmed and in turn support was bolstered.

Given the demonstrated positive impact of Healthy Start programs, a crucial focus of overall Healthy Start program goals has shifted from effectiveness to sustainability. The Healthy Start Operational Grant of $300,000 was originally awarded to sites for a period of 3 years. Due to concerns about the ability of grantees to achieve their services, programmatic and sustainability goals in a 3-year operational grant period, in 1995, sites were given an option to extend their grant periods from 3 years to 5 years with the same amount of funds. While the success of grantees within the operational grant period has been well documented, little is known about the experience of grantees or programs beyond the Operational grant period. Many important questions need to be asked about these post-funding grantees:

- How many grantees are successful in sustaining their services and support systems after the operational grant?


\textsuperscript{38}Both the SRI evaluation as well as the Healthy Start statewide evaluations have showed improved academic scores in districts with Healthy Start initiatives.
What are the primary factors that determine the sustainability of these grantees; what are the major differences between those sustained and those not?

What are the primary sources of funding for grantees whose activities continued after the operational grant?

Who are the primary collaborative partners for grantees whose activities continued after the operational grant?

Is there a success formula that is common across post-funding grantees that continued to provide services after the operational grant, that could benefit grantees currently in the operational grant period?

Our research attempts to answer these important research and policy questions.

The current policy context highlights the need to learn more about the components necessary to foster self-sustainability when funding periods expire. A bill introduced by Senator Alpert of San Diego, SB 197, would have required the Superintendent of Public Instruction to award sustainability grants to Healthy Start collaboratives. Grants would have been awarded annually in the amount of $50,000. However, Governor Gray Davis vetoed this bill on September 25, 2000 believing that it "represents a significant departure from the state's commitment to provide funding for Healthy Start as only 'seed' money for an initial period of up to five years, after which programs are expected to be self-sustaining". Irrespective of the Governor's veto of SB 197 in the Fall of 2000, there are still ongoing attempts to provide performance-based sustainability funding to Healthy Start grantees/sites. Currently the California legislature is considering AB 892 that would offer one-time funds to partnerships to boost efforts toward locally maintained Healthy Start initiatives.

Given that there are no State funds allocated to extend funding to Healthy Start grantees upon completion of their operational grant periods, it is essential to look to successful grantees across the state to determine what factors have contributed to a site's sustainability and provide insights into policy changes, additional resources, and technical assistance needed to maintain and build on the collaborative family-school-community infrastructure developed by Healthy Start.

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32 AB 892 – Healthy Start Support Services (Introduced on February 23, 2001). This legislation recognizes the success of the Healthy Start in improving academic results for students and functioning for families, integrating well researched services that foster school success, and connecting community agencies with the children and families they serve. It also recognizes that the coordination of these strategies and programs that support these successes require a minimal base of financial support so that the maximizing and leveraging of core state investments can continue; student and family successes can grow; and the Healthy Start “service platform” can be used by complimentary initiatives such as Proposition 10 in California. Focus of the bill AB892This bill would require the Superintendent of Public Instruction to develop an equitable process for the awarding of $50,000 one-time strategic planning grants to local educational agencies or consortia after a program's 3- to 5-year operational grant period. There would be no new continued funding. To be eligible to receive a grant, a local educational agency or consortium would be required to submit a plan demonstrating that the program meets certain criteria. The bill would require each program site, on an annual basis, to submit a report to the state and its regional network that updates the status of the local program in fulfilling the criteria and includes input, process, and outcome indicators and quality assessment. The bill would authorize $50,000 a year for four years for an evaluation of the strategic planning grants and would increase the amount allocated to regional grants to $1,100,000.
DATA AND METHODS

DATA:

Survey Development and Administration
This report is based on survey data collected from the Healthy Start Sustainability Survey in the spring and summer of 2000. During the month of March 2000, the survey was mailed to 470 Healthy Start funded operational grantees funded between 1991 and 1999 (N=470)\textsuperscript{42}. Follow-up postcards were sent and phone calls were made to encourage grantees to complete and return surveys. In total, 286 completed surveys were received (61%). The survey was conducted by the Center for Healthier Children, Families, and Communities (CHCFC), for the California Department of Education, in the Spring of 2000.

Survey questions were developed around the Six Elements of Success for Healthy Start grantees. The CDE defined these elements necessary for success as: 1) The provision of services in a comfortable and accessible facility, 2) The existence of an active local collaborative, 3) The employment of a full time coordinator who works to improve and sustain services for families, 4) The facilitation of combining resources in a manner that shows a long term commitment to children, 5) Continued evaluation and dissemination of findings, and 6) Integration with the local school site. These elements of success are based on the findings of a statewide Healthy Start evaluation conducted in 1996.

Given the large number of potential questions, two different and complementary versions of the survey were created to decrease respondent burden. Survey versions were randomly mailed to different grantees. Each version had a common core set of questions and one of two sets of additional questions. The core group of questions focused on the coordinator and grantee characteristics, types of services offered/ coordinated by the grantees, funding sources, partnerships and sustainability. Version One (V1) also included questions about case management, site integration, and the facilitating factors for providing integrated services. Version Two (V2) contained a series of more in depth questions on collaboration and evaluation.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|}
\hline
Survey Sections & V1 & V2 & Number of responses
\hline
Coordinator Characteristics & * & * & 286
Grantee Characteristics & * & * & 286
Site Integration Chart & * & * & 286
CDE Funding Chart & * & * & 286
LEA Medi-Cal & * & * & 286
Sustainability & * & * & 286
Case Management & * & & 142
Site Integration & * & & 142
Successes & Challenges & * & & 142
Collaboration & * & & 144
Evaluation & * & & 144
\hline
\end{tabular}
\caption{Distribution of survey sections in the two versions of the survey}
\end{table}

\textsuperscript{42}These grants support sites serving 1,122 schools and 865,205 students (CDE).
The overall response rate was 61.3% (N=286). Response rates did not differ by the version received. A total of 142 Version 1 surveys were returned while 144 Version 2 surveys were returned (Appendix 1, Table 1B).

Out of the 470 sites/grantees surveyed, 286 were included in the analyses. Excluded from the analyses were 7 grantees reporting closures, 4 grantees who turned in one survey, and 173 grantees who did not return the survey.

Cohort: Grantees who responded varied by cohort and region. Grantees who had recently received grants (later cohorts) were more likely to respond than grantees who were several years past their grant period (early cohorts). For example, the table on cohort response rates shows that the lowest response rate (38%) came from grantees that received their grant during the first funding cycle in 1991-92 while the highest response rate (71%) is seen among grantees who received their first grant installment this past year (1999-2000). Cohort 2 (1992-93) was an exception to this trend with 68% of the 25 grantees responding.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>38%</td>
<td>68%</td>
<td>51%</td>
<td>51%</td>
<td>68%</td>
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<td>61%</td>
<td>71%</td>
<td>61%</td>
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</tr>
<tr>
<td>Closed</td>
<td>8%</td>
<td>4%</td>
<td>6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1%</td>
<td>7</td>
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<tr>
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<td>8%</td>
<td>3%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1%</td>
<td>4</td>
</tr>
<tr>
<td>Not received</td>
<td>48%</td>
<td>28%</td>
<td>43%</td>
<td>46%</td>
<td>32%</td>
<td>36%</td>
<td>39%</td>
<td>29%</td>
<td>34%</td>
<td>173</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>25</td>
<td>47</td>
<td>37</td>
<td>72</td>
<td>74</td>
<td>93</td>
<td>82</td>
<td>99%</td>
<td>470</td>
</tr>
</tbody>
</table>

---

*aSurveys from 16 grantees were received after data analyses had been initiated. This reduces the 173 "not received" group to 157. Of the 16, 11 were currently funded and 5 were post-funding grantees.

*This group includes grantees that may have closed.
Table 1C: Response rates by cohort

Distribution of Responding Grantees by Cohort

Figure 1C: Distribution of Responding Grantees by Cohort

Region: Grantees who responded varied by region (Appendix 1, Figure 1B) with a response rate of 48% from region 7 to 82% from region 1.

<table>
<thead>
<tr>
<th>Region</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>Total</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>82%</td>
<td>61%</td>
<td>76%</td>
<td>45%</td>
<td>67%</td>
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<td>61%</td>
<td>286</td>
</tr>
<tr>
<td>Closed</td>
<td>13%</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>7</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Unable to use</td>
<td>7%</td>
<td>1%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not received</td>
<td>18%</td>
<td>26%</td>
<td>24%</td>
<td>54%</td>
<td>26%</td>
<td>32%</td>
<td>48%</td>
<td>24%</td>
<td>34%</td>
<td>42%</td>
<td>40%</td>
<td>36%</td>
<td>173</td>
</tr>
<tr>
<td>N</td>
<td>22</td>
<td>23</td>
<td>34</td>
<td>73</td>
<td>54</td>
<td>19</td>
<td>29</td>
<td>33</td>
<td>47</td>
<td>33</td>
<td>103</td>
<td>99%</td>
<td>470</td>
</tr>
</tbody>
</table>

Table 1D: Response rates by region

Case Studies

In addition to the survey, the California Department of Education commissioned the CHCFC to examine six exemplary Healthy Start grantees across the state of California in the Spring of 2000. Grantees included urban, rural and suburban school sites and were selected based on their demonstrated ability to sustain services past their grant period, and on their unique program strengths. The review included a site visit with structured interviews of representatives from major stakeholder groups such as grantees coordinators, grantee staff, partner agencies, parents, school administrators and teachers. The site visits also included a review of site sustainability surveys and their financial information. The specific grantees visited included Folsom Cordova USD, Pomo Elementary-Lake County, Pixley Elementary School- Tulare County, Long Beach USD, Robertson Road- Modesto, and O'Farrell Community School- San Diego. These case studies have been summarized in a separate report.

46 This group includes grantees that may have closed.
METHODS:

Funding Status Categorizations
The operational grant period for which Healthy Start funding is available to grantees ranges from 3 to 5 years. From 1992 to 1994, funding was available to all Healthy Start grantees for an operational grant period of 3 years. Starting in 1995, grantees have been given an option to extend their grant periods from 3 years to 5 years. For analytical purposes, grantees in Cohort 1 (1991-92), Cohort 2 (1992-93), and Cohort 3 (1993-94) were categorized as post-funding grantees. Grantees in Cohort 6 (1996-97), Cohort 7 (1997-98), and Cohort 8 (1998-99) were categorized as currently funded grantees. Grantees in the intermediate cohorts, Cohort 4 (1994-95) and Cohort 5 (1995-96) were classified as either currently funded or post funding depending on whether they extended their operational period from 3 to 5 years or not. Grantees who took the grant extension were categorized as currently funded. Those that did not take the extension were categorized as post-funding. Of a total of 286 grantees responding, 69% (197) were categorized as currently funded grantees and 31% (89) were categorized as post-funding grantees.

To estimate how non-responding post-funding grantees differed from responding post-funding grantees, an attempt was made to contact all of the post-funding grantees (N=81) among the 157 non-responders to determine closure rates. Twenty-two of the 81 non-responding post-funding grantees were found to have closed; 51 were found to be open and functional; and the status of approximately 8 of these grantees was undetermined.

Overall, approximately 16-20 percent of the total number of post funding grantees (N=186) are known to have closed. Therefore, between 80-84 percent of grantees continue to operate and provide services post funding.

Measurement of Sustainability
The survey data was analyzed to obtain descriptive grantee information and identify characteristics significantly related to sustainability. For the purpose of this study, sustainability was conceptually defined as "the ability to continue providing an appropriate level of services when operational grant funding expires". Several different strategies were used to operationalize indicators of sustainability. Sustainability is a characteristic of a program that is manifested over time. The optimal approach to measuring sustainability is collecting longitudinal data, to document the "natural history" of program activities across the funded and post-funding periods. In this way it is possible to first identify whether a grantee is continuing to provide services, the level and intensity of those services, and any changes in relationship to the elimination of state/CDE funding. The cross sectional nature of this study precludes the use of any other direct measures of sustainability, other than those grantees that are still operational after grant funding ended. As a result, several indirect measures were used as indicators of sustainability. The amount of funding, number of services provided, and the number of partners per grantee were used as indicators of sustainability because each of these factors contribute to the likelihood of continued service provision. Self-reported ratings of service capacity changes were also used to suggest whether service capacity had increased, remained stable, or declined in the post-funding era.

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4Out of the 470 sites/grantees surveyed, 288 responded and were included in the analyses. Excluded from the analyses were 7 grantees reporting closures, 4 grantees under four grants who turned in one survey, 16 grantees who returned the survey after the study period was complete and 157 grantees who did not return the survey.
44The sum of all grantees in cohorts 1-5 not including survey respondents who reported taking the grant extension and classified as currently funded (N=35).
45The exact percentage depends on the assumption that the 8 grantees with undetermined status are functional, resulting in a closure rate of 16%, or closed resulting in a closure rate of 20%.
46Some key indicators of sustainability may not be easy to measure. Literature and experience would suggest that factors such as leadership, vision, and quality of partnerships would be at least as important, if not more so, than other easier to measure indicators.
The following strategies were used to identify characteristics related to sustainability:

a. **Assessment of self-reported plans for sustainability and post-operational program changes:** Currently funded grantees were asked if they had developed and implemented long-term sustainability plans, and to identify the collaborative partners named in those plans. Post-funding grantees were asked to report changes in services and staff (numbers and qualifications) after the operational grant period, and to identify collaborative partners who played a key role in the post-funding period.

b. **Comparing post-funding grantees to currently funded grantees:** Those grantees that have continued to operate in the post-funding period have (by definition) sustained at least some functions. Their characteristics (such as collaborative partners and funding sources) provide insight into what program features have successfully continued functioning, and the level at which they are operating. It is likely that some but not all of the currently funded grantees will sustain current levels of service delivery after Healthy Start funding ends. Finding significant differences between the currently funded and post funding grantees is one way to potentially identify factors associated with future sustainability based on the assumption that the currently funded group is a mix of both sustainable and not sustainable grantees. To make these comparisons proxy (substitute or indirect) measures of sustainability such as funding amounts, number of service types offered and number of collaborating partners were used. Hypothesized predictors of sustainability include total funding, number of service types offered and number of collaborating partners. Each is related to "the ability to continue providing an appropriate level of services when operational grant funding expires".

c. **Trajectories in the post-funding period:** Knowing which programs are struggling to survive, which are able to maintain their mix of services provided when funded by Healthy Start, and which are expanding in the post grant period, provides a better picture of sustainability than simply looking at survival. Post-funded grantees were asked to self-assess their service capacity in the post-funding period – specifically whether funding had increased, stayed the same or decreased. To analyze this self-assessed measure of service capacity, grantees were grouped into three trajectories: 1) those grantees who reported an increase in service capacity (upward trajectory), those with the same service capacity (same level trajectory), and those who reported a decrease in service capacity in the post-funding period (downward trajectory).

**Potential Limitations**

This cross-sectional data collection permits a limited analysis of sustainability based on data collected at one point in time. Further inference about sustainability was derived by indirect measures.

In addition, a policy change in 1995 allowed grantees to extend their grant period from three to five years. The total amount of funding allotted to grantees opting for the extension remains the same. If this "no cost" grant extension has contributed to the sustainability or viability of grantees, it could make the comparisons between currently funded and post-funding grantees less clear. This is because the currently funded group includes two different types of grantees: 1) currently funded grantees who extended their operational period from 3 to 5 years; and 2) currently funded grantees who did not take the extension and are in the first 3 years of the operational period. Some of the currently funded grantees who opted for the extension are in effect more like post funding grantees because they have been functional for more than 3 years and have had more time to develop partnerships and cultivate funding streams to support and sustain their sites.

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31The "amount of funding" variable was created from the CDE's Partnerships Supporting Sustainability Chart. The total amount of funding for post-funding grantees includes Medi-Cal reimbursements, grants received from non-Healthy Start sources such as foundations or government agencies, and school or district funds that have been redirected to support qualifying Healthy Start activities. In addition, grantees were asked to give a monetary value to in-kind services provided by partners and for equipment and space donations. These sources were combined to create a total amount of funding (support) received by the grantees.

32The word "trajectory" has been used to depict the path or progress of the Healthy Start Initiative based on change in post-funding service capacity. It is possible to use a variety of measures to determine sustainability trajectories, such as funding, number of collaborative partners, types of services among others. However, given the data collected, a service-capacity trajectory was used as a proxy measure for level of sustainability.
The reported findings may also be affected by the absence of a standardizing variable, such as school size, which would make the amount of funding the grantees receive more meaningful. Ideally we would have included a measure for the amount of funding per child in need of service. A large school that is struggling to maintain services and serving only a fraction of the students in need (and potentially not sustainable) could actually have a larger budget (thus appearing sustainable on one of the measures used) than a smaller school that meets the needs of most of their children and is expanding services. Unfortunately, these data were not available, and this limits the utility of the measure of total funding that was used.

Further, as mentioned in the Methods, this study is subject to non-response bias. If non-responding grantees are in some way different from those responding, the ability to generalize our findings to all Healthy Start grantees is somewhat limited. For example, if non-responding grantees were from programs that were struggling or closed completely, the study findings will be overly optimistic. It is likely that the post-funding grantees that responded (N=89) are not representative of the overall post-funding grantee population (N=186).

No closure data was available when this study was initiated. The evaluation team made follow-up calls to all non-responding post-funding grantees to determine closure rates.
GRANTEES CHARACTERISTICS

A profile of Healthy Start grantees in California shows what services have been provided and how the types of services currently offered varies by funding status. Questions about grantee characteristics were included in both versions of the survey (N=286).

Findings:

- Both currently funded and post-funded grantees reported providing an average 12 of the 15 different service types asked about. The minimum number of service types provided was 4 and the maximum was 15.
- The most frequently offered service types were Family Support and Functioning Services, Case Management Services, Parenting Education, Basic Needs Services, and Mental Health Services.
- On-site Medi-Cal enrollment was the only service showing much difference between current and post grantees. Approximately 83% of currently funded grantees offered on-site Medi-Cal enrollment compared to 74% of post-funding grantees.
- The most frequently reported offered services using shared staff\textsuperscript{53} were Youth Academic Services, After School Programs, Mental Health Services, Health Education Services, and Parenting Education. Services that rarely involved shared staff were CHDP Exams, Sign-up for Medi-Cal, and Employment Services and Income Maintenance.
- Reported use of shared or blended funding\textsuperscript{54} was highest for service types of Youth Academic Services, Youth Development Services, Family Support and Functioning Services, and Parenting Education. Services for which shared/blended funding was less frequently reported were CHDP Exams, Sign-ups for Medi-Cal, and Employment Services and Income Maintenance.

Service Provision

The number and types of services provided by grantees was evaluated. Grantees were provided with a list of 15 service areas and asked about service provision.

Number of service types covered

The number of service types that grantees provide or coordinate is a function of several factors such as funding availability, staff, collaborative partners, and accessibility. Grantees were asked to identify service provision in 15 different broad service categorizations. These included: Youth Academic Services; After-school Programs; Youth Development Services; Medical and Health Services; CHDP Exams; Mental Health Services; Dental Screenings/Services; Health Education Services; Family Support and Functioning Services; Basic Needs Services; Case Management Services; Sign-up for Medi-Cal; Employment Services and Income Maintenance; Parenting Education; and Adult Education.

Information was limited to service provision in each of these service areas. Information on the units (volume) of services provided within each service categorization was not collected. Most grantees reported service provision in most of the 15 service types listed (average of 12) (Figure 1-1). There were few differences in the minimum and maximum number of service types provided by currently funded and post-funding grantees (minimum of 4, maximum of 15) (Appendix 2-1, Table 2-1.1).

\textsuperscript{53}Shared staff is defined as the use of staff funded by one agency and providing services to multiple partners, or staff that service one agency or school but are funded by more than one entity.

\textsuperscript{54}Shared funding is defined as the use of combined funding resources to provide a service or a set of services.
Types of services provided
In terms of actual services provided, there was very little difference between currently and post funding grantees (Figure 1-1). The top five most frequently provided services across funding types were Family Support and Functioning Services (93%), Case Management Services (96%), Parenting Education (91%), Basic Needs Services (90%), and Mental Health Services (91%) (Appendix 2-1, Table 2-1.2). The top five least often provided services were also similar for currently versus post-funding grantees. These services include Employment Services and Income Maintenance (48%), CHDP Exams (61%), Dental Screenings and Services (65%), and Youth Development Services (75%), and Adult Education (68%). Sign-up for Medi-Cal was the only service showing much difference between currently and post-funding Healthy Start grantees. Of currently funded grantees 83.3% offered Medi-Cal Sign-ups, whereas 73.8% of post funded grantees reported this service (Service Provision Bar Graph Figure 1-2).

Location of service provision
Grantees were also asked to report on the location of services provided, whether they were provided off-site, on-site or both (Table 1-4). Family Support and Functioning Services, Case Management Services, Parenting Education, Youth Development Services, and Health Education Services were most likely to be provided on-site for both current and post funded grantees. Employment Services and Income Maintenance, CHDP Exams, and Dental Screenings were the services least likely to be provided on-site. Very few services were reported as provided off-site (Service Provision Table 1-1).

Shared staff for service provision
Healthy Start grantees also reported on shared staff by services provided. Shared staff is an important indicator of service and staff levels of integration. The top five services with shared staff were Youth Academic

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55 Sites were asked to report on case management services in the Service Integration charts included in the surveys. Examples of case management included coordination of multidisciplinary teams and home visitation. All sites were asked this question. Version 1 of the survey included a separate section on case management, where case management was defined as a system in which individuals are responsible for coordinating student and/or family care across agencies.

56 Shared staff is defined as the use of staff funded by one agency and providing services to multiple partners, or staff that service one agency or school but are funded by more than one entity.
Services, After School Programs, Mental Health Services, Health Education Services, and Parenting Education. Services with the least reported shared staff included CHDP Exams, Sign-up for Medi-Cal, and Employment Services and Income Maintenance (Service Provision Table 1-1).

**Shared funding for service provision**

Shared funding is another indicator of service integration. Youth Academic Services, Youth Development Services, Family Support and Functioning Services, and Parenting Education were the most commonly reported service types for having shared funding. Services with the least reported shared or blended funding were CHDP Exams, Sign-ups for Medi-Cal, and Employment Services and Income Maintenance (Service Provision Table 1-1).
Figure 1-2: Service Provision Bar Graph

SEPARATE ATTACHMENT – EXCEL BAR GRAPH
<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PROVISION OF SERVICES</th>
<th>LOCATION OF SERVICES</th>
<th>SHARED STAFF</th>
<th>SHARED OR BLENDED FUNDING</th>
<th>LEVEL OF INTEGRATION (On a scale of 1-5, 1 being low and 5 being high)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
<td>N</td>
<td>Offsite (%)</td>
<td>Onsite/ Both (%)</td>
<td>Yes (%)</td>
</tr>
<tr>
<td>Current Youth Academic Services</td>
<td>81.1</td>
<td>190</td>
<td>9.8</td>
<td>90.2</td>
<td>72.8</td>
</tr>
<tr>
<td>Post</td>
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<td>183</td>
<td>7.8</td>
<td>92.2</td>
<td>73.0</td>
</tr>
<tr>
<td>Current After School Programs- Mentoring/Tutoring</td>
<td>87.4</td>
<td>191</td>
<td>9.2</td>
<td>90.8</td>
<td>69.3</td>
</tr>
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<td>186</td>
<td>5.3</td>
<td>94.7</td>
<td>67.6</td>
</tr>
<tr>
<td>Current Youth Development Services</td>
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</tr>
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</tr>
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<td>36.4</td>
<td>63.6</td>
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</tr>
<tr>
<td>Post</td>
<td>63.3</td>
<td>79</td>
<td>32.0</td>
<td>68.0</td>
<td>53.1</td>
</tr>
<tr>
<td>Current Mental Health Services</td>
<td>91.3</td>
<td>195</td>
<td>11.9</td>
<td>88.1</td>
<td>68.8</td>
</tr>
<tr>
<td>Post</td>
<td>91.4</td>
<td>81</td>
<td>12.2</td>
<td>87.8</td>
<td>65.8</td>
</tr>
<tr>
<td>Current Dental Screening/Services</td>
<td>67.0</td>
<td>191</td>
<td>25.8</td>
<td>74.2</td>
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</tr>
<tr>
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<tr>
<td>Current Health Education Services</td>
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<td>4.2</td>
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<tr>
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<td>79</td>
<td>4.5</td>
<td>95.5</td>
<td>60.9</td>
</tr>
</tbody>
</table>
**Grant extension**
The results indicate that grantees in cohorts 4-8 (1994-1998) reported that the extension is or would be helpful. The grant extension has very important implications. While the amount of funding remains the same, the extension option gives grantees additional time to work on service coordination. It also provides additional time (and opportunity) to seek new collaborative partners and additional sources of funding as well as develop community infrastructures that would help grantees in sustaining their services beyond the operational grant period. The first cohort to receive this extension option was cohort 4 (1994-95). Therefore, grantees in cohorts 4-8 (230 grantees) were asked to report whether the grant extension has been or would potentially be helpful or not. Approximately 73% (169) of these grantees responded to this question (Appendix 2-1, Table 2-1.3). Findings suggest that 38% of grantees (64 of 169 grantees) in cohorts 4-8 reported the extension to be helpful (Appendix 2-1, Table 2-1.4). Approximately 2% (4 of 169) reported the extension as not helpful. Approximately 27% (46 of 169 grantees), mostly in cohorts 6 (1996-97), 7 (1997-98), and 8 (1998-99), reported that they had not taken the extension.

**Grantee Site Space, Comfort and Accessibility**
Grantees can include one or more schools in the Healthy Start grant. The physical characteristics of individual grantees can often play a very important role in sustaining them. For example, grantees that are not easily accessible to target populations or are short of space are limited not only in their ability to provide services but in the long run, may have more difficulty in sustaining and expanding their service delivery. Space, comfort and accessibility are three such important physical grantee characteristics that can have an indirect or direct impact on site/grantee sustainability. To develop a profile on such characteristics, grantees were asked to rate their sites in terms of space, comfort and accessibility on a scale of 1 to 10, with 1 representing the lowest and 10 representing the highest rating.

![Grantee Site Space Ratings](image)

**Figure 1-3: Grantee Site Space Ratings**

Overall, the average grantee rating for physical space was approximately 7. Approximately 65% (187 out of 286 grantees) gave their sites a “high” score (6 and above). There were very few differences between currently and post-funding grantee ratings for physical space (Appendix 2-1, Table 2-1.5).
Grantee Site Comfort

Site Comfort Ratings

- Missing: 3.1%
- Low: 19.9%
- High: 76.9%

Figure 1-4: Grantee Site Comfort Ratings

Overall, the average grantee rating for level of site comfort was approximately 8. Approximately 77% (220 of the 286 grantees) gave their sites a "high" score (score of 6 and above) for site comfort levels. Both currently funded and post-funding grantees rated their sites highly for comfort (Appendix 2-1, Table 2-1.6).

Grantee Site Accessibility

Site Accessibility Ratings

- Missing: 3.1%
- Low: 15.4%
- High: 81.5%

Figure 1-5: Grantee Site Accessibility Ratings

Overall, the average grantee rating for accessibility was approximately 9. Approximately 82% (233 of the 286 grantees) gave a "high" score (score of 6 and above) when asked to rate the Healthy Start site in terms of accessibility. Both currently funded and post-funding grantees rated their sites highly for accessibility (Appendix 2-1, Table 2-1.7).

The results indicate that both currently funded and post funding grantees rated their sites highly in terms of these three characteristics, although currently funded grantees were slightly more likely to rate themselves as having more adequate space. These results have to be treated with caution mainly due to the subjectivity of these measures\(^{57}\).

\(^{57}\) For example, there were no differences in space adequacy rating between those with larger physical spaces, and those with smaller physical spaces (case study data).
COORDINATOR CHARACTERISTICS

Healthy Start coordinators play a central role in Healthy Start programs by: 1) coordinating services for families; and 2) administratively coordinating the activities of the direct service providers and partners. Thus coordinator skills may be associated with program success. Proxy measures for management abilities include educational background, and experience measured as tenure with the Healthy Start site. Dedicated coordinator time across Healthy Start activities could differ with site maturation. Questions on coordinator characteristics were included in both versions of the survey (N=286).

Findings:

- Coordinators spent 1-2 years as coordinators of the Healthy Start site/initiative (the standard deviation was 2.4 years).
- Currently funded grantee coordinators spend an average of 90% time coordinating Healthy Start activities whereas post funded coordinators spend an average of 75% coordinating these activities.
- 61% of coordinators reported having a Master's degree and 28% reported having a four-year degree. There were no major differences between currently and post funded grantees.

Number of years as grantee coordinator

Coordinators were asked to report on their number of years as coordinator at that site. The study found the average number of years as grantee coordinator at a particular site to be a little less than 2 years. Currently funded grantee coordinators reported an average time of a little over 1 year whereas post-funding grantee coordinators reported an average time of 2 years as grantee coordinators (Appendix 2-2, Table 2-2.1). There are potentially several factors that may have influenced this finding – factors that cannot be accounted for in this cross-sectional snapshot of sites. This does not give us any information on the overall number of years as grantee coordinators, or the overall number of years as coordinator of a currently or post-funding site. It is possible that coordinators move from site to site because the overall skills required for currently funded sites differ from those required for post-funding sites. The decision to move could also be influenced by funding issues.

Percentage of time coordinating Healthy Start activities

Another important characteristic is amount of funding available for the coordinator position. Coordinators with a steady and predictable source of funding may have one less issue to focus on. Currently funded grantee coordinators are more likely to get most of their time paid by Healthy Start funds. Post-funding grantee coordinators (as well as coordinators at the end of the operational period) who are no longer funded by Healthy Start funding have to rely on new/alternate funding and collaborative partners for resources and have to be written into grant proposals and budgets.

Coordinators were asked for the percentage of time that they spent to coordinate Healthy Start activities. Overall, coordinators reported an average of 90% time. This would imply that coordinators also take on other activities, so that 100% of their time is not dedicated to coordinating Healthy Start activities. When analyzed by funding status, currently funded coordinators responding (N=197) reported that an average of 90% of their time was spent coordinating Healthy Start activities and post funded coordinators (N=89) reported an average of 75% of their time (Appendix 2-2, Table 2-2.2). The reduction in time allocated to Healthy Start Coordination

The need for a full time coordinator at a single site could also influence sustainability. When coordinators coordinate single (as opposed to multiple) sites, they can dedicate more of their efforts to program development, service coordination and collaboration (case study data).
raises some concern as other research has suggested that having a full time staff person dedicated to systems change is essential to the long-term success of integrated programs.

**Coordinator during Planning grant**

Two types of grants are authorized under the Healthy Start Support Services for Children Act: planning and operational grants. The collaborative planning grants may be awarded to LEAs and their partners if they demonstrate a willingness to plan for school-integrated support services for children and families. Proposals are submitted to the State of California for Healthy Start funding. The State in turn awards Planning grants for a period of 2 years. The purpose of the planning grant is to give sites/grantees and coordinators a certain period of time to plan for future activities such as selection and delivery of services, staff allocations, funding, potential collaborative partners, community partnerships and so on.

For purposes of continuity, grantees with the same coordinator during the planning and operational grants would benefit more than those with different coordinators for the two grant phases.

Two hundred and seventy one coordinators responded to this question. Only 27% (74 out of the 271) reported that they were grantee coordinators during the planning grant. However, these results have to be treated with caution because there is no information on the hiring of coordinators during the planning grant. For example, do planning grantees usually have a coordinator on staff or do they usually wait until they get an operational grant to hire a coordinator (which in turn would influence the hiring of someone involved in the planning process versus someone who has no familiarity with the previous history)?

When analyzed by funding status, currently funded grantee coordinators (30%) were more likely to report that they had been planning grantee coordinators than post-funding coordinators (21%) (Appendix 2-2, Table 2-2.3). One possible explanation for this finding is the issue of program maturation. It is possible that in this one point in time study, currently funded grantee coordinators are reporting on their status as grantee coordinators over a shorter-time period than those at post funding sites.

![Maximum Level of Education - All Coordinators](image)

**Figure 2-1: Coordinator level of education**

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46Dennis, Deborah J., Cocozza, Joseph J., Ph.D.; Steadman, Henry J., Ph.D. What Do We Know About Systems Integration and Homelessness? [link]
47From the "Request for Applications for Healthy Start."
Maximum Level of Coordinator Education
The educational level of the grantee coordinators is an indicator of experience. Out of the 276 grantees responding approximately 61% (N=169) reported that they had a Master's degree. Approximately 28% (N=76) reported that they had a four-year college degree and only 11% (N=31) reported an AA degree (or less) (Appendix 2-2, Table 2-2.4, 2-2.5). An analysis by funding status did not show any significant differences between currently and post funding grantees. These results indicate that coordinators were more likely to report having a Master's degree (maximum level of education) than any other degree – across all sites/grantees and that there were no significant differences in coordinator level of education between currently and post-funding grantees.
THE COLLABORATION PROCESS

One of the primary responsibilities of the coordinator is to build relationships with outside agencies and groups. These collaborators either directly provide services to children, or fund the services. Local Healthy Start collaborators can play many important roles. The collaborative process can help agencies plan more efficient service delivery, eliminate duplication of services, and identify and fill gaps in service to families. For long-term sustainability of Healthy Start grantees, relationships must be built with the decision-makers in collaborating local agencies who can assign staff, or direct funds to fulfill the Healthy Start collaborative service needs. These relationships are considered as the foundation for future commitments to service at the Healthy Start initiatives. Questions on collaboration were included in Version 2 of the survey (N=144).

Findings:

- The four most common groups reported to participate in collaborative meetings were public and private agencies (88%), CBO's (83%), schools (79%) and families (60%).
- 60% of grantees with agencies involved in their collaborative meetings reported that the agency representatives had decision-making power for the agencies. Post-funding grantees were more likely to have decision-makers involved on a usual basis than currently funded grantees (68% vs. 57%).
- Most of the grantees reported active collaborative participation by local school districts, city and county agencies, with school districts (or county office of education) having the most frequent involvement (92%), followed by counties (76%) and cities (73%). More than half of the grantees reported that the school district provided facilities (71%), policies (67%), governance (56%), funding (55%), or staff (51%). The top two areas of involvement for cities and counties were staffing (42% and 51%) and funding (31% and 34%).
- Nineteen percent of grantees reported no county involvement and 24% reported no city involvement. Because not all initiatives are using resources provided by county and city partners, these may be untapped resources for some. Coordinators may not be aware of these funding possibilities or have yet to establish relationships with them. Conversely, these potential partners may not have the administration, operations, or structure that enable local community initiatives like Healthy Start.
- Grantees reported that successful collaborations resulted in: improved services to families, better coordination between service providers, easier access to services for families, less duplication of services; and improvements in school attendance and academic outcomes.
- The most frequently reported barriers to collaboration were finding time for multiple agencies to meet (63%) and communication problems (32%). Overall, grantees were more likely to report benefits of collaboration than difficulties with the process.

Collaborative Partners

Healthy Start collaboratives include district, community and agency representatives who together plan for or provide services to children and families through the local school site. Partnering groups include agencies, CBO's, schools, families, county departments, city offices, local business and students. The four most common groups reported to participate in collaborative meetings were agencies (88%), CBO's (83%), schools (79%) and families (60%).

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Table 3-1: Percent of Grantees Reporting Collaborative Meeting Attendance by Each Group

Collaborative meetings - frequency and attendance
Most grantees (57%) reported that their collaboratives met at least once a month (Appendix 2-3, Table 2-3.1). Agencies were the most frequently mentioned participants (88%) and were most often represented by service providers (64%), followed by directors/administrators (53%) and caseworkers (44%) (Appendix 2-3, Table 2-3.2). This type of multilevel representation is potentially important for the different functions of the collaborative that include day-to-day operational support as well as securing long term funding.

Decision-making power of agency representatives
Overall, 60% of grantees with agencies involved in their collaborative meetings reported that the agency representatives had decision-making power for the agencies. Post-funding grantees were more likely to have decision-makers involved on a usual basis than currently funded grantees (58% vs. 57%) (Appendix 2-3, Table 2-3.3). This may be the result of the program/site maturation process, with post-funding grantees having more established relationships and procedures related to their collaboratives. This may also be an essential component for sustainability suggesting that relationships with decision makers must be made early on in order to secure continued funding and service provision for the local program.

Participation of school districts, city and county agencies
Grantees were also asked about collaborative relationships with local school districts, counties and city agencies. The school district, the county and the city are vital collaborative partners who have much to offer Healthy Start programs. In addition to providing space, school districts can direct a number of federal funding streams into Healthy Start sponsored activities (LEA Medi-cal reimbursements, Title 1, Title X(*) etc.); cities who often sponsor a variety of after-school programs, also provide facilities that can be used for various activities; and county partnerships can result in a wide array of services including mental health, social services, and medical programs. Most of the grantees reported active participation by these three entities, with school districts (or county office of education) having the most frequent involvement (92%), followed by counties (76%) and cities (73%). More than half of the grantees reported that the school district provided facilities (71%), policies (67%), governance (56%), funding (55%), or staff (51%). The top two areas of involvement for cities and counties were staffing (42% and 51%) and funding (31% and 34%). In addition, 24% of grantees reported that the city provided facilities for Healthy Start activities, and 27% indicated that counties provided policies that helped to guide the Healthy Start program (Appendix 2-3, Tables 2-3.4, 2-3.5, 2-3.6, 2-3.7).

(*) The Title 1 and Title X funds came about as part of the Federal Elementary and Secondary Education Act (ESEA).
A number of grantees reported having no involvement by these three entities. Of all the grantees responding to this question (N=144), 6% reported no district involvement, 19% reported no county involvement, and 24% reported no city involvement. Some of the Healthy Start grantees are in unincorporated areas of a county reducing the potential for city partnerships. Still, these percentages merit some concern about potential resources that might be availed. It is possible that some coordinators may not be aware of these funding possibilities or have yet to establish relationships with them. Conversely, these potential partners may not have the administration, operations, or structure that enable local community initiatives like Healthy Start.

**Benefits of the collaborative process**

The vast majority of grantees reported multiple benefits from the collaborative process. The most prevalent benefit reported was improved services to families (89%), which is the primary mission of Healthy Start. Other benefits like better coordination between service providers (89%), easier access to services for families (81%) and less duplication of services (72%) describe in more detail, how the services were improved. In addition, 69% of grantees reported improvements in attendance and academic outcomes as benefits of the collaborative process (Appendix 2-3, Table 2-3.8).

**Difficulties with the collaborative process**

Grantees were also asked about the difficulties encountered during the collaborative process. The most pronounced barrier to collaboration was finding time for multiple agencies to meet (63%), followed by communication problems (32%). Overall, grantees were more likely to report benefits of collaboration than to indicate difficulties with the process (Appendix 2-3, Table 2-3.9).

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In Tulare County, the collaborative at the Pixley Elementary Healthy Start includes representatives from social work, probation, education, mental health and medical service providers. Each of these groups comes to the table with a different vocabulary. By sharing common goals and working together as a collaborative, they began to better understand each other.
THE CASE MANAGEMENT PROCESS

Case management is an integral component of service coordination. Case managers can link families with multiple needs to the services they need. In the survey, case management has been defined as "a system in which individuals were responsible for coordinating student or family care across agencies". Questions on case management were included in Version 1 of the survey (N=142).

Findings:

- Most grantees (96%) reported the provision of case management services.
- 54% of the grantees providing case management used Healthy Start Staff. About 44% provided case management through a combination of both Healthy Start and partner agency staff. Post-funding grantees were more likely to share case management responsibilities with agency staff than currently funded grantees (51% vs. 40%) or to rely on the case management systems of other agencies entirely (5% vs. 1%) although this was rare.
- For follow-up of cases (case-managing) by grantees, 80% reported conducting follow-up by contacting service agencies, 93% reported following up by directly contacting students and families.
- More than half of the grantees reporting case-managing students and families reported the use of computer software for the case management process.

Ninety-nine percent of currently funded grantees and 91% of post-funding grantees reported the provision of case management services to students and their families (Appendix 2-4, Table 2-4.1). Fifty-four percent of those providing this service provided it through Healthy Start Staff while 44% provided it through a combination of both Healthy Start and partner agency staff. Post-funding grantees were more likely to share case management responsibilities with agency staff than currently funded grantees (51% vs. 40%). They were also more likely to rely on the case management systems of other agencies entirely (5% vs. 1%). (Appendix 2-4, Table 2-4.2). This may indicate a prominent change in the case management process as sites mature, with post-funding grantees slightly less likely to provide case management services, but more likely than currently funding grantees to share (or rely) case management responsibilities with other agency staff. Conversely, it may be that these post-funding grantees have always shared this responsibility with other agencies allowing them to invest their initial grant money elsewhere. Efforts should be directed at maintaining case management services in the post-funding period through collaboration with agencies providing case management or through the identification and acquisition of funds available to support this service.

The few grantees that did not offer case management services (N=9) reported that case management systems were too costly or that they lacked funding to support this specific service. In addition, one grantee said they were too small, another had specific personnel issues that year that interfered with their case management system and still another said that they couldn't find a system that fit their needs.
Referrals
When grantees do offer case management, children and families receive this service through both informal and formal means. Formal referral mechanisms are established with intervention teams that are part of the school's existing structure. These groups have been formed to intervene when academic, behavioral, or attendance related problems arise. Grantees were asked if they referred students to, or received referrals from three of the more common types of school-based teams: the Student Success Team, the Student Attendance Review Board and a more general category of Student Assistance Programs. The Student Study/Success Teams' primary objective is to intervene when students are having academic or behavioral difficulties. Student Assistance Programs have a similar role. The Student Attendance Review Board has a more specific mission; to intervene when a child's attendance record raises some concern. Grantees frequently received referrals from (or provided referrals to) these and other school groups. The most common source of referrals among these three was the Student Study/Success Team (90%) followed by the Student Attendance Review Board (67%) and Student Assistance Programs (37%). Note that some grantees received and provided referrals to multiple school-based teams (Appendix 2-4, Table 2-4.3).

Follow-up
After receiving referrals, case managers assess the students seen, and refer the students or their families to services provided on site or in the community. They may arrange an appointment with the service agency on the family's behalf, or in some cases, case managers may even provide transportation services for the client to ensure an off-site appointment is kept. A vital component of case management is follow-up after a referral is made. This is especially true when services are provided off-site. In their evaluation of Cohort 2 (1992-93) grantees, Wagner and Golan (1996)\(^6\) found that when clients were referred outside agencies, less than half kept their appointments. Of the Healthy Start grantees case managing students and families, 93% reported following up by contacting the students and families to see if the appointment was kept, and 80% reported contacting the service agency, with some case managers contacting both (Appendix 2-4, Table 2-4.4).

Computerized Systems

Figure 4-2: Computerization of Case Management Data

Maintaining an effective case management system can be facilitated by several factors, such as the availability and use of a computerized system for case management data. Grantees were asked about the use of computerized data systems for case managed students and families. More than half of them reported that their case management data was computerized.

Common Processes
Grantees were also asked about common referral, intake and assessment processes with partnering agencies and if they shared data with other partnering agencies. Data sharing was found to be the most common practice, with 43% of grantees reporting that they shared data with most or all of their partner agencies. About half of the grantees surveyed indicated that they did not have an intake or referral process in common with any of their partners and about a third didn't have a common referral process (Appendix 2-4, Table 2-4.5).
5 THE INTEGRATION PROCESS

Having a positive relationship with the school site and district can result in significant benefits for Healthy Start grantees, especially in the post-funding period. The school has control over space allocated to the Healthy Start program. Both schools and districts have funding streams that could help to support Healthy Start services. In the survey, integration has been defined as "organized with or a part of other efforts or services". Questions on integration were included in Version 1 (N=142).

Findings:

- 49% of grantees reported that Healthy Start efforts were well integrated with the school sites while 46% reported that it was somewhat integrated.
- Grantees reported that they were highly supported by school administrators and school site staff.

Most grantees reported that Healthy Start's efforts were well-integrated (49%) or somewhat integrated (46%) with schools, school missions, and school site plans (Appendix 2-5, Table 2-5.1). In addition, grantees indicated that they felt supported by various groups in the school community (Appendix 2-5, Table 2-5.2). Using a 1-10 scale, grantees were asked to rate the school community's recognition and support of Healthy Start programs as necessary to the academic success of all students. In response, grantees gave administrators and school site staff a median score of 8, and assigned teachers and parents a median score of 7. Scores for each group ranged from 1-10.
THE EVALUATION PROCESS

Evaluation is a required component of the Healthy Start program during the grant period. The California Department of Education (CDE) conducts Healthy Start grantee evaluations on an annual basis. The evaluation process can help to improve service delivery and demonstrate program impact on child and family outcomes, relative to program goals or targets. Evaluation has become even more important as other possible Healthy Start/service funders begin to require outcomes based evaluations to determine their own funding priorities. This makes evaluation important for new or continued funding. Grantees that have already conducted separate evaluations on one or more Healthy Start components may obtain information that helps them improve and thus sustain their activities. Grantees were asked to report on “additional” evaluations, that is, evaluations other than those required by the CDE. Questions on Evaluation were asked in Version 2 of the survey (N=144).

Findings:

- Nearly half of the grantees did not report any additional evaluation efforts. Twenty four percent of currently funded and 56% of post-funding grantees reported having undergone “additional” evaluations (34% of grantees overall).
- Additional evaluations were most frequently conducted by external entities (59%) followed by their schools/districts (35%) and collaborative partners (30%). (Multiple responses were allowed for grantees undergoing more that one evaluation, thus, percentages do not equal 100).
- Grantees reporting these additional evaluations most frequently reported that their evaluations focused on student outcomes (78%). Currently funded grantee evaluations were more likely to focus on client satisfaction whereas post-funding grantee evaluations were more likely to focus on student service processes.
- Additional evaluation results were shared with local schools (76%) followed by agencies and community based organizations (73% and 71%).
- Most grantees (98%) reported that the evaluation process (overall Healthy Start evaluation or site-specific evaluation) was helpful in improving operations, 96% in seeking additional resources, and 95% in sustaining partner commitment.

Additional Evaluations
When asked to report on additional evaluations, that is, evaluations other than those required by the CDE, 24% of currently funded and 56% of post-funding grantees reported that they had had additional evaluations (34% of grantees overall). Additional evaluations were most frequently conducted by external entities (59%) followed by schools/districts (35%), and collaborative partners (30%) (multiple responses were allowed for grantees undergoing more that one evaluation, thus, percentages do not equal 100) (Appendix 2-6, Tables 2-6.1 and 2-6.2).
Figure 6-1: Participation in additional evaluations

**Evaluation Focus**
Grantees were also asked to report on the most common focus of evaluation efforts. Student outcomes were the most common focus of evaluation measures for both currently and post-funding grantees (78% overall), followed by client satisfaction and student service process. A larger proportion of currently funded grantees (70%) than post-funding grantees (57%) reported evaluating client satisfaction. Grantees past their grant period more frequently reported evaluating the student service process (65%) than currently funded grantees (45%) (Appendix 2-6, Table 2-6.3).

**Sharing Evaluation Findings**
The entities with whom evaluation results were most frequently shared were local schools (76%) followed by agencies and community based organizations (73% and 71%). Currently funded grantees were more likely than post-funding grantees to share results with CBO's (82% vs. 61%). Post-funded grantees were more likely to share results with school sites (83% vs. 68%). The level of administrative support perceived by Healthy Start grantees may be associated with whether or not the Healthy Start grantee shares evaluation results with the school. However, no significant associations were obtained. Post-funding grantees were more likely to report higher, than lower, ratings for administrator support. Sharing results with partnering organizations may help to secure future commitments or inform future planning efforts (Appendix 2-6, Table 2-6.4).

**Helpfulness of Evaluations**
Grantees, irrespective of additional evaluation efforts, were also asked to rate the helpfulness of evaluation efforts. Almost all of the grantees reported that the evaluation process was at least somewhat helpful. Ninety-eight percent reported that evaluations were helpful in improving program operations, 96% believed evaluations were helpful in seeking additional resources, and 95% reported evaluations were helpful in sustaining partner commitment (Appendix 2-6, Table 2-6.5).
LEA MEDI-CAL FUNDS

On-going funding is a key determinant of grantee sustainability. A number of factors ride on the procurement of funds. Funding plays an important role in dictating what services can be offered, capacity to meet parent and child needs, staff size and type, and staff turnover rates (which may indirectly affect program function and quality). Reliable core funding is most important for grantee sustainability. Potential funding sources include state and local agencies, local partnerships, private businesses, and other collaborative partners, depending on the kinds of collaborative partnerships grantees develop.

In 1989, Congress provided an option for school districts to recover a portion of the costs of providing Medicaid services to eligible and enrolled children. The program became available to California local education agencies (LEA), as the LEA Medi-Cal Billing Option, through a State Partnership between the Governor, Superintendent of Public Instruction, the Foundation Consortium for School-Linked Services in California and the Department of Health Services in 1993. The California Department of Health Services (DHS) administers the LEA Medi-Cal funds. More than 400 California school districts and county offices of education currently claim federal revenue through the LEA Medi-Cal Billing Option, and statewide reimbursements exceed $50 million. These funds are used to support and expand school-linked services for students and their families.

By enrolling as LEA Medi-Cal Billing Option providers with the DHS, school districts can claim reimbursement for covered services to students enrolled in Medi-Cal, provided that services are delivered by licensed or credentialed providers, such as school nurses and/or specialized special education staff. School districts must be willing to reinvest reimbursed funds in services for school children and their families and have school-linked services collaborative group set priorities for reinvestment of funds made available through the LEA Medi-Cal Billing Option.

The California Department of Education (CDE) has actively promoted the use of LEA Medi-Cal funds as a key strategy for sustaining Healthy Start initiatives, since the inception of the program. However, the extent to which Healthy Start initiatives are able to access or compete for these funds is dependent upon many factors, including district strategy and leadership regarding school-linked services, composition of the collaborative, and effectiveness of the Healthy Start site supporters at developing relationships and mobilizing support.

Some of the factors that influence LEA Medi-Cal reinvestment priorities and Healthy Start's access to these funds include the following:

1. The LEA Medi-Cal reinvestment provision does not specify or require collaboratives and/or districts to allocate any reimbursed funds to Healthy Start initiatives.
2. Only districts or county offices of education can enroll as LEA providers. Schools cannot enroll as providers. This is in contrast to Healthy Start - which is school or school cluster specific. Healthy Start grantees may be actually providing covered services as well as billing - but the overall billing is done by the district as services provided by district employees.

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* Covered services include, but are not limited to, health services provided to students as part of an Individualized Education Plan (IEP), Individualized Family Support Plan (IFSP), of Individualized Health Services Plan (IHSP).

52
3. There may be multiple district stakeholders competing for these funds. There is significant pressure to return all or a portion of the LEA Medi-Cal Billing Option revenue to the district departments/staff units responsible for generating the funds. School nurses and special education specialists are usually responsible for generating most of the LEA Medi-Cal revenue for districts.

4. Once a school district has fully established a LEA Medi-Cal billing program, revenue will likely be relatively stable/flat. However, the number of Healthy Start sites may increase over the years as districts continue to respond to the annual availability of new Healthy Start funds. This may lead to increased competition between local Healthy Start grantees/sites and other stakeholders within the district (i.e., special education, health services) for LEA Medi-Cal funds.

5. The LEA Medi-Cal Billing Option provides partial reimbursement to local education agencies for the provision of certain school-based services delivered by staff who meet DHS qualification standards (primarily licenses or credentialed specialists) to students enrolled in Medi-Cal. Because of the strict staff/practitioner qualification standards, most Healthy Start grantees/staff are limited in their capacity to provide billable services or generate LEA Medi-Cal reimbursement. For this reason, Healthy Start grantees are more likely to be consumers of LEA Medi-Cal revenue than producers.

6. Some districts began participating in the LEA Medi-Cal Billing Option before they had any Healthy Start grants/sites. In some cases, this has resulted in no Healthy Start representation in the interagency collaborative decision-making body — and the reinvestment priorities and mechanisms reflect the needs of the then existing stakeholders.

Recent Changes in the LEA Medi-Cal Billing Option

Reduction in Targeted Case Management Reimbursable Services:
As of July 1, 2001, the DHS eliminated reimbursement for Targeted Case Management (TCM) services to students who have an Individual Health Service Plan (IHSP) and limited TCM reimbursement to students enrolled in Special Education Programs. This will severely limit the ability of Healthy Start grantees to claim reimbursement for TCM, which is the cornerstone of Healthy Start.

Expansion of Covered Practitioners - more Revenue for Reinvestment:
DHS is developing new regulations, which will significantly increase the number of school personnel whose services can be billed. They may add credentialed school psychologists and speech/language pathologists to the lists of eligible providers. Billing for these services has previously been limited to licensed practitioners only. Because most of these services in California are provided by credentialed, rather than licensed providers, this is expected to result in a significant increase in overall LEA reimbursement revenue which can be used to sustain Healthy Starts depending upon the decisions of the local interagency collaborative.

Findings:

- Contrary to concern about low levels of awareness of the potential use of LEA Medi-Cal funds for grantee/site sustainability, the findings suggest both, a high level of awareness of the potential availability of LEA funds as well as high rates of district billing and procurement of funds. Approximately 86% (N=237) of grantees reported that their districts currently billed for LEA Medi-Cal money. Approximately 7% (N=18) reported that their districts were not billing for LEA Medi-Cal funds. Most grantees reported that their districts were either billing, or planning to bill for LEA Medi-Cal funds (93% of currently funded grantees and 90% of post-funding grantees).

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6Multiple stakeholders for LEA Medi-Cal funds include Special Education and Health Services departments as well as special programs and services such as the Early Mental Health Initiative, Families and Schools Together (FAST), tutoring and parent education programs.
• Not all grantees bill for LEA Medi-Cal funds, and not all that bill necessarily receive funding. Moreover, there may be differences between current and post grantee success in procuring LEA funds. Descriptive analysis indicated that the average LEA sum promised or awarded to grantees was reported to be $20,000, with post-funding grantees (Cohorts 1, 2 and 3) reporting higher amounts of money (median $25,000) than currently funded grantees (median $15,000).

• However, while approximately 86% of grantees (N=237) reported that their districts billed for LEA Medi-Cal money, 59% (N=140) of these grantees reported receiving LEA monies. The remaining 41% (N=97) reported not receiving any LEA money even though their districts billed for LEA monies.

• Fifty-three percent of currently funded grantees reported that the Healthy Start Collaboratives68 made spending decisions. Other decision-makers on LEA funding were LEA Medi-Cal collaboratives and school districts. Even when LEA funds are procured for Healthy Start grantees, the Healthy Start program may not make funding allocation decisions.

**District billing for LEA-Medi-Cal services**
Grantees were asked to report on district billing for LEA Medi-Cal funds. Of the 276 grantees that responded, approximately 86% (N=237) reported that their districts billed for LEA Medi-Cal money. Six-percent (N=17) reported that their districts were in the planning process, that is, were planning to bill for these funds. Approximately 7% (N=18) reported that their districts did not bill for LEA Medi-Cal funds.

Both currently (84%) and post-funding grantees (90%) reported that their districts were billing for LEA Medi-Cal funds (Appendix 2-7, Table 2-7.1). When those grantees who reported that their districts were "planning" to bill for LEA funds were included, the numbers increased - approximately 93% of currently funded grantees (N=176) and 90% of post-funding grantees reported that their districts were either billing for LEA Medi-Cal funds or were planning to do so in the near future.

The 17 grantees who reported their districts were planning to bill for LEA funds were mostly in cohorts 5, 6, 7 and 8. Only one of these grantees was post-funded. The 18 grantees who reported that their districts did not bill for LEA funds were distributed across the 8 cohorts (Appendix 2-7, Table 2-7.2). Eleven were currently funded and 7 were post-funding grantees. The reasons for district non-billing ranged from District decisions to not bill at this time (N=1) to complicated billing procedures (N=1).

Therefore, contrary to concern about low levels of awareness of the potential use of LEA Medi-Cal funds for grantee sustainability, the findings suggest both, a high level of awareness of the potential availability of LEA funds as well as high rates of district billing and procurement of funds.

**LEA-money promised/received by grantees**
Grantees who reported that their districts were billing for LEA Medi-Cal monies (N=237) were asked to report on the amount of funds promised or received by them. Several grantees responded with percentages instead of actual amounts. The average LEA sum promised or awarded to grantees who reported dollar amounts (N=143) was reported to be $20,000 (median value).

Post-funding grantees reported higher amounts of money (median $25,000) than currently funded grantees (median $15,000) (Appendix 2-7, Table 2-7.3).

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68DHS requires that decisions about the reinvestment of LEA Medi-Cal revenue be made by an interagency collaborative – which could either be a Healthy Start collaborative or other existing interagency collaborative.
One possible explanation for this could be that post-funding grantees are better situated because of relationships, history, or credibility to warrant funding from the collaborative. Or that the collaborative provides less funding for “current” grantees because they still have state funding to sustain them.

An analysis by cohorts indicates that earlier cohorts (Cohorts 1, 2, and 3) reported higher levels of LEA funds than more recent cohorts.

**Distribution of funds across cohorts**

![Graph](image)

Figure 7-1: Distribution of LEA monies (median values) across cohorts. Grantees reporting percentages were excluded.

**Distribution of grantees receiving LEA monies by cohort**

![Graph](image)

Figure 7-2: Distribution of Grantees receiving LEA monies by Cohort.

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69 Personal communication with Don Boloe, Director, LEA Medi-Cal Technical Assistance Project, Santa Clara County Office of Education, San Jose, [http://www.leamedicalli.org](http://www.leamedicalli.org)


71 The cohorts and funding years are listed in the previous footnote.
These results indicate that grantees are receiving significant amounts of LEA funds. Grantees in earlier cohorts are acquiring more LEA funds than grantees in more recent cohorts.

**LEA district billing and reimbursement at the individual grantee level**
While approximately 86% (N=237) reported that their districts billed²² for LEA Medi-Cal money, 59% (N=140) of these grantees reported receiving LEA monies. The remaining 41% (N=97) did not receive any LEA money even though their districts billed for LEA monies. This suggests that many grantees that are billing for LEA Medi-Cal funds are not receiving the reimbursed funds from schools districts²³.

**LEA fund spending decisions by HS Collaborative**
The distribution of reimbursed LEA Medi-Cal monies involves a systematic decision-making process. LEA Medi-Cal funds received by districts usually go through a collaborative for determining how they will be used. Currently funded grantees who reported that their districts were billing for LEA monies (N=159) were asked to report on the role of Healthy Start collaboratives in making LEA spending decisions. Of the 152 grantees responding, approximately 53% (N=80) reported that Healthy Start Collaboratives made spending decisions while 47% (N=72) reported that spending decisions were not made by the Healthy Start collaboratives (Appendix 2-7, Table 2-7.4).

Grantees who reported that HS collaboratives did not make LEA spending decisions were asked to report on other decision-making bodies for distribution of LEA monies. They were most likely to report LEA Medi-Cal collaboratives and school districts as major decision-makers for the distribution of LEA monies.

Since these collaboratives play such an important role in LEA allocation, they can potentially play an important role in bridging the gap between district level billing and reimbursements at the individual grantee level. They can serve as the link between the district and individual grantees in the reimbursement process.

Contrary to concern about low levels of awareness of the potential use of LEA Medi-Cal funds for grantee sustainability, the findings suggest both, a high level of awareness of the potential availability of LEA funds as well as high rates of district billing and procurement of funds. Despite high levels of LEA billing, attention should still be paid to the few who are not doing so. These districts and grantees should be made aware of their options and be encouraged to procure LEA monies. In addition, these findings highlights the importance of a shift in focus from raising awareness and billing rates to bridging the gap between district/grantee billing for LEA Medi-Cal funds and district reimbursement at the individual grantee level.

²²Healthy Start grantees may be actually providing covered services as well as billing – but the overall billing is done by the district as services provided by district employees (Don Bolce).
²³There are several possible explanations for this – such as those listed in the introduction of this section.
SUSTAINABILITY

The different measures of Healthy Start grantee sustainability, all measures of the ability to continue providing services at an appropriate level when funding expires produced several findings.

First measure of Sustainability
The first measure used predictors of sustainability for currently funded grantees (presence and content of a sustainability plan), and for post-funding grantees, any post-funding changes as measured by an assessment of grantee self-reported changes in service and staff (numbers and qualifications) to measure sustainability.

Currently funded grantees:
- Grantees may not be beginning the process of developing and implementing sustainability plans in sufficient time to preclude long-term sustainability difficulties. Approximately 66% of currently funded grantees reported having developed a long-term sustainability plan, and 75% of these reported that they had begun implementing their plans. Grantees in more recent cohorts [cohort 8 (1998-99), cohort 7 (1998-98) and cohort 6 (1996-97)] were more likely to report not having or not yet implementing a sustainability plan.
- The most frequently reported collaborative partners reported in sustainability plans were school districts, community-based organizations, and county and city agencies.

Post-funding grantees:
- As with currently funded grantees, primary collaborative partners reported by post-funding grantees after the operational grant period were schools, county agencies, and nonprofit agencies.
- A significant proportion of post-funding grantees reported offering a combination of services following the Healthy Start operational grant period. Few grantees reported that the quality of services declined after the operational grant period.
- Post-funding grantees frequently reported a decline in staff numbers after the operational grant period (47%), and very infrequently reported an increase in staff numbers after the operational period (24%).
- Post-funding grantees generally reported that staff qualifications did not decline or improve after the operational grant period.
- Cohort analysis: A cohort analysis of the post funding grantees indicated that a substantial number of grantees within each cohort (more than 20%) reported a decline in the number of services offered after the operational grant. Post-funding grantees in the earlier cohorts [cohort 1 (1991-92) and cohort 2 (1992-93)] were more likely to report a decrease in staff numbers after the operational grant than grantees in later cohorts [cohort 4 (1994-95) and cohort 5 (1995-96)]. No significant differences were found in the number of service areas offered or the number of collaborative partners reported by grantees in the 5 cohorts. Overall, grantees in earlier cohorts reported lower funding amounts than grantees in later cohorts. This potentially indicates that erosion of funding is taking place over time, and suggests that problems with sustainability may not necessarily manifest themselves immediately after state Healthy Start grants are terminated.

Second Measure of Sustainability
A second measure of sustainability was also used. This measure was based on more money, number of services and number of collaborating partners in the post-funding period.

- When considering factors for sustaining services, funding (82%) followed by collaboration (40%) and administrative support (39%) were ranked as the important factors for sustaining services by grantees overall.
• Funding was reported as the most important factor for sustaining services by 82% of the grantees. Funding is paramount for grantees trying to maintain services.

• The average amount of funding reported by grantees was approximately $220,400 (median value). Post-funding grantees reported higher amounts of both LEA and overall funding amounts than currently funded grantees. Grantees in the earlier cohorts were more likely to report higher LEA and higher overall funding amounts than those in more recent cohorts.

Grantees that have higher funding amounts may have other characteristics associated with sustainability:

• Grantees reporting higher funding amounts were also more likely to report receiving more LEA Medi-Cal funds. This finding implies that higher (total) amounts of LEA funds are associated with higher total funding amounts. This also highlights the important role of LEA funds in determining the total funding obtained by grantees and in turn their odds for sustainability. Post-funding grantees were more likely to report that their districts were billing for LEA funds, as well as receiving more LEA funds than currently funded grantees. This finding may be associated with the increased likelihood of post-funding grantees using LEA monies as funds for the continued provision of services than currently funded grantees. It also may mean that it takes time to organize how to bill and receive LEA Medi-Cal funds.

• Recent cohorts reported lower funding totals.

• Funding amounts reported by grantees were also associated with the number of collaborative partners reported by them. Grantees with more money were more likely to report more collaborative partners than grantees with less money.

• Post-funding grantees were more likely to report that their sites had conducted additional evaluations (other than the HS evaluation) than currently funded grantees. Currently funded programs tend to only take part in the California Department of Education evaluation, as they are not in the process of seeking funding. It is likely that post-funding grantees have had greater need, opportunity and time for additional evaluations and that evaluation data were used to justify further funding. Both currently funded and post-funding grantees reported evaluation findings to have been helpful in sustaining the commitment of collaborative partners.

• Currently funded grantees (97%) were more likely to report the use of a case management system than post-funding grantees (87%). This suggests that grantees may have difficulty maintaining case management services in the transition from Healthy Start funding.

Third Measure of Sustainability
The third measure used grantee self-assessment of changes in their post funding service capacity to designate a functional trajectory in the post-funding period to distinguish between different levels of sustainability in the post-funding period. Using a self-assessed measure of service capacity, a "service trajectory" was created for all post-funding grantees. Three levels of sustainability were developed to represent the ongoing (post-funding) service delivery capacity: 1) Post funding grantees who reported an increase in service capacity after Healthy Start funding ceased - were designated as being on an upward service trajectory (30%); 2) Post funding grantees with no change in service capacity (or reporting different services) - on a "same level" functional trajectory (33%); and 3) Post funding grantees reporting a decrease in service capacity - on a "decreasing" functional trajectory (37%). Evaluating the sustainability of Healthy Start Initiatives based upon the self-assessed service capacity of the collaboratives is only one potential indicator of sustainability. In order to do a more comprehensive examination of factors relating to sustainability, longitudinal data should be collected.

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41It should be noted that there are potentially several measures as well as techniques that can be used to measure sustainability. Service capacity was used as a measure in this study because of the nature of the data collected. However, the use of service capacity as a measure of sustainability is somewhat limited. A more reliable measure could result by the inclusion of different measures in the designation of trajectories, such as funding and staff, in addition to service capacity.
- Post-funding grantees in the upward sustainability trajectories (who reported an increase in service capacity after the operational period) reported the highest rate of participation in additional evaluations (other than those required by the CDE).
- Higher amounts of funding were found for grantees in the upward trajectories (mean value $761,300); lower amounts were found for those in the no change trajectory (mean value $380,852); and the lowest amounts were found for those in the downward trajectory (mean value $281,090).
- No significant associations were found between the sustainability trajectory measure and LEA funds or the number of collaborative partners reported.

FIRST MEASURE OF SUSTAINABILITY

CURRENT GRANTEES
Planning for Sustainability
In order for grantees to continue to provide services after Healthy Start funds run out, plans for ongoing provision of services and funding need to be made while the grantees are in the operational period. A key component of sustainability plans is the procurement of additional and alternate funds as well as identification of potential collaborative partners to help grantees continue to operate during the post-operational period and help in making the transition smoother.

Sustainability Plans – Development and Implementation
To determine the prevalence of sustainability measures in the operational period, currently funded grantees were asked to report on the development of sustainability plans. Approximately 66% (110 out of 167) of those responding reported the development of a plan for sustaining and developing services and supports beyond the 3 year Healthy Start funding period. Most of the remaining grantees without a long-term sustainability plan (N=57) were in the more recent cohorts (cohorts 6, 7 and 8). No conclusions could be drawn about sites in cohorts 4 and 5 because of the low response rates (Appendix 2-8, Table 2-8.1).

Grantees who reported the development of sustainability plans were asked to report on the implementation of their sustainability plans. Of the 108 grantees responding, approximately 75% (N=81) reported that they had begun implementing their long-term sustainability plan (Appendix 2-8, Table 2-8.2).

Approximately 25% of those who reported the development of a sustainability plan reported that they had not begun implementing their long-term sustainability plans. An analysis by cohort indicates that all these grantees were in either cohorts 6 (1996-97), 7 (1997-98) or 8 (1998-99), and at the time were in year one, two or three of their grant. These grantees could still be in the process of completing their sustainability plans. One question that arises from this analysis is whether grantees are beginning the process of developing and implementing their plans in a timely fashion. Delays could result in long-term sustainability difficulties. However, this could not be ascertained through available data.

Primary Collaborative Partners in Sustainability Plan
Identification of collaborative partners and strategies to develop partnerships are a key component of any future plan for site sustainability. These collaborative partners can play a role in site sustainability in several ways including but not limited to the provision of funds as well as integrating service delivery by providing staff and/or space.

Grantees who reported the development of sustainability plans (N=110) were asked to report on the three primary collaborative partners included in their sustainability plans. Approximately 97% (N=107) of those reporting the development of a sustainability plan identified their collaborative partners. The most frequently
reported collaborative partners were school districts, community based organizations, and county public health agencies. Several county level collaborative partners were reported as well. The summation of all county collaborative partners into one "county" category would result in counties as the second most reported category. Overall, the most frequently reported collaborative partners in plans for sustainability were school districts, community based organizations, and city and county agencies.

No major differences in numbers of collaborative partners were found between grantees with and without sustainability plans. Grantees reporting sustainability plans reported 14 partners on an average (median value) while those without sustainability plans reported 13 partners. The range for number of partners was the same for both.

**POST-FUNDING SITES**
The sustainability analysis of post-funding grantees was conceptualized as changes in staff and services that occurred due to the transition from the operational to the post-operational phase. In effect, grantees were asked to compare current services and staff during and after the operational grant period. They were also asked to identify the key collaborative partners that played an important role in sustaining their sites after the operational period.

**Primary Collaborative Partners after Operational Grant**
As mentioned earlier in this report, collaborative partners are considered to play a potentially important role in site sustainability. Ideally, grantees in their planning grant period plan to develop partnerships and collaborative relations with key partners. During the operational period, grantees begin implementing these plans for operational as well as post-operational goals. While collaborative partners may be varied and numerous, the purpose of this analysis was to observe common patterns in the types of collaborative partners reported by post-funding grantees. Information on the existence of common collaborators across grantees could potentially be shared with currently funded grantees in the operational period.

Post-funding grantees were asked to report on primary collaborative partners who played a role in site sustainability after the operational grant period was over. They were asked about the following possible partners: 1) Schools 2) County agencies 3) City agencies 4) Districts/County Office of Education (COE) 5) Nonprofit agencies 6) Businesses. Post-funding grantees most frequently reported schools (78%), county agencies (63%) and nonprofit agencies (40.4%) as primary collaborative partners after the operational grant period was over. Businesses (5%) were least frequently reported as key partners (Appendix 2-8, Tables 2-8.3 and 2-8.4).

**Changes in services after operational grant**
Post-funding grantees were asked to report on program service changes after the operational period was over. They were provided with the following options: 1) More services were offered 2) Fewer services offered 3) Different combination of services offered 4) Quality of services improved 5) Quality of services declined. Post-funding grantees most frequently reported that a different combination of services was offered. They were least likely to report that the quality of services declined after the operational grant period was over (Appendix 2-8, Tables 2-8.5 and 2-8.6).

**Changes in staff numbers after operational grant**
Post-funding grantees were asked to report on changes in staff numbers after the operational grant period was over. They were provided with 3 options: increase in staff numbers, decrease in staff numbers, and no change. Post-funding grantees most frequently reported a decrease in staff numbers after the operational
grant period was over (47%) and least frequently reported an increase in staff numbers (24%) after the operational grant period was over (Appendix 2-8, Table 2-8.7).

**Changes in staff qualifications after operational grant**
Post-funding grantees were asked to report on changes in staff qualifications after the operational grant period as a proxy measure for staff quality. They were asked to report on the level of improvement or decline on a 5-point scale: 1) Definitely improved 2) Somewhat improved 3) Did not decline or improve 4) Somewhat declined 5) Definitely declined. Grantees were more likely to report that staff qualifications did not decline or improve after the operational grant period (Appendix 2-8, Table 2-8.8).

**Cohort Analysis**
Finally, a cohort analysis of post-funding grantees (Cohorts 1-5) was conducted using the information provided by these grantees in the survey. A substantial number of grantees within each of these cohorts (more than 20%) reported a decline in the number of services offered after the operational grant. In addition, grantees in the earlier cohorts were more likely to report that staff numbers had decreased than grantees in later cohorts but all reported no change in staff qualifications. For all cohorts the median number of service areas offered fell between 11 and 12 services (out of the 15 service areas included in the survey). In reporting about the level of integration, 11% to 29% of grantees in all cohorts reported being well integrated with school sites with the exception of cohort 5 (1995-96) where 45% of grantees reported being well integrated. The median for number of collaborative partners ranged from 10 to 14 for the 5 cohorts. Overall, grantees in earlier cohorts reported lower funding amounts than grantees in later cohorts potentially indicating an erosion of funding over time, and suggesting that problems with sustainability do not necessarily manifest themselves immediately (Appendix 2-8, Table 2-8.22).

**SECOND MEASURE OF SUSTAINABILITY**

**Number of Collaborative Partners**
The average number of collaborative partners reported by all grantees was 13 (median value). Currently funded grantees reported a slightly higher number of collaborative partners (N=14) than post-funding grantees (12 partners) (Appendix 2-8, Table 2-8.9). While the average number of partners was higher for currently funded grantees, no significant differences were found between the average numbers of collaborative partners for currently funded and post-funding grantees (Appendix 2-8, Table 2-8.10).

**Facilitating Factors and Barriers**
As an additional component of this sustainability analysis, different factors that might be associated with the successful implementation and maintenance of integrated services were profiled. Grantees were asked to report on facilitating factors and barriers related to the continued provision of services.

Three common factors (with differing levels of importance) were identified as facilitating factors for the provision of both integrated and sustained services. Collaboration with other agencies was ranked as the most important factor for providing integrated services (51%) followed by funding and leadership. When considering factors for sustaining services, funding (82%) followed by collaboration (40%) and administrative support (39%) were ranked as the important factors for sustaining services (Appendix 2-8, Table 2-8.11 – 2-8.14). The identification of *funding* as the most important factor by 82% of the grantees indicates that this issue is paramount for grantees trying to maintain services.
Table 8-1. Comparing facilitating factors and barriers to providing and sustaining school-based integrated services.

**Funding**

Both currently and post-funding grantees were asked to report the amounts of funding received by their sites. The average amount of funding reported was approximately $220,400 (median value). When analyzed by funding status, post-funding grantees were more likely to report a higher average amount ($321,000 median value) than currently funded grantees ($194,500 median value) (Appendix 2-8, Table 2-8.15).

**Distribution of funds across cohorts**

The graph above indicates that grantees in the earlier cohorts were more likely to report higher amounts of funding than grantees in more recent cohorts. Therefore, grantees in the earlier cohorts were more likely to report higher amounts of LEA monies as well as higher amounts of overall funding than those in the recent cohorts.

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76The "amount of funding" variable was created from the CDE’s Partnerships Supporting Sustainability Chart. The total amount of funding for post-funding grantees includes Medi-Cal reimbursements, grants received from non-Healthy Start sources such as foundations or government agencies, and school or district funds that have been redirected to support qualifying Healthy Start activities. In addition, grantees were asked to give a monetary value to in-kind services provided by partners and for equipment and space donations. These sources were combined to create a total amount of funding (support) received by the grantees. This information should be treated with caution since a number of grantees reported collaborative partners but no funding amounts or reported percentages. To improve the validity of CDE chart information, a reliability score ranging from 0-2 was given to the funding amounts reported by grantees. Only grantees with a reliability score above 0 were included in the analyses.

Tests of significant associations between funding, funding status and other factors potentially related to sustainability:

**LEA money:** Funding amounts were significantly associated with LEA Medi-Cal funds reported as received or promised to grantees. This is as would be expected since the total funding amounts reported are inclusive of LEA funds reported. This finding implies that higher (total) amounts of LEA funds are associated with higher total funding amounts. This also highlights the important role of LEA funds in determining the total funding obtained by grantees and in turn their odds for sustainability.

A significant association was found between funding status and the amount of LEA monies reported by grantees. Post-funding grantees were more likely to report higher LEA amounts (mean value $40,255) than currently funded grantees (mean value $29,632).

**LEA Medi-Cal Funds/district billing:** LEA Medi-Cal funds can potentially play a very important role in sustaining sites, especially after the operational grant period. The results indicate that a majority of grantees reported that their districts were billing for LEA Medi-Cal funds. Funding status was significantly associated with billing for LEA Medi-Cal money. Post-funding grantees were more likely to report that their districts were billing for LEA than currently funded grantees (those planning to bill were excluded). Therefore, it seems that while the level of billing for LEA monies is very high among the respondents, post-funding grantees are more likely to report that their districts have been billing for LEA money (and acquiring more LEA money than currently funded grantees). This finding may be associated with the increased likelihood of post-funding grantees using LEA monies as funds for the continued provision of services than currently funded grantees.

**Number of Collaborative Partners:** Funding amounts reported by grantees were significantly associated with the number of collaborative partners reported by them. Grantees with more money were more likely to report a higher number of collaborative partners than grantees with less money. No significant associations were found between the number of collaborative partners reported by grantees and their funding status.

**Cohorts:** A significant association was found between funding amounts reported and cohorts (that is, an association beyond chance). Funding amounts were negatively correlated with cohorts. This would imply that as cohorts increase from 1 to 8, the amount of funding reported decreases. In effect, this implies that post-funding grantees have higher amounts of funding than currently funded grantees. This finding could be influenced by the fact that earlier cohorts are obtaining more LEA monies, which adds to the total amount of funding received by grantees.

**Evaluations:** Funding allocations are increasingly becoming contingent upon demonstrated results. Funding agencies and collaborative partners want information on the beneficial impacts of services provided. One way of extracting site performance information is through site evaluations. Grantees were asked to report if their sites had had any additional evaluations (other than those required by the Healthy Start). The tests indicated a significant association between funding status and evaluations. A larger proportion of post-funding grantees (56.1%) reported that their sites had ever been evaluated (other than the HS evaluation) compared to currently funded grantees (24.2%) (Appendix 2-6, Table 2-8.16). While many reasons could explicate this finding, one that may apply is the difference between currently funded and post funding grantees in seeking additional funds. Currently funded grantees usually have to participate in a mandatory annual Healthy Start evaluation for their funding. Post-funding grantees usually have to participate in outside agency evaluations to get additional funding – conditional on the results of the evaluations and demonstration of positive results or outcomes. This has been interpreted to indicate that evaluation data were used to justify further funding.
Furthermore, grantees were asked to rate the helpfulness of evaluation findings in improving program operations and in sustaining the commitment of collaborative partners. No significant associations were observed between funding status and improvement in program operations. However, funding status was found to be significantly associated with the role of evaluation findings in sustaining commitment of partners. Grantees were provided with the options of extremely helpful, helpful, somewhat helpful, not very helpful and not helpful at all. Approximately 40% of grantees (N=55) asked this question reported that evaluations were helpful in sustaining the commitment of partners. Currently funded grantees were more likely to rate the evaluation findings as somewhat helpful or helpful than post-funding grantees even though they were less likely to report evaluations than post-funding grantees (Appendix 2-8, Table 2-8.17). This could be because of their participation in the statewide report and the year-by-year funding which is contingent on these evaluative results. Irrespective of reference points, the analyses indicate that both currently and post-funding grantees report evaluation findings to have been definitely helpful in sustaining the commitment of collaborative partners. No significant associations were found between the reporting of additional evaluations and funding amounts reported by grantees.

Case management. Grantees were asked to report whether their sites used a case management system or not. Case management was defined as "a system in which individuals are responsible for coordinating student and/or family care across agencies." The analysis revealed a significant association between funding status and the existence of a case management system. Currently funded grantees (97%) were more likely to report the existence of a case management system than post-funding grantees (87%) (Appendix 2-8, Table 2-8.18).

This difference may represent a maturational effect. It appears that one of the characteristics of the transition from current to post status is the reorganization of some services at some sites. Some services stay and some go. Perhaps the provision of case management services by currently funded grantees is somehow connected to Healthy Start funding. However, once grantees move on to the post-operational period, case management services may be less sustainable without dedicated funds available. This might also shed light on policy and funding issues behind the maintenance of case management systems by currently and post-funding grantees. The observation that post-funding grantees are less likely to report the existence of a case management system raises questions about ways to maintain case management services in the transition from current to post-funding status.

In addition, a significant association was found between the existence of a case management system and the amount of funding reported by grantees (for all grantees). Those that reported a case management system were also likely to report lower amounts of funding (mean value $293,618) than those without a case management system (mean value $543,486). This result could be influenced by funding status, since currently funded grantees were more likely to report the existence of case-management systems as well as lower amounts of funding than post-funding grantees.

77Questions on case management were asked two times in the survey. The first one was in the Service Integration charts and was defined as "coordination of multidisciplinary teams and home visitation." All grantees were asked this question (N=286). Version 1 of the survey included a separate section on case management, where case management was defined as "a system in which individuals are responsible for coordinating student and/or family care across agencies." Only 142 grantees responded to this question. There were no significant differences between current and post grantees for the chart question. However, significant differences were found for the V1 question (cross-tab analyses, significant at the 0.05 level). These differences may be due to the two different definitions of case management used in the survey.
THIRD MEASURE OF SUSTAINABILITY - POST-FUNDING SITE SUSTAINABILITY TRAJECTORIES

In an attempt to further understand the characteristics of sites that continue to operate after Healthy Start funds are over, additional analyses were conducted on post-funding grantees. All post-funding grantees were investigated in order to examine their functional trajectory of sustainability. Three levels of sustainability were conceptualized:

1. Post-funding grantees on an "upward" functional trajectory;

2. Post-funding grantees on a "same level" functional trajectory;

3. Post-funding grantees on a "decreasing" functional trajectory.

These levels were operationalized by creating a new measure based on self-assessments of service capacity after the operational grant period reported by the 89 post-funding grantees78 (Appendix 2-8, Table 2-8.19) The three corresponding categories included those that reported...

1) An increase in service capacity (upward trajectory); 30% of post-funded grantees.

2) Same level of service capacity (or different services) (same level trajectory); 33% of post-funding grantees.

3) A decrease in service capacity (downward trajectory); 37% of post-funding grantees.

Tests of significant associations between the new trajectory measure and other potentially related to sustainability:

Additional Evaluations: Initial analyses indicated a significant association between funding status and additional evaluations – with post-funding grantees more likely to report additional evaluations (other than the those required by the CDE). Tests of association were run between the new trajectory measure and additional evaluations reported by grantees. A significant association was found between the service trajectory measure and additional evaluations (Appendix 2-8, Table 2-8.20). Overall, grantees in the upward trajectories (who reported an increase in service provision after the operational period) were also more likely to report additional evaluations. Fifty-two percent of all post-funding grantees reporting evaluations also reported providing more services after the operational period. Post-funding grantees in the same level or downward trajectories were less likely to report being evaluated in addition to the CDE evaluation79.

Funding: Higher amounts of funding were also associated with grantees in the upward trajectories (mean value $761,300); lower amounts were associated with those in the no change trajectory (mean value $380,852); lowest amounts were associated with those in the downward trajectory (mean value $281,090). Grantees in upward sustainability trajectories were also more likely to report higher amounts of funding whereas grantees with no change or downward sustainability trajectories were more likely to report lower amounts of funding.

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78It should be noted that there are potentially several measures as well as techniques that can be used to measure sustainability. Service capacity was used as a measure in this study because of the nature of data collected. However, the use of service capacity as a measure of sustainability is somewhat limited. A more reliable measure could result by the inclusion of different measures in the designation of trajectories, such as funding and staff, in addition to service capacity.

79Grantees in the downward trajectory (providing fewer services) were more likely to report undergoing additional evaluations than those in the same level trajectory (providing the same number of services post operationally). It could be assumed that the downward trajectory grantees were more inclined to undergo evaluations to justify additional or new funding than grantees in the same level trajectory. Of that evaluation data was used more often by the downward trajectory grantees (providing fewer services) to determine the elimination of certain services. However, no conclusions can be drawn without additional data.
No significant associations were found between the sustainability trajectory measure and the number of collaborative partners reported by post-funding grantees (Appendix 2-8, Table 2-8.21). In addition, no significant associations were found between the trajectory measure and LEA funds reported by post-funding grantees.

This represents an attempt to model the concept of sustainability by using self-assessments of service capacity in the post funded period as a way of calculating post-funding functional trajectories. A third of the grantees demonstrated positive trajectories, a third appeared to be on a same level trajectory and the remaining third appeared to be on a downward trajectory. Grantees in the most positive functional sustainability trajectories were also likely to report more money and more use of evaluations during their tenure. This analysis indicates that grantees can provide a self assessment of the their functional status post-funding and that this can be used to project potential long term sustainability irrespective of their short term continued operation. Other characteristics and possible determinants of a more positive functional trajectory can be determined with additional analyses.

Because these measures of sustainability are taken at a specific point in time they are limited in their ability to show whether the individual grantees are increasing, decreasing or maintaining a constant level of service. For example, grantees currently on a "same-level" trajectory may progress to a more positive trajectory or conversely may decline and follow a downward trajectory (and head for possible closure) next year. Therefore, the ideal method for operationalizing this concept of sustainability would be to follow individual grantee service trajectories over time, monitoring their progress or demise. Comparisons could then be made to determine factors that differentiate grantees in a state of decline from those maintaining or expanding programs.