How to Develop a Statewide System to Link Families with Community Resources: A Manual for Replication of the *Help Me Grow* System

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The Facts:

- Children with developmental/behavioral problems are eluding early detection.
- While programs exist to provide services to young children and their families, child health care providers face challenges in connecting at-risk children with needed services.
- Children and their families benefit from a coordinated, statewide system of early detection and intervention for children at risk.

Help Me Grow (*HMG*) is a unique system that assists families, primary care practices, and other community-based providers in identifying developmental or behavioral concerns in children from birth through age 8; establishes an inventory of appropriate resources; and helps families connect with these programs and services. Program components include: a statewide toll-free telephone number that providers and families can use to access care; partnerships with community-based agencies throughout the state; and child development community liaisons.

This online manual offers guidance for exploring, creating, and/or enhancing an easily accessible system for connecting children with or at risk for developmental or behavioral problems with community resources. The material is based on Connecticut's *HMG* initiative, a program of the State of Connecticut's Children's Trust Fund within the Department of Social Services.

Based on lessons learned in Connecticut, there has been interest in replicating *HMG* in other states and communities. The *HMG* program has already been replicated in Polk County, Iowa and Orange County, California. To assist other states, the Connecticut Children's Medical Center has received a $340,049 two-year grant (2008 – 2010) from The Commonwealth Fund. The project provides technical assistance and guidance to five sites, Colorado, Kentucky, New York, Oregon and South Carolina, which were selected through a competitive application process**.** (See National Replication brief and presentation.) This manual also provides descriptions of the implementation efforts occurring in these states, as well as in Orange County, California.

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Framing the Issue / General Guidance:	Framing the Issue / The Connecticut Experience:
Undetected behavioral and developmental problems in children can have a profound impact not only on the lives of children and families involved, but also on our society in terms of costs related to mental health, education, and juvenile justice. Nationwide, it is estimated that approximately 12 to 16 percent of American children experience developmental, behavioral, and/or emotional disorders. Child health providers agree that early detection of developmental delays offers the best hope for optimal long-term outcomes. Even when children's developmental needs are recognized, however, connecting children to services often proves difficult. Linking children to services requires knowledge about community-based programs and eligibility requirements and persistence. Many states have some of the necessary components for a comprehensive, coordinated system of early identification and referral of children for developmental and behavioral problems. However, few have been able to create a truly comprehensive system that effectively connects families to services.	Connecticut *HMG*, under the auspices of the Connecticut Children's Trust Fund, is a universal system that provides a cost-effective, efficient, and user-friendly mechanism for identifying children from birth through the age of 8 with developmental or behavioral problems and connecting them to appropriate community resources in a timely manner. The *Help Me Grow* System has five interrelated components that work to: • **Ensure that child health providers are trained in effective developmental surveillance and screening,** including how to contact *HMG* if a concern is identified. The Child Health and Development Institute conducts the training using a module in the Educating Practices in the Community (EPIC) curriculum. • **Offer a free and confidential telephone access point** that links young children and families to existing services and supports and offers families the opportunity to participate in the Ages and Stages Questionnaire (ASQ). The ASQ is a tracking system that helps parents and child health providers monitor a child's development. The Child Development Infoline (CDI), a specialized call center of the United Way 2-1-1, serves as the *HMG* access point. • **Maintain an inventory of community-based programs** used by the telephone care coordinators to serve children, families and providers. Resource information is maintained by the United Way 2-1-1 Information Department. • **Maximize the use of resources available to those who contact the call center**. Community liaisons from the Children's Trust Fund serve as conduits between local programs and the call center. In this capacity they contribute information to the resource inventory used by the call center and support providers by facilitating local networking opportunities.

	• **Conduct an annual outcome evaluation** of who calls *Help Me Grow*, as well as the nature of the calls and how effectively the family was matched with program services. The evaluation also assesses the program's effectiveness in meeting annual goals and fulfilling state criteria for results-based accountability. Evaluations are conducted by the Center for Social Research at the University of Hartford.

Administrative Oversight / General Guidance:

The design and implementation of an *HMG* system is dependent on communication, coordination, and integration of resources and services. Genuine collaboration is required to make changes in policies, governance, and operating procedures at both administrative and direct service levels.

A number of barriers to collaboration have been identified in the literature and by practitioners in the field. One of the most challenging is the issue of control—who "owns" the program. Additional barriers include: competitiveness; lack of compelling mutual interest; parochial interests; lack of skill in coordinating; difficulty communicating across disciplines; preoccupation with administrative rather than functional structures; concerns about client confidentiality; resistance to change; external pressures; lack of accountability; lack of monitoring and evaluation procedures; inadequate knowledge of other agencies; negative attitudes; and little consideration for political bases. However, research indicates that most of these barriers can be addressed, at least in part, through attention to the process of collaboration.

One of the first steps in the development of a *HMG* system is to enlist partners who have mutual interests, serve the same populations, and/or who have the capacity to move the agenda forward.

Once you identify potential partners, ask yourself "What's in it for them?" How would they benefit from having one or more of the following in their community: a single-point-of-access system; a program that connects children "at-risk" to services; and providers trained in developmental screening? Strategies for approaching partners will vary depending on who is being approached and their potential roles. The following guidance is offered in recognizing, recruiting, and retaining partners.

- Is there a strong advocate who is well-connected and respected who could become your champion? If so, that person should be recruited first as that support will add leverage and credibility.

Administrative Oversight / The Connecticut Experience:

Today, *HMG* involves a close collaboration between the Children's Trust Fund, which administers the program, and the United Way of Connecticut, which the Trust Fund contracts with to offer a free and confidential telephone access point to link young children and families with services and supports.

HMG was originally a city pilot, known as *ChildServ*, that began in Hartford in 1998 with funding from the Hartford Foundation for Public Giving, in response to the evident need for a coordinated system of developmental surveillance serving the large number of Hartford children with developmental and behavioral concerns. In 2002, it expanded into statewide project with funding from the state.

Meanwhile, Connecticut's Birth to Three Infoline was established in 1993 by the United Way of Connecticut to serve as the single point of telephone access for Connecticut's Early Intervention program known as Birth to Three. In 2002, the Birth to Three Infoline became the Child Development Infoline (CDI) and began to serve as the access point for several programs serving children, including *HMG*.

Along with *HMG*, CDI serves as the access point for Birth to Three, Early Childhood Special Education services, and the Children and Youth with Special Health Care Needs program. Thanks to this collaboration, the help line offers one-stop shopping for users and is supported by blended funding streams. (See CDI Chart.)

A steering committee consisting of representatives from each of these programs meets regularly to share information and to develop protocols to ensure a smooth referral process for families. Funding for the program is facilitated by blending financial and administrative resources across departments and agencies, including the Children's Trust Fund, the Department of Developmental Services, the Department of Education, the Department of Public Health, and United Way of Connecticut.

- Document current gaps/barriers in the systems that serve at-risk children from the perspective of families, health care providers, child care programs, other direct service providers, policymakers, funders, and other stakeholders. Be able to discuss these barriers from all perspectives.

- Develop a draft of core principles to share with potential partners. Be open to reviewing and revising them; new partners will want their issues and needs reflected in the document.

- Clarify the roles and responsibilities of each partner and how they will be supported.

- Know what is needed from a systems and fiscal perspective and how your proposal will:
  - be cost-effective,
  - coordinate systems,
  - offer "one-stop shopping," and
  - be family-focused.

- Obtain consensus on the design and implementation of a formal system for communication among all partners. Once implemented, be prepared to revise it.

- Build in a method for ongoing tracking and monitoring of the system and share this information regularly with all partners.

- Address issues/concerns as they occur in an environment that is open, direct, and non-threatening.
- Remember to celebrate successes and acknowledge those involved with them.

Outreach to Primary Care Practices / General Guidance:

Child health providers have near universal access to young children and are in a unique position to identify children who are at risk for developmental delay. Their work with families also requires that they provide ongoing monitoring of children's developmental status. A primary component of *Help Me Grow* (*HMG*) is to ensure that child health providers are trained in effective developmental surveillance and screening and utilization of *HMG* through its centralized call center.

Developmental surveillance, unlike developmental screening, is a flexible, continuous process in which knowledgeable professionals perform observations of children while providing care. Development is continuously monitored within the context of overall well-being, rather than viewed in isolation during a testing session. Developmental surveillance is broader in scope than screening and occurs at every well child visit.

Components of developmental surveillance include:

- eliciting and attending to parental concerns;
- documenting and maintaining a developmental history;
- observing the child;
- identifying risks and protective factors; and
- maintaining an accurate record of findings over time, which includes input from others (child care providers, schools, etc.).

Because research has shown that parental concerns are important indicators of problems, soliciting parents' input is critical to developmental surveillance. Properly employed, developmental surveillance is family-focused, accurate, and efficient and can guide clinical decision-making.

Utilization of specific screening instruments compliments developmental surveillance. It has been shown that child health providers are extremely accurate in identifying children with developmental delays, but that they could identify children who would benefit from intervention services earlier if they used standardized screening tools.

Outreach to Primary Care Practices / The Connecticut Experience:

Educating Practices in the Community (EPIC), a program of the Child Health and Development Institute of Connecticut, is designed to improve the content and delivery of child health services by assisting providers in implementing new clinical advancements and using available state resources to improve patient care. Research on changing physician behavior suggests that traditional methods of education, such as conferences, hospital-based seminars, and the distribution of literature have little impact on changing practice.

Instead, EPIC provides on-site practice education using trained peer professionals (physicians, psychologists, care coordinators). Training involves topic-specific presentations to physicians and office staff over lunch or at another convenient time. Practices receive resource materials to help them implement the desired change. EPIC is provided at no cost to practices.

Seven EPIC modules have been developed and disseminated to pediatric and family medicine practices in Connecticut. These modules address: child abuse prevention, infant oral health, developmental monitoring, brief behavioral counseling, connecting children to behavioral health services, care coordination, and autism spectrum disorders. More than 200 practices have been visited over the past four years, and feedback from practices has been excellent.

A project steering committee, which includes representation from local chapters of the American Academies of Pediatrics and Family Physicians and providers in EPIC clinical content areas, oversees development of new modules, including identification of topic areas, and implementation of existing modules.

HMG developed an EPIC module that provides in-office education to child health practices on developmental surveillance, screening and referral of at-risk children. Through support from The Commonwealth Fund, *HMG* visited and trained more than 50 percent of the community-based practices in Connecticut—200 practices in all. Maintaining

The American Academy of Pediatrics recommends that, in addition to performing developmental surveillance at every well-child visit, pediatricians use standardized screening tools at the 9, 18 and 30 (or 24) month visits. Several screening instruments have been standardized across the child population and are easy to integrate into pediatric primary care settings. Two screening tools that are widely used are the *Ages and Stages Questionnaire* (ASQ) and *Parents Evaluation of Developmental Status* (PEDS).

ASQ	PEDS
4 months to 5 years	Birth to 9 years
Parent completes, but may need assistance as well as manipulatives such as crayons and blocks	Parent completes
Number of questions varies by age	The same 10 questions used at all ages
10 to 15 minutes to complete, 1 to 2 minutes to score	5 minutes to complete, 1 to 2 minutes to score
Pass/fail	Pass/fail
Available in several languages	Available in several languages
Cost is one-time $200 fee and then all materials can be copies	Cost is about $1.10 per visit, and materials cannot be copied
There is an online program for parents to use to complete and submit questionnaires prior to the visit. Materials include activities for parents to use to promote development.	Materials include a composite scoring sheet that can be maintained in the medical record for easy reference of developmental status over time.

In some states, child health providers can be reimbursed for developmental screening with a formal tool on the same day as a well child exam. Reimbursement is available through Medicaid as well as commercial insurers. The standard CPT code to use for obtaining reimbursement is 96110, although some providers prefer to use modifier 25 with E and M codes. If your state accepts utilization of

physician outreach programs for a variety of topics under the umbrella of EPIC reinforces the *HMG* message and ensures that child health providers are not inundated with requests for office presentations and training. (See EPIC Developmental Screening PowerPoint.)

Basic rules for office-based outreach include:

1. Include the entire office staff because implementing screening and utilization of Child Development Infoline requires staff collaboration.
2. Remember that you are at the mercy of the practice's schedule: presentations must stick to the time allotted, providers will be late and leave early, and emergencies will keep some from attending.
3. Be prepared to answer a lot of questions during and after the presentation.
4. Bring resources that will help the practice implement screening and referral such as magnets with the call line's telephone number, sample copies of screening tools, and stickers for charts that remind providers that children have been referred to *HMG*.
5. Bring food to draw staff away from their desks.
6. Be flexible in terms of providing practices with the information they want. Some already screen and have a list of referral options. Work with these.
7. Distribute feedback forms to assess how your presentations are going. Regularly review feedback and make adjustments accordingly.

96110, it is a good idea to use this as it allows states and practices to track screening rates. To determine whether or not reimbursement is available in your state for developmental screening contact your state Medicaid program and the major commercial insurers in your state.

Bibliography of related articles:

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The Call Center, Resource Inventory and Data Collection / General Guidance:	The Call Center, Resource Inventory and Data Collection / The Connecticut Experience:
A. Establishing a Call Center: The *HMG* experience has shown that, on average, it takes approximately 12 phone calls to connect a family with concerns about a child's behavior to the needed service. That kind of burdensome process can be an impediment to getting children the help they need—an impediment that a toll-free number can eliminate. Telephone services are cost-effective, easy to promote, efficient in identifying needs, and effective in supporting callers and triaging to appropriate services. They also can be used to collect data on both resources and callers. If call centers in your area are already serving families and children, partnering with those centers is the most efficient way to create access to services. **B. Identifying who will serve as the HMG call center:** The first step is to convene a workgroup to assess the various *HMG* call center options. The group will need to look at existing call centers in your community/state. Examples include: 2-1-1, child care resource and referral services, maternal and child health (MCH) hotlines, intake lines for early intervention and early childhood special education, and parenting help lines. Questions to consider, include: 1. What is the target population of each call center? Note: The goal of *HMG* is to serve as a universal resource. 2. What is the capacity of each call center? What kind of training and support is provided to the direct-service staff? What is the staff turnover rate? Can existing staff handle an increase in volume? Is there funding, resources, and space available to support an increase in staff?	**A. Child Development Infoline (CDI)**, formerly known as Birth to Three Infoline, was selected to serve as the access point for *HMG* in 2002. The decision to expand Birth to Three Infoline, the single point of entry to Connecticut's early intervention program, to serve as the access point for *Help Me Grow*, Early Childhood Special Education (ECSE), and the Children and Youth with Special Health Care Needs (CYSHCN) program, was based on its capacity to offer "one-stop shopping" for families seeking services. CDI is staffed by care coordinators, who are skilled in determining a child's and her/his family's needs in order to share accurate information, make a timely referral(s), and, if necessary advocate on behalf of the family. As a specialized call center within the 2-1-1 system, a number of supports are available to assist the care coordinators in finding appropriate resources in a timely manner. CDI staff have access to REFER, a searchable computerized database that consists of a comprehensive inventory of Connecticut's health and human services. REFER maintains information on 4,795 providers, 47,200 service sites and 1,900 support groups. CDI staff also use the knowledge and expertise available from the other call centers of the 2-1-1 system, including the comprehensive 2-1-1 center and other centers such as Child Care 2-1-1, which helps parents find child care and related services, and HUSKY 2-1-1, which informs families about health coverage eligibility and benefits of the state's HUSKY program. Having access to and the support of the other 2-1-1 call centers ensures that CDI is able to meet families' full range of needs. **B. CDI has the following features:** - Staffing: - 5 FTE Care Coordinators

4. How and by whom is the database of resources maintained? Is the database easily accessible to families and providers? Does the database include resources to address needs of *HMG* callers on learning, behavior and development?

6. Is the data collected consistent? How is the information being used? Are there other uses for this information? Can additional fields be added to the database? Does a separate database for *HMG* client tracking need to be created?

7. What is the funding and sustainability of each participating organization? (Is there an ongoing secure source of funding?)

C. Staffing a Call Center

The staff who answer the phones are crucial to a successful system. Callers must feel safe, respected, and heard. The center must be adequately staffed with individuals who are trained in telephone casework and cultural sensitivity and who have backgrounds in child development.

In phone interviews there is no eye contact or observation of body language and no opportunity to provide feedback or encouragement by nodding or smiling. However, seasoned and well-trained telephone caseworkers have honed their listening skills—How does the caller sound? Are there background noises, such as a baby crying?—as well as their telephone interviewing techniques.

Part of the role of the call center staff is to provide education and support to families around specific developmental or behavioral concerns or questions. This can be accomplished by helping the family to understand what is typical for a child at a given age; exploring what has been tried before and what has and has not worked; discussing new strategies; sending topic-specific information; suggesting the family enroll their child in a developmental monitoring program, such as the Ages and Stages Child Monitoring Program; providing referrals to parenting and support programs; and providing follow-up and advocacy as needed.

- 1 FTE Supervisor
- 1 FTE Director
- 1 FTE Administrative Assistant
- The unit is open M-F from 8 am- 6 pm, except on holidays. There is an option to leave a message on voicemail.
- Bilingual staff, as well as access to TTY/tele-interpreters.
- On average, staff handle 20,000 incoming calls and about 40,000 outgoing calls annually.
- Data collection/client tracking systems
- Access to 2-1-1's computerized resource inventory and to other 2-1-1 call centers.

C. Telephone care coordinators who staff the CDI unit utilize the United Way of CT / 2-1-1 framework for handling a call
This includes:
- building a relationship with the caller/family;
- conducting an assessment, including gathering information and defining the needs of the caller/family/child;
- educating the caller/family about appropriate resources;
- making referrals as appropriate; and
- conducting follow-up with callers/families.

Care coordinators consider program eligibility requirements, along with the service needs of the caller/family, to help determine the most appropriate referrals for a family. To assist with this process, information from the caller/family is needed, including:

- the age of the child;
- diagnosis or health condition of child;
- concerns about a child's development, including adaptive, cognitive, communication, motor, social- emotional, health, vision, hearing and/or behavioral concerns;
- need for parenting/family support;
- at-risk living conditions;
- health insurance;
- language or culture of the home;
- involvement with other services or agencies;
- involvement of the primary health provider; and/or
- use of a family's own resources and supports.

Collaborating with a call center that is already operating helps to ensure you are working with a staff experienced in telephone casework. However, depending on the call center's target population, additional staff training in child development and early childhood behavior problems may be needed. The following Web sites have information on these topics: DBPeds.org, the Centers for Disease Control's Learn the Signs, Act Early, and Zero to Three.

D. Maintaining Resource Information

For call center staff to make appropriate referrals, resource information must be maintained and updated. Ideally, the inventory of resources should be supplemented with up-to-date information prior to making a referral to ensure that there is no waiting list and that service criteria have not changed. Calling the resource prior to giving the information to the family will ensure that you have the latest information. The care coordinator may also need to obtain very specific information for the family such as times of services, locations, or whether child care or transportation is available. If the family gives permission, the care coordinator may also be able to have the program call the family directly. This can help to ease the burden for overwhelmed families.

The Alliance of Information and Referral Systems (AIRS) and 2-1-1LA County offer support and guidance on developing a "human service taxonomy," defined on the AIRS/2-1-1 LA Taxonomy of Human Services as "a classification system that allows you to index and access community resources based on the services they provide and the target populations they serve, if any. It provides a structure for your information and it tells people what is in your information system and how to find it."

As you research and meet with call centers within your area, keep the following in mind:
- How is resource information collected, maintained, and made available to staff?
- How and how often and by whom are updates made to the system?
- What types of information would you like made available to call center staff and ultimately to families?

Because of the nature of the calls, the care coordinator needs to establish a safe and trusting relationship with that caller/family. Therefore, the care coordinator takes cues from the caller/family to determine how much information can be elicited without overwhelming or disengaging them. Together, with the caller/family, the care coordinator develops a plan of action, which may be a referral to a particular program, sending information to the caller to help with decision making, or giving information to the caller/family so that they may contact a resource on their own. Follow-up is offered to callers/families to help ensure that they got connected to services or to see if there are additional issues that need to be addressed. (See Intake Sheet).

Staff training:

There are multiple avenues for training a new staff member and for continuously developing skills of the care coordinators They include participating in training modules, reading materials, role playing, job shadowing, peer-to-peer mentoring, call listening, case discussion, participating in workshops and in-services, and meetings with collaborators. (See Case examples and Notes from parents.)

CDI's training modules/topics include:
- Assessment skills
- Attitude survey
- Case studies
- Data systems and Coding
- Developmental questions to ask
- Ecomaps / Questions to ask
- Handling crisis calls
- Handling difficult callers
- Listening skills
- Other 2-1-1 call centers
- Resources for families
- Review of procedures for B-3, *HMG*, ECSE, CYSHCN
- Systems overview

- Be aware of possible legal issues related to referring to for-profit services or practices. If those are important resources for families in your area, think about how that information can be shared.

E. Data collection

Call centers are in a unique position to collect data that reflect system-level issues—information not only on who calls and why, but on what happens to families seeking help.

All call centers should collect:
- information on how callers heard about the service;
- caller demographics;
- facts about the person in need;
- information on what assistance is being requested;
- records of actions taken to assist callers; and
- outcomes of the contacts with the call center

Many call centers also have the ability to track barriers experienced by families referred for services. Think about what information you would like collected, how the data should be generated, and with whom you would share the data.

The importance of gathering, reviewing, and reporting program data cannot be overemphasized—it will be of use to policy makers, program administers, advocates, families, and funders.

Call center staff also give callers the opportunity to participate in the Ages and Stages Child (ASQ) Monitoring Program. The ASQ offered by *HMG* can help reduce any worries a parent has about their child's development by providing a fun, interactive way to understand the many changes a child goes through.

ASQ questionnaires are available for 4, 8, 12, 16, 20, 24, 27, 30, 33, 36, 42, 48, 54 and 60 months of age. Participation in this program is voluntary and at no cost to the family. To begin the process the family completes the enrollment form and sends it to CDI. At the appropriate age, a questionnaire is sent to the family. After the questionnaire is returned and scored, the family is contacted.

If a completed questionnaire shows that the child is developing on schedule, a letter with the result is sent to the family along with fun activities for the family and child to enjoy. The next age-level questionnaire is mailed to the family at the appropriate time.

If the completed questionnaire leads to a concern about the child's development, a CDI care coordinator will contact the family to discuss the concern. The family may then choose to have their child's development evaluated through the Connecticut Birth to Three System, if the child is under age three, or by the local school district, if the child is between three and five years old.

Results of the questionnaires may also be sent to the child's primary health provider if the parent signs consent.

Quality Assurance:

The supervisor and/or director monitor the quality of services and provide feedback through regular call listening and case audits. Results are discussed in regularly scheduled one-on-one meetings. Training needs may also be identified through the QA process.

D. Resource Inventory:

The 2-1-1 REFER database serves as the foundation for finding information on services for families. This rich resource has been enhanced with information obtained through *Help Me Grow*. There are standards for what type of information can be included in the 2-1-1 database and on how this information is updated are available at http://www.211ct.org/AboutUs/2002is.asp.

Care coordinators often start their by contacting those resources listed in the REFER database to ensure that they will meet that family's particular needs. For example, the coordinator will ask if the service offers child care or transportation, if is there is a fee, if they provide the service in the family's primary language, etc. Depending on the family's wishes, a referral can then be made on the family's behalf, or the information can be given to the family to pursue on their own. In addition, the care coordinators use the relationships they have developed with various programs/groups, as well as co-workers or listservs to assist in finding services, parenting classes or groups or other information for families.

E. Data collection:

CDI has developed an electronic client tracking system to collect information on *HMG*. The client tracking system captures the issues families are experiencing, the actions taken on their behalf, and how well the referrals addressed the identified issues.

The specific information collected on *HMG* calls include the following:
- the date the case is opened;
- child and family demographics;
- confirmation that permission was obtained from a family, when appropriate, allowing the care coordinator to make referrals to specific services/agencies on behalf of the child. (Note: permission is indicated through a check box.)
- medical information on child;
- who called in the referral (via a drop-down listing);
- how the caller heard about *HMG* (via a drop down listing);
- family concerns regarding their child (via a drop-down listing);

	- a case narrative that allows the care coordinator to capture the work being done for the family; - issues addressed during the call and/or by referrals to services (via a drop-down listing); - actions taken by the care coordinator to assist family (via a drop-down listing); - outcomes for the family based on the efforts of the care coordinator (via a drop-down listing); - gaps and barriers experienced by the family as they sought services for their child (via a drop-down listing); and the - final disposition (via a drop down listing) and date when the case is closed. A hard copy of the resources shared with the family via phone is sent to the family and/or the referral source.

Community Involvement / General Guidance:	Community Involvement / The Connecticut Experience:
A community presence encourages support for the *HMG* concept and can help with marketing the service. It also facilitates the gathering of resource information to include in the resource directory. Community Liaisons serve as a conduit between local programs and the call center, and support local providers by facilitating local networking opportunities.	In Connecticut, the Children's Trust Fund has hired primary prevention specialists who serve as the Community Liaisons for *HMG*. They organize and facilitate community networking breakfasts throughout the state, where they bring local providers together to discuss relevant issues or hear guest speakers talk about new services. They also provide trainings to physicians, parents, and other community groups about developmental surveillance, the Ages and Stages Child Monitoring Program, and services available through *HMG*. The liaisons also maintain a listserv through which timely information on services, current issues, and classes available to families is shared with providers.

Evaluation / General Guidance:

Information on how well the *HMG* system is operating is critical to ensuring that children's developmental needs are recognized and that families are connected to the right services in an appropriate and timely manner. An evaluation of the *HMG* system helps to assess how well it is working or what may need to be changed to improve the service. This information also helps to inform funders and policy makers about families' experiences and guide their thinking around service delivery.

- Introduce formal evaluation as soon as possible and include the evaluator in the design of the project to make the most out of your efforts (i.e., include as member of the core committee).
- Identify an individual or organization (e.g., university) that can provide methods and expertise and focus the team (e.g., core committee and others) on how, what, and when to collect data and measure progress.
- Working with all the partners, the evaluator(s) should develop a database program and process for collecting and tracking data on:
  1. *HMG* callers: how many people call, who callers are, how they learned of the program, and their presenting issues and needs.
  2. Referrals made on behalf of the *HMG* families and outcomes of referrals (i.e., number of times families are linked to services).
  3. Community outreach activities: networking, training, inventory of community programs and resources.
  4. Outreach activities and training for pediatricians and other health care providers; should begin with a complete inventory of practices in designated area.
  5. Developmental screening: who is conducting it, who is making referrals, and how many families are participating.
  6. Gaps and barriers in services from child health care practices to community-based services.

- Descriptive and outcome data should be routinely analyzed and used for monitoring trends over time.

Evaluation / General Guidance:

The Center for Social Research conducts an annual evaluation of Connecticut's *Help Me Grow* Program.

Evaluation results*:*

HOW MUCH ARE WE DOING?
Who calls *HMG?* During the 2007-2008 program year, *HMG* received 2,522 calls from parents, pediatricians and other providers who were concerned about a child's behavior, learning, or development. The majority of the callers were parents or guardians; however, there was an increase in calls from pediatricians (14% increase over 2006-2007), due to the increase in pediatrician outreach and trainings.

Nature of the phone calls. As in earlier years, the 2007-08 data shows the majority of calls are inquiries about specific child development programs, questions related to general developmental concerns, and families seeking evaluations for their children. Families also call with questions or concerns regarding their children's social or emotional behavior, their child's health, special health care needs, or their child's disability.

HOW WELL ARE WE DOING IT?
Program implementation: care coordination. Both quantitative and qualitative data indicate that program implementation has improved as the program has evolved and stabilized, particularly with regard to assessment of the child and care coordination for the family. For example, the number of presenting issues that are identified (per family) at time of intake has increased over the past two years, and the number of successful *HMG* referrals to service programs increased by 26% over previous year.

Program implementation: community outreach. There was a dramatic (43%) increase in the number of families entering the Ages and Stages program in the past year, from 840 to 1,203 families. This increase is explained by the outreach and training provided to pediatricians, including the promotion of universal monitoring of development from an early age.

	IS ANYONE BETTER OFF?
	Outcomes. Similar to previous years, the rate of successful outcomes (i.e., families who are successfully connected to a service) is high: 80% of service needs were addressed for the 2007-2008 year. However, these figures do not illuminate all the efforts of the care coordinators and families who are typically confronted with gaps and barriers to services. Persistent follow through and coordination, a great deal of problem solving, and sometimes a modification in expectations (i.e., finding the next best program) enable care coordinators to eventually link families to needed services.

Other States Experiences with Help Me Grow

Background

National Dissemination of Comprehensive, Coordinated Systems of Early Identification and Referral of Children at Risk for Developmental or Behavioral Problems was a technical assistance project designed to replicate Connecticut's *Help Me Grow* model in other states. Based on lessons learned in Connecticut, this project provided technical assistance and guidance to five selected sites as they replicated *Help Me Grow*.

The project guided the sites in their implementation of system reform and program development to promote both early detection and service delivery. The project also prioritized promoting awareness of the importance of early identification and intervention among parents, clinicians, policymakers, and the public, and, ultimately, the promotion of children's optimal development.

Links below highlight the implementation efforts in the participating states of Colorado, Kentucky, New York, Oregon, and South Carolina. We have also included information on the Orange County *Help Me Grow*, which is the first site to replicate the model.

- Colorado
- Kentucky
- New York
- Oregon
- South Carolina
- California

Closing Comments

Our project's work has yielded valuable insights on the evolution of systems in support of young children's healthy development and on the key attributes of successful efforts to replicate and disseminate innovative programs. While our work began in the child health services sector with a focus on the promotion of effective developmental surveillance and screening and the early identification of at-risk children, it quickly evolved to include linking at-risk children and their families to programs and services. For example, we were stunned to learn that despite identification of both an at-risk child and appropriate intervention programs and services, about seven contacts are required to ensure a successful linkage of child and family to program and service. As a result, our work has emphasized the critical need for programs and policies that support care coordination efforts.

Our work has also demonstrated the critical need for cross-sector collaboration in the evolution of a system in support of children's healthy development. Early detection is not confined to child health services, but should also be a priority within the early care, education, and family support sectors. *Help Me Grow* acknowledges such cross-sector collaboration by encouraging the training of child care providers in effective developmental surveillance and screening and in enabling the use of parent-completed developmental questionnaires (e.g., Ages and Stages). Furthermore, the needs of at-risk children and their families are typically addressed not through the provision of medical services but rather through access to early care, education, and family support programs and services. Thus, our work also emphasizes the need for the development of a comprehensive system in support of young children's healthy development through integration of efforts across child health, early care and integration, and family support services. The implications for both program support and public policy have been detailed in a publication of the Child Health and Development Institute of Connecticut, [A Framework for Child Health Services-Supporting the Healthy Development and School Readiness of Connecticut's Children](#).

The success of our efforts to support replication activities of sites has yielded valuable insights on the process of providing technical assistance.

The Commonwealth Fund and the Connecticut Children's Medical Center hope the information in this online tool helps others address the potentially serious consequences of undetected developmental problems by offering practical guidance for creating an effective system of early intervention, referral, and support.

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