Child FIRST

Child and Family Interagency Resource, Support, and Training

Strong Families… Healthy Children

Business Plan 2012-2015

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The need and the opportunity: Growing national momentum to mitigate the devastating effects of adversity on young children

Some of our nation's most difficult and costly social problems are rooted in early childhood – child abuse and neglect, school failure, mental illness, poverty, poor health, and crime. Scientific research has revealed that the impact of adverse childhood experiences (the cumulative burden of multiple risk factors, including deep poverty, neglect, abuse, parental substance abuse and mental illness, homelessness, and exposure to violence) can have a toxic effect on early brain development and ultimately the chances of a productive life. Across the nation, there has been growing attention to early childhood programs that show promise in addressing these problems, including multi-billion dollar investments by the federal government in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants and the Early Learning Challenge Race to the Top. Many state governments are also working to create comprehensive early childhood systems that ensure a continuum of care, from universal interventions to those tailored for the most vulnerable young children and their families. Child FIRST, a home-based intervention, is among the most promising of these models.

Child FIRST: A proven model with potential for national scale

Founded and driven by the vision of a developmental and behavioral pediatrician, Child FIRST is a federally designated, evidence-based home visitation model that works to prevent the devastating effects of early childhood adversity. It is unique among home visiting models because it focuses on the most vulnerable children and families with multiple risk factors, using a two-generation approach, without regard to the number of children in the family, beginning any time in the first six years of life. Child FIRST prevents serious emotional disturbance, developmental and learning problems, and abuse and neglect by intervening with high risk families at the earliest possible time. It uses a two-pronged approach: decreasing adversity or toxic stress by connecting families to broad, well-integrated community-based resources though an **early childhood system of care**, while protecting the developing brain by **strengthening the nurturing parent-child relationship** through home-based parent guidance and parent-child psychotherapeutic services.

Child FIRST is an evidence-based model with proven results that has over a decade of experience with implementation and a track record of successful replication in Connecticut. Based on strong evidence of impact, including excellent results from a randomized controlled trial with children ages 0-3, Child FIRST has expanded its reach from children and families in a single community in 2001 to current capacity to serve 650 children annually in ten regions across Connecticut in 2012. In 2013, Child FIRST will reach 15 Connecticut regions, one affiliated with each of the 15 Area Offices of the Department of Children and Families (DCF), increasing capacity to serve 1050 children and families annually. Child FIRST now has an opportunity to build on the national momentum behind home visitation and offer replication to other communities across the country looking for models that meet the challenges experienced by extremely high risk families. To achieve its mission of mitigating the effects of adverse childhood experiences on the nation's most vulnerable and hard-to-reach families, in the next three years Child FIRST is seeking to expand and solidify current operations throughout Connecticut and replicate the model in at least two new states.

To achieve this expanded impact, Child FIRST will concentrate on four strategic priorities:

1. Build the Child FIRST Central Program Office
2. Strengthen and continuously improve the Child FIRST network in Connecticut
3. Replicate Child FIRST in selected states and communities beyond Connecticut
4. Conduct a randomized controlled trial documenting outcomes for children ages 3-6.

Carrying out these priorities between now and 2015, including operations in the two new states, will require an increase in Child FIRST's total budget from $1.5M in FY 2013 to $1.8M in FY 2014 and $2.0M in FY 2015. To support its expanding operations in Connecticut and beyond, Child FIRST intends to fund its operations with fees from local implementing agencies, government funding (from states and national sources), and philanthropy.

Child FIRST is a powerful and proven model with the opportunity to improve the life prospects of vulnerable young children and families across the nation. Funds invested in Child FIRST to support the priorities outlined here provide a strong return on investment in reduced future costs in the child welfare, health, mental health, education, and justice systems, and for the taxpayers who pay these costs.

INTRODUCTION

> *"I consider Child FIRST one of the most impressive interventions for young children that I have ever witnessed in my long lifetime."*
>
> Dr. Edward Zigler,
> Founder and Director Emeritus, Yale's Zigler Center for Child Development and Social Policy, and Co-Developer of Head Start

The Need

The early childhood years – from the prenatal period to age six – lay the foundation for later economic productivity, responsible citizenship, and a lifetime of sound mental health, cognitive development, and physical health.

Scientific research on early brain development clearly indicates that high risk environments of extreme poverty, maternal depression, domestic violence, substance abuse, homelessness, and other factors lead to levels of stress that can be toxic to the young, developing brain. Without the buffering effect of strong, nurturing relationships, children can suffer profound, long term damage, permanently altering brain architecture and resulting in decreased learning, behavioral and emotional problems, and poor health extending well into adulthood. This is well documented by the Adverse Childhood Experiences study.

Current data illustrates the risks to our most vulnerable children. 24 percent of children under five years of age are living in extreme poverty, a figure that has grown annually since 2001. Between 40 and 60 percent of low income mothers with young children report symptoms of maternal depression. Homelessness for families with young children has risen 33 percent in the last three years. These social problems do not occur in isolation. Between 30 and 60 percent of child abuse incidents involve substance abuse. These are among the serious stressors that create toxic environments for young children.

Child FIRST works to address these factors and has demonstrated statistically and clinically effective interventions for the most vulnerable young children and their families.

Child FIRST History and Evidence of Effectiveness

The Child FIRST intervention was developed in 1998 by Darcy Lowell, MD, a developmental and behavioral pediatrician, in response to the lack of resources targeting the emotional and behavioral problems experienced by vulnerable young children and the typically fragmented and limited services available to serve the complex needs of high risk children and families. The Child FIRST approach has been validated by scientific research in brain development which has demonstrated that high adversity leads to levels of stress that can result in long-term damage to young, developing brains – including decreased cognitive development, behavioral and emotional problems, and poor health.

In 2001, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) funded a randomized controlled trial (RCT) of the Child FIRST program, to test the effectiveness of an integrated home-based, psychotherapeutic, family intervention embedded in an early childhood system of care with young, vulnerable children from high risk families. The RCT was

focused on children ages zero to three identified through screening at the Bridgeport Hospital Pediatric Primary Care Center and the Bridgeport Health Department's Women, Infants, and Children (WIC) Nutrition program. The results demonstrated impressive statistically significant and clinically effective outcomes in young children and their families receiving the Child FIRST intervention compared to Usual Care Controls at 12 months follow-up:

- Child FIRST children were 68% less likely to have language problems.
- Child FIRST children were 42% less likely to have aggressive and defiant behaviors.
- Child FIRST mothers were 64% less likely to have clinically-concerning levels of psychological distress and/or depression.
- Child FIRST families were 39% less likely to be involved with child protective services, by parent report.
- Child FIRST family members were 98% more likely to access community-based services and supports.

At three-year follow up:

- Child FIRST families were 33% less likely to be involved with child protective services, by DCF records.

A summary of the RCT results is attached as Appendix A and the full results of the randomized controlled trial were published in a peer reviewed article in *Child Development* (January/February 2011)[1].

Based upon the evidence of effectiveness, the Robert Wood Johnson Foundation supported the replication of Child FIRST in Connecticut through a public-private partnership with 19 other philanthropic funders, the CT Department of Children and Families (DCF), and CT Early Childhood Cabinet. In 2011, Child FIRST was designated by the U.S. Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) as one of 12 national "evidence-based home visiting models" for the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

Over the past 11 years, Child FIRST has expanded its reach from services for children and families in a single community in 2001 to current capacity to serve 650 children annually in ten regions across Connecticut in 2012. In 2013, with funding from MIECHV, Child FIRST will reach 15 CT regions, one affiliated with each of the 15 Area Offices of DCF, increasing annual capacity to 1050 children and families. This will enable Child FIRST services to be available to families throughout Connecticut. Based on the effectiveness of early, intensive intervention with the most vulnerable children, DCF has integrated the first six programs, which have completed all training, into the DCF budget. DCF anticipates that the Child FIRST model will be sustained in all 15 sites in the future through a combination of state funding and Medicaid reimbursement.

[1] Lowell, D.I., Carter, A.S., Godoy, L., Paulicin, B., Briggs-Gowan, M.J. (2011). A Randomized Controlled Trial of Child FIRST: A Comprehensive, Home-Based Intervention Translating Research Into Early Childhood Practice. *Child Development, 82*(1). 193-208.

What Distinguishes Child FIRST?

There are many home visiting programs; however, Child FIRST has some unique features that make it particularly well suited to addressing the challenges and opportunities facing America's most vulnerable families. The model:

- Engages children and families facing the most challenging circumstances, including extreme poverty, maternal depression, domestic violence, substance use, homelessness, abuse and neglect, and incarceration.
- Works with families of children prenatal to age six years at any point in this age range and serves families with one or more children.
- Focuses on early relationships and the mental or behavioral health of the young child.
- Uses a team of a Masters level Mental Health/Developmental Clinician to provide a psychotherapeutic relationship-based approach for parents and children, combined with a Bachelor's level Care Coordinator who connects children and families with comprehensive community-based services and supports.
- Provides a two-generational intervention, focused not only on the needs of the child but on the challenges of the parents or caregivers as well.
- Provides the intensive training and continuous professional supervision and coaching necessary to serve the most needy families: year-long initial, intensive training through a Learning Collaborative with ongoing topical training and Annual Conference; intensive reflective clinical consultation during the first year of training with ongoing reflective clinical supervision for all staff; and continuous, data-driven quality improvement and technical assistance.

Child FIRST's Theory of Change

Child FIRST's vision is that all young children will have the nurturing, support, and services that they need to promote optimal social-emotional, cognitive, and physical health and development. Scientific research on the developing brain has shown that high risk psycho-social environments (e.g., poverty, maternal depression, domestic violence, abuse and neglect, substance use, homelessness) are associated with "adverse childhood experiences" leading to high levels of chronic stress and elevated cortisol. This stress is "toxic" to the developing brain of the young child, causing impairment in social-emotional development and cognition, as well as interfering with physiologic functioning leading to lifelong health impairment (e.g., cardiovascular disease and diabetes). The goal of Child FIRST is to reduce the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among the highest risk young children, prenatal to age six years. Child FIRST accomplishes this by (1) implementing a two-pronged approach within its home-based intervention and (2) embedding the model into the early childhood system.

The Child FIRST Home-based Intervention within a System of Care

For Child FIRST to achieve its desired outcomes for families and the systems that support them, there must be collaboration at two levels: intensive home-based intervention through partnership with families and close collaboration with the existing services and supports within a community to build a system of care. Ultimately, the Child FIRST model should be fully integrated into the early childhood continuum of care within a state.

The two levels of the Child FIRST model are:

Home-based intervention: Child FIRST employs an intensive, two-pronged approach, based on the scientific research, to support parents and their children:

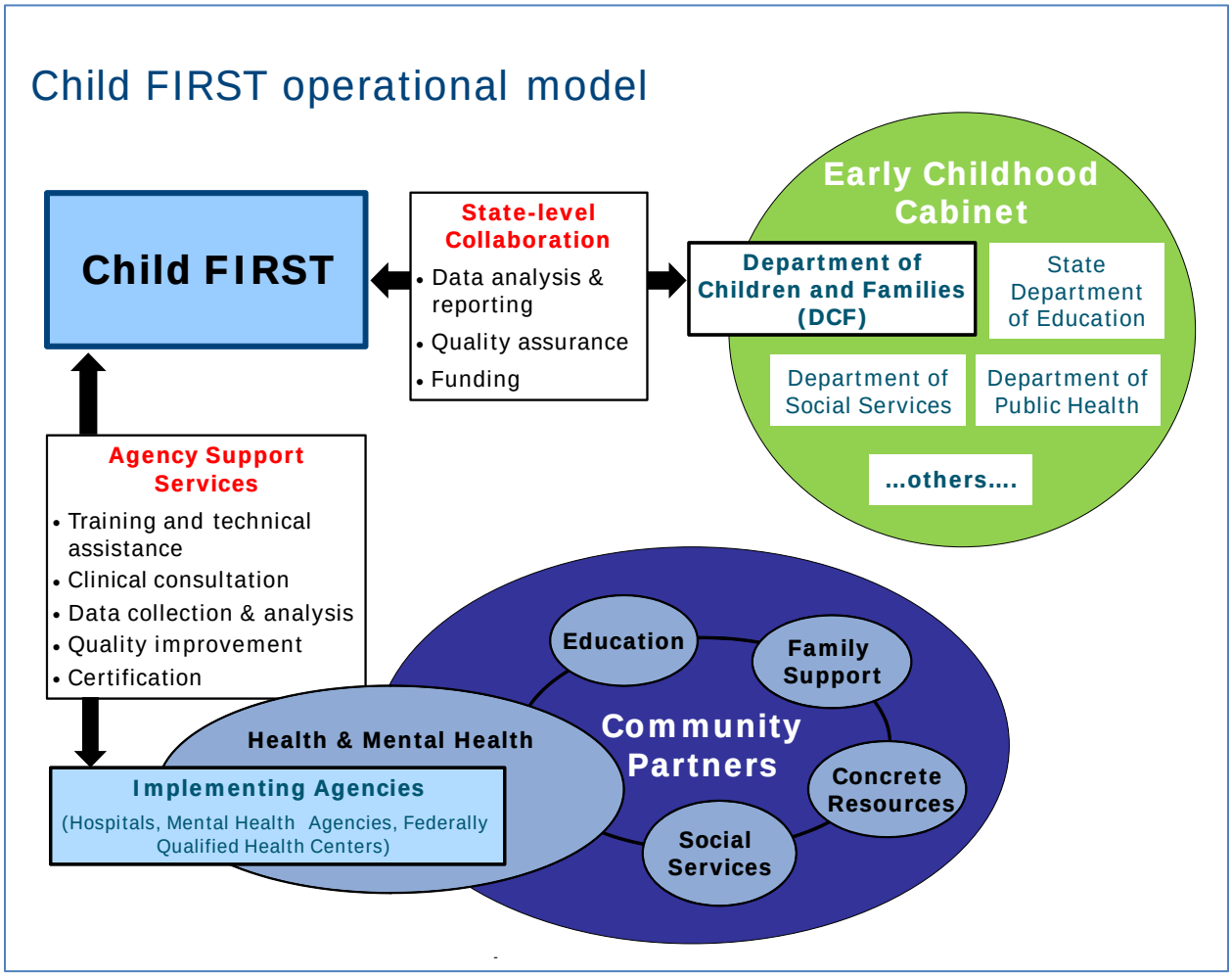
1. Child FIRST promotes a nurturing, consistent, and responsive parent-child relationship, which buffers and protects the developing brain and body from toxic insults. Secure attachment has been documented to prevent the rise of cortisol in the face of stress. Therefore, our Master's level Mental Health/Developmental Clinician provides a two generation, parent-child psychotherapeutic intervention and parent guidance, which enhances nurturing and responsive parent-child interactions, and promotes positive social-emotional and cognitive development.

2. Child FIRST intervention seeks to decrease toxic stress and prevent damage to the developing brain by targeting family challenges through care coordination and case management. The Child FIRST Care Coordinator connects the family with comprehensive, community-based services and supports (e.g., domestic violence services, early education, housing). This further facilitates healthy growth and development.

Local Early Childhood System of Care: The Child FIRST model is embedded in a community-based early childhood system of care comprised of a broad collaborative of early childhood and adult service providers, parents, and other stakeholders with a shared commitment for achieving positive outcomes for families without duplicating efforts. This comprehensive, integrated system of care is essential in order for families with multiple challenges to receive the services they need and to decrease the number of families who "fall through the cracks." Child FIRST anticipates that its collaborative model will contribute to significant improvements in existing community collaboration, service integration, and development of comprehensive early childhood systems of care in the communities in which it works. Child FIRST has found that its collaborative approach has led to the development of strong relationships among providers, which has led to cross-referrals and increased access to services for many children and families with challenges, who may not need the intensity of Child FIRST services.

A detailed diagram of Child FIRST's Logic Model is attached as Appendix B. Child FIRST's position within Connecticut's early childhood system is illustrated on the next page.

Child FIRST: Integrated within Connecticut's early childhood system of care



Path to Increased Impact

Child FIRST believes that to have the impact it desires, it must establish a strong presence in new states through close collaboration with state partners and full integration into the existing system, rather than develop separate or individual programs which stand apart. To achieve this, Child FIRST must develop state level support, adequate funding to deliver the model with fidelity, and strong collaborative partners so that it is fully integrated into the continuum of care for young children and families. Within this continuum, Child FIRST's unique expertise is serving those children who have experienced the greatest adversity. Child FIRST is willing to start working in a state at the invitation of a state agency (e.g., child welfare, education, or agency responsible for home visitation) or under the auspices of a leading philanthropy. Some states serve as national leaders in early childhood systems innovation. Their success demonstrates to other states that they too can achieve the strong positive outcomes for the most challenging families at a good ratio of cost to benefit.

How Child FIRST Operates

In each of the 10 current sites, Child FIRST works with a local lead agency that is responsible for the implementation of the intervention. This agency has broad responsibility and must provide all the staffing, long term clinical and administrative supervision, and financial structure for implementation. The lead agency serves as the agent of the community.

Through its Central Program Office, Child FIRST collaborates with state partners to help identify agencies that are qualified and ready to implement the Child FIRST model. It provides all training - including the Learning Collaborative, specialty training, topical training, new staff training, and Annual Conference - reflective clinical consultation, technical assistance, and conducts ongoing quality assurance for fidelity to the model, including mandatory reporting and annual certification. The depth and intensity of Child FIRST's training and ongoing support is key to the effectiveness of the model. It helps local agencies implement with fidelity, address challenges as they arise, and use data and other feedback to improve the quality of engagement and intervention with vulnerable children and families.

Training through the Learning Collaborative: All Child FIRST communities participate in extensive training of all staff as active members of a Learning Community using the Learning Collaborative methodology, developed by the Institute for Healthcare Improvement. The Learning Collaborative facilitates the dissemination and adoption of best practices through system-wide organizational change, development of a Learning Community, and continuous improvement. Child FIRST conducts the Learning Collaborative over a period of 12 months.

- An initial week of intensive start-up training is followed by three Learning Sessions of two to three days of interactive training. Between each Learning Session, there is a period of one to three months of active intervention with families where staff are mastering the skills they have learned.

- Specialized trainings on key therapeutic components are provided (e.g., Child-Parent Psychotherapy, Circle of Security, Diagnostic Classification 0-3, Video Intervention Training).

- After the 12 month Learning Collaborative, cross-site topical conferences are provided on a quarterly basis, along with specialty trainings and the Annual Conference.

- The Child FIRST Training Manual and Child FIRST Toolkit provide information on intervention and procedures and provide the formal assessments and forms needed for implementation.

Use of data analysis and feedback—metrics and outcome data: Child FIRST agencies and their staff are required to complete monthly Metrics and Fidelity Checklists so that they are able to track their personal progress and that of their site. The Central Program Office analyzes this information and provides feedback to the sites, so that they can devise quality improvement strategies that fit their unique community. All Child FIRST sites must also enter data (into the Child FIRST cross-site database) about the families they serve at baseline, six months, and discharge. Analyzing change over time, with feedback and technical assistance, insures that each site is conducting the intervention effectively. Together, these procedures help ensure continuous quality improvement and model fidelity.

Consultation and supervision: Reflective clinical consultation for each program site is a central component of the training process for Child FIRST implementation. The Child FIRST State Clinical Director/Consultant works individually with the Clinical Director/Supervisor of each site as well as with all staff members as a group. This consultation is provided weekly for the first six months, biweekly for the next six months, and monthly for the following six months, on-site, through web-based video conferencing, or by phone. This consultation includes a combination of case discussion, video review, and problem solving around all model components.

Both during and beyond the initial training period, ongoing, weekly, reflective supervision is provided by the Clinical Director/Supervisor of the site individually to each Clinician and Care Coordinator, as a team, and as a group. This maintains quality, ensures model fidelity, and decreases staff burnout that can result from the vicarious traumatization associated with working with very high risk families.

Child FIRST Network or Learning Community: Child FIRST Leadership engages regularly with the staff involved in the implementation of Child FIRST at each site. The Child FIRST Executive and Clinical &Training Directors meet monthly with the site Clinical Directors who supervise the teams that serve families. This ensures that they provide high quality clinical and administrative supervision to their staff. Child FIRST Leadership also conducts regular phone conferences with site executive directors and other agency senior leaders to ensure full Child FIRST integration into their organization and to provide technical assistance.

Fidelity and certification**:** A model's evidence base means little if sites do not implement it with fidelity. A hallmark of the Child FIRST approach is its rigorous standards for quality improvement. Fidelity to the Child FIRST model is required for Annual Certification of each program site. Standards for model fidelity include participation in the Learning Collaborative and all additional trainings, participation in reflective clinical consultation and ongoing reflective supervision, adherence to model structure with regard to implementation, meeting of all clinical standards, parent satisfaction with services, entry of process and outcome data meeting standards for effectiveness, participation of site clinical and executive leadership in the Child FIRST Network, and regular meetings of the regional Child FIRST Community Advisory Board.

Child FIRST Central Program Office

Organizationally, Child FIRST has grown impressively since its initial founding in 2001 at Bridgeport Hospital. During the past three years, growth has accelerated, fueled by major funding from the Robert Wood Johnson Foundation with support from 22 CT funders, most notably, the Grossman Family Foundation and eight federal funding programs. The Connecticut Department of Children and Families has assumed the cost of funding for implementation of the initial six sites, while philanthropic support is funding an additional three sites, SAMHSA is funding one site, and the Maternal, Infant and Early Childhood Home Visiting Program will fund five new sites and expand three existing ones. In addition, the original Child FIRST site has secured Medicaid reimbursement, providing an ongoing revenue stream to support the program. Over the past three years, Child FIRST has worked closely with the Child Health and Development Institute, which acted as implementation partner, fiduciary agent, and guided the development of the Learning Collaborative approach for replication of Child FIRST.

In the last six months, Child FIRST has established critical organizational infrastructure to accommodate growth and continue to effectively deliver its program. Specifically, it has established a Central Program Office and expanded the core Leadership Team. The Central

Program Office will provide a number of critical functions in support of the growing network of implementing agencies. It will:

- Provide training, technical assistance, supervision, and policies/systems to Child FIRST implementing partners to ensure fidelity to the model
- Collect data and conduct analysis on model fidelity and family outcomes to ensure quality implementation and drive improvement
- Cultivate and manage key relationships at the state and community level in Child FIRST states to ensure sustained funding and support
- Cultivate relationships in prospective communities/states and make decisions on which states, communities, and agencies become part of the Child FIRST Network
- Build national awareness for Child FIRST and set strategic direction for the Network
- Secure financial resources through fundraising and agency fees to sustain Central Program Office operations

To lead these functions, the Leadership Team has been expanded to a team of four professionals. An overview of their roles is below. (Detailed descriptions of the roles of the Leadership Team and their biographies are found in Appendices E and F.) In addition, the Central Program Office also has contracts for Quality Improvement and for Evaluation and Research. Over the next six months, the Child FIRST Central Program Office will further expand, adding three full time staff and four part-time consultants as described in the "Goals and Priorities" section (Priority 3).

Founder and Chief Executive Officer

The Founder and CEO is Child FIRST's primary spokesperson and leading expert on the Child FIRST model. She advocates for the needs of vulnerable children and families within and outside Connecticut and for the value of the Child FIRST model in meeting those needs. She is Child FIRST's lead strategist, working in close partnership with the organization's Board of Directors, state leadership, philanthropic funders, and organizational leadership within the Child FIRST Network. She is directly involved in setting Child FIRST's fidelity standards and model improvement and innovation process. In addition, she supports and drives relevant policy agendas at national and state levels, especially with regard to early childhood system development and mental health.

Managing Director

The Managing Director is responsible for the day-to-day operations of Child FIRST's Central Program Office and building the systems necessary to support the Child FIRST network. She coordinates the Child FIRST Leadership Team's work and partners with the CEO on strategic planning. She works closely with the CEO in developing and maintaining relationships with key leaders in Connecticut, philanthropy, and national organizations, as well as board engagement and business planning. She is responsible for management of all Child FIRST finances and contracts.

Clinical and Training Director

The Clinical and Training Director is responsible for all processes and activities related to training, clinical consultation, and supervision, and oversees Child FIRST's Training & Consultation Team. The Clinical and Training Director also collaborates with the Quality Improvement team at CHDI with respect to clinical aspects of model fidelity.

Director of National Programming

The Director of National Programming manages Child FIRST's relationships with key stakeholders from prospective new communities and states and guides Child FIRST's strategic expansion. She also leads Child FIRST's communications strategy and develops promotional materials and messaging for the organization.

Quality Improvement Team

The Quality Improvement Team is subcontracted from the Child Health and Development Institute of CT. They work in close collaboration with the Child FIRST Leadership Team and are primarily responsible for data reporting, cleaning, and providing technical assistance to Child FIRST agencies. The QI Team also supports the Child FIRST Central Program Office in developing data-relevant systems and processes and training agency staff on data practices and policies.

Evaluation and Research Team

The Evaluation and Research Team is subcontracted from the University of CT Health Center, Department of Psychiatry. They are responsible for analyzing all outcome data and reporting to the Child FIRST Leadership Team as well as individual sites. They work closely with the CEO to answer questions relating to effectiveness and opportunities to further improve the quality of the intervention.

Most recently, in September 2012, Child FIRST became a separate legal entity by incorporating as a nonprofit (including application for IRS 501(c)3 status) and building a strong founding board consisting of experts in early childhood, organizational development, mental health, and state systems.

GOALS AND PRIORITIES

Child FIRST aspires to create positive outcomes for the most vulnerable children and families in Connecticut and nationally, through careful and measured replication with fidelity. In the next three years, Child FIRST will move toward this goal by expanding and solidifying operations in Connecticut and launching the program model in at least two new states.

Child FIRST will stage its growth by pursuing four priorities between now and 2015:

Priority 1: Build Capacity of Child FIRST Central Program Office

To support replication of its model in Connecticut and at least two new states, Child FIRST will strengthen operations by hiring key staff for its Central Program Office and further refining its training method, program model, quality improvement (QI), and certification processes.

- Expand Central Program Office Team: In FY 2013 Child FIRST plans to hire the following:
    - Associate Clinical Director (full time) to assist in providing training and reflective consultation to implementing agency staff, especially within Connecticut.
    - CT Program Director (full time) to oversee programmatic operations across the state and maintain relationships with key state and community level stakeholders, especially: the Department of Children and Families, the Department of Public Health, the Department of Social Services, State Medicaid Director, community councils/committees, and private funders.
    - CT Clinical Consultants (part time) to provide reflective consultation to implementing agency staff in Connecticut
    - Office Manager (full time) to provide administrative and logistical support to the Central Program Office team.

    In addition, over the next three years, Child FIRST will consider building in-house capacity for quality improvement (rather than subcontract).

- Refine training method: Child FIRST has a high-quality training system that supports sites as they learn to implement the model. In the next three years, Child FIRST will reduce the cost and increase the effectiveness of its training approach by further developing its internal training capacity and leveraging technology and distance learning.
    - The organization's Clinical Leadership will develop more efficient means of delivering relevant components of its specialty trainings. For example, they will work closely with Child-Parent Psychotherapy and Circle of Security to more formally integrate these components into the Child FIRST model.
    - Clinical Leadership will provide specialized training for site Clinical Directors. This will better prepare agency Clinical Directors prior to the initial Learning Collaborative, as well as enable Clinical Directors to provide their own interim training for new staff when there is turnover.

- Child FIRST will invest in technology-based training (web-based use of interactive strategies and video), including pre-training, modules that complement in-person training, and additional modules and resources for content not covered in training.

- **Refine program model:** Child FIRST has formalized its model by developing the Child FIRST Training Manual and Toolkit and the Learning Collaborative Training Curriculum. It will continuously improve the model by learning from the experiences of implementing sites and communities, including their designing and executing "small tests of change." It will continuously analyze process and outcome data from implementing agencies and make model refinements based on new understanding of the communities and families that it serves.

- **Refine quality improvement and certification processes:** Committed to continuous quality improvement, Child FIRST has identified the essential elements for implementing agencies. It has long term relationships with partner organizations to conduct data collection and analysis, specifically the University of Connecticut Health Center will provide analysis of outcomes and the Child Health and Development Institute of Connecticut, Center for Effective Practice, with concentrate on continuous quality improvement (QI). In 2013, Child FIRST will deploy its new QI and certification process, and continually refine its approach in the coming years, by:

  - Collaborating with implementing agencies and state partners to ensure successful adoption of its new Cross-site Database.

  - Implementing the Annual Site Certification (described in detail above) that includes video and chart reviews, a review of fidelity and outcome indicators, site visits and quality improvement planning, especially for underperforming sites.

  - Building additional capacity to support sites in new states.

Priority 2: Strengthen and Continuously Improve the Child FIRST Network in Connecticut

In 2012, Child FIRST expanded its Connecticut network from six to ten sites and will complete its statewide footprint in 2013 by adding five new sites for a total of 15 sites, corresponding to the 15 Area Offices of the CT Department of Children and Families (DCF). Simultaneously, the Child FIRST Central Program Office will continue to strengthen its infrastructure to support the implementing agencies in Connecticut and participate in ongoing efforts in CT to build a strong, comprehensive, statewide early childhood system. Over the next three years, it will continue its commitment to vulnerable children and families across the state by:

- Supporting implementing agencies: Child FIRST will support implementing agencies with the ongoing training, clinical consultation, and technical assistance necessary to deliver and replicate the model across the state; maintain fidelity to the program model; and continue to improve outcomes for children and families.

  - The increased capacity and action items described in Priority 1 will support this goal, including:

    - Addition of an Associate Clinical Director, whose major function will be ongoing consultation and technical assistance in Connecticut

- Addition of expert Clinical Consultants who will work with the individual sites within Connecticut.

- Implementation of a Cross-Site Database to be used by all Child FIRST CT sites, which will not only enhance data analysis, but will enable Child FIRST to provide our CT lead agency, DCF, with necessary administrative and outcome data through upload into their PSDCRS system. Child FIRST will subcontract with a consultant in information technology to assist in this process.

- Subcontract with CHDI and the CT Center for Effective Practice (CCEP) in order to build a Performance Improvement system that includes both a Quality Improvement Manager (through CCEP) and the Child FIRST Clinical and Associate Clinical Directors working to improve both the Child FIRST implementation process and the clinical outcomes at each site.

- Implementation of a Certification Process for all Child FIRST sites that will insure fidelity to the model and enable CT sites to bill for Medicaid reimbursement for children with a mental health diagnosis.

- Building and sustaining relationships: Child FIRST will continue to build and maintain relationships with key state and local-level decision-makers in Connecticut who have been critical to the expansion of the program and will continue to be vital to its long-term sustainability. Child FIRST will work with key leaders and partners to create public awareness about the unique role that Child FIRST plays within Connecticut's early childhood system, clearly position the program within the array of available services, and identify opportunities to strengthen and build Child FIRST Network service capacity.

    - To support this goal, Child FIRST will add a full-time, Connecticut Program Director to the Central Program Office team in January 2013, as described above.

- Highlighting and publicizing the flagship work of Child FIRST in CT: Child FIRST will focus on its Connecticut network to spotlight the effectiveness of the model and its role within a state system. It will also serve as the primary site to test innovation and implement improvements to the model. Connecticut will also serve as the home base for the model's Central Program Office.

Priority 3: Replicate Child FIRST in Carefully Selected New States and Communities

Replication of Child FIRST's model in at least two new states is central to Child FIRST's strategy for impact over the next three years. Detailed planning for how to select states for replication and how to manage growth has been completed and the resources needed for this growth identified.

- Engaging prospective communities: In order to expand the Child FIRST program in at least two new states, the Leadership Team will cultivate and manage relationships with key state and local-level stakeholders important to launching and sustaining the program model. Given the importance of understanding the local context and collaboration, the need to be connected to decision-makers, and the ongoing and long-term investment

required to maintain the necessary relationships, Child FIRST has developed a focused approach to engaging prospective communities that will require the addition of a part-time State Director to the Central Program Office team. The State Director will manage key relationships such as those with the State Medicaid director and other identified key state and private partners once a state or community has been selected for Child FIRST replication.

- Selecting states in which to grow: Child FIRST will prioritize states with the best ingredients for sustainable, successful operations. A State Selection Criteria Framework guides its decisions about where to replicate. States that serve as national leaders in early childhood systems innovation and whose success demonstrates to other states the strong positive outcomes that are possible for the most challenging children and families are good candidates for Child FIRST replication. The six priority selection criteria for new states are:

    - Commitment to early childhood and specifically to early childhood mental health
    - High level of need
    - Potential for multiple funding sources
    - Strong interest from state leaders of child welfare or other relevant agencies
    - Local champions
    - National leaders in early childhood system development and innovation.

A state selection rubric has been developed to determine states' readiness.

- Guidelines for launching in a new state: Child FIRST has developed guidelines which clarify expectations about launching in a new state or community that will help inform conversations with key stakeholders in the state. There are five key elements:

    - *Systems of care*: Because the Child FIRST program requires strong community collaboration, it is important to understand the state's current early childhood system development and the array of resources already engaged in helping vulnerable children and families. At the community level, it is essential for Child FIRST to understand existing relationships among providers and how the current system of care functions to ensure integration of Child FIRST into the continuum of care.
    - *Funding*: Sustaining the program beyond the start-up phase will require a clear understanding and ability to navigate the funding landscape in the private and public sectors, blending and braiding funds from specific programs such as MIECHV and working toward Medicaid reimbursement, when applicable. It will be required that there is a local champion for Child FIRST, who is well versed in the early childhood landscape in the state, understands the program, and can articulate the value of bringing the program to the state. The champion will serve as an advocate for Child FIRST and work to secure and sustain funding commitments as well as help navigate and build the key relationships required for success.

- *State-level support and advisors*: The buy-in of strong and influential state leaders will ensure that Child FIRST enters an environment which supports its success. The state agency lead or local champion should recruit a state Advisory Council, a group of individuals who are committed to effectively integrating Child FIRST into the state through advocacy and relationship-building.

- *Community need and resources*: Given Child FIRST's mission and the population it serves, it is important to work within the communities identified by a state as having the highest need. It is an asset when these communities have or are developing support services for vulnerable children and families.

- *Qualified staff*: At the heart of the Child FIRST program are the Clinicians and Care Coordinators who deliver the intervention and the Clinical Directors/Supervisors who oversee their work. The presence of experienced professionals who can assume leadership positions within the growing Child FIRST Network and conduct trainings and ongoing reflective supervision will be critical to the long-term viability of the program in the state.

- Building capacity to support implementation in new states: As it is preparing for launch in a new state, the Central Program Office will build capacity in that state to oversee programmatic operations across the state, train and support agencies and maintain relationships with key state and community level stakeholders. This will be a small team of dedicated state staff: a State Program Director, State Clinical Director/Consultant, and a State Administrative Assistant, all as part-time roles.

- Supporting collaboration, contributing to innovation, building awareness: Child FIRST's replication depends upon broader awareness of the importance of early childhood relationships and knowledge of the Child FIRST model itself. Child FIRST will make a number of investments to expand its profile and contribute to the field. It will:

  - Develop a comprehensive communication strategy, which will include:

    - An array of communications materials for key local and national experts and thought leaders, state decision makers, and potential partners, such as one page descriptions of the operating model, cost per family, funding sources, and training timeline

    - A professional website with easily available materials for downloading

    - Professional brochures for funders, state agencies, implementing agencies, and parents

  - Further refine the cost-benefit case by continuing to examine outcomes from the Child FIRST intervention

  - Increase awareness of the importance of early brain development and the impact of adversity by strategically participating in the national dialogue on issues relevant to early childhood, mental health, and systems of care

Priority 4: Conduct Second Randomized Controlled Trial (RCT)

Child FIRST's initial RCT played a major role in its growth, serving as the basis for Medicaid reimbursement and thereby contributing to financial sustainability for implementing agencies. Most importantly, it has been the basis for the program's growing national reputation as an evidence-based model eligible for MIECHV grant funding. In the coming years, Child FIRST will further bolster its evidence base through a second RCT to demonstrate outcomes of the intervention, particularly for three to six year-olds. It will work with a well-regarded research institution to develop and conduct the second RCT, and will collaborate with that research institution to publish results in a peer-reviewed journal.

FINANCIAL PROJECTIONS AND FUNDING STRATEGY

Child FIRST Central Program Office

Carrying out these priorities between now and 2015, including operations in the two new states, will require an increase in Child FIRST's Central Program Office total budget from $1.49M in FY 2013 to $1.82M in FY 2014 and $1.99M in FY 2015.

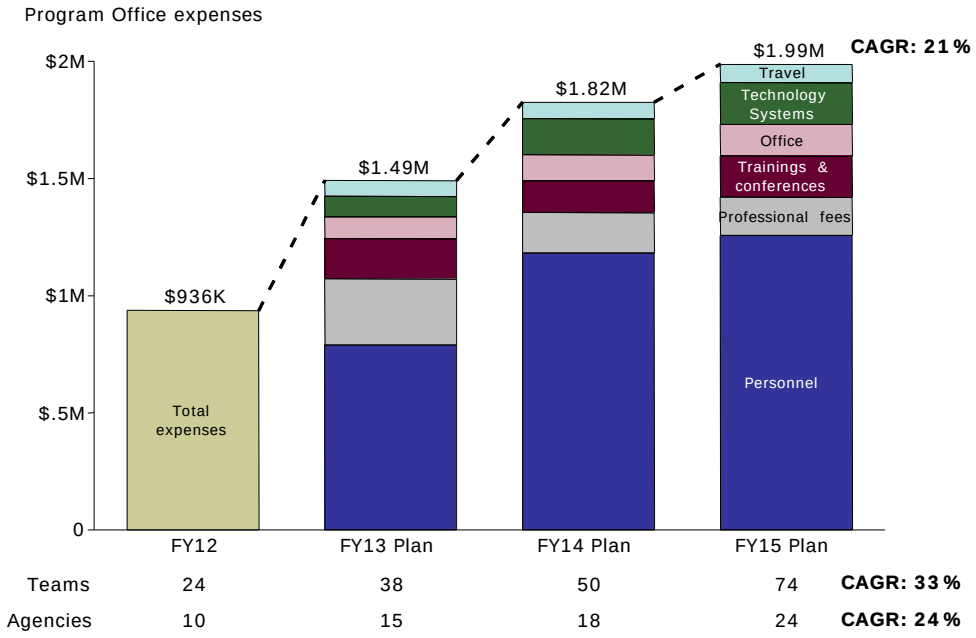
In FY 2013, Child FIRST will be investing in continued operations in Connecticut, as well as:

- Ramping-up and training up to five new implementing agencies in new communities and expansion of existing programs into three additional communities in Connecticut
- Developing Child FIRST's new Cross-Site Database to collect and analyze data, monitor fidelity and outcomes, and provide input into certification decisions
- Creating communications materials to build awareness of Child FIRST and support conversations with prospective partners
- Building infrastructure to support an independent nonprofit organization
- Building staff capacity to engage funders, stakeholders and implementing partners from prospective states for future replication of the model

In subsequent years, the Child FIRST Central Program Office budget will gradually expand as it continues its replication in new states. Child FIRST intends to stage this replication across FY14 and 15. (Current assumption for launch in a new site includes three agencies, four teams per agency or 12 teams, and one Learning Collaborative). The graphic below illustrates Child FIRST's budget growth in the coming years. It also illustrates the fact that Child FIRST's growth is cost efficient: **it will increase its reach by a compounded annual growth rate of 33%, while only increasing expenses at a rate of 21% per year**.

Child FIRST pro forma expenses: FY13 – FY15

Child FIRST pro forma expenses (FY13 – FY15)



	FY 13 Plan	FY 14 Plan	FY15 Plan
Operating expenses			
Personnel (salary and benefits)	$ 789,455	$ 1,182,644	$ 1,257,529
Professional fees	$ 282,370	$ 172,000	$ 162,000
Travel costs	$ 66,427	$ 69,705	$ 78,562
Trainings & conferences	$ 170,305	$ 134,954	$ 175,909
Technology systems	$ 87,333	$ 153,000	$ 178,000
Rent and office operations	$ 94,971	$ 112,062	$ 135,700
Total operating expenses	**$ 1,490,861**	**$ 1,824,364**	**$ 1,987,700**

Revenue Model

Child FIRST's anticipated revenue model is supported by revenue data from other evidenced-based home visiting programs. Comparable organizations like Nurse Family Partnership—which also provide implementing agencies with an intensive package of training, supervision, and ongoing support services—rely primarily on philanthropy and government funding (~60% of revenue) and receive some fees from implementing agencies.

Child FIRST anticipates that it will need to raise approximately $1.7M over the next three years to successfully execute against its business plan and build capacity ahead of its projected growth. Child FIRST will pursue blended and braided funding for its Central Program Office drawing on five key sources:

- State government: At the core of Child FIRST's strategy and revenue model is its intent to build state-wide scale and state government funding to support Central Program Office operations. Child FIRST's contract with the Connecticut Department of Children and Families is an illustration of this strategy in action. Based in part on Child FIRST's ability to serve families in all DCF Areas across Connecticut, DCF is planning to provide annual funding for Child FIRST's fidelity and continuous quality improvement work. Going forward, Child FIRST will continue to pursue state government funding as a core source of support for Central Program Office operations, in Connecticut and beyond.

- Federal government: To date, Child FIRST has received federal grant funding for discrete projects. A grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) funded its RCT and the Health Resources and Service Administration's Maternal Infant Early Care Home Visiting (MIECHV) program is supporting expansion in CT. (MIECHV funds flow to the Child FIRST Central Program Office in the form of fees paid by implementing agencies.) The MIECHV program has been an important source of growth funding for Child FIRST and other home visiting models, however future funding is uncertain. Going forward, Child FIRST will continue to seek out and apply for additional federal grants, such as inclusion in Race to the Top and the SAMHSA Child Mental Health Initiative. Child FIRST will also be exploring federal funding streams that may provide ongoing support for Child FIRST's Central Program Office infrastructure. Possibilities for further investigation include CAPTA, TANF, tobacco funds, and IDEA.

- Agency fees: An important revenue stream for organizations like Child FIRST is fee income from implementing agencies. In FY13, Child FIRST will receive $72K ($12,000 per agency) from agencies that have completed their initial training year, thereby recovering nearly 70% of the costs it incurs to support them in steady state. As Child FIRST enters new states, it will need to recover a greater portion of these agency support costs by introducing a new fee structure, clearly communicating actual costs with prospective state agencies, and collaborating with states to identify viable sources of funding if costs cannot be supported by state budget. Child FIRST anticipates that the recovery rate will vary from state to state, given the local context and other sources of funding available. Importantly, however, Child FIRST will only launch replication in a state where there is a plan for long term financial sustainability of the program.

- National philanthropy: Child FIRST currently receives national philanthropic support from the Robert Wood Johnson Foundation, which constitutes 19% of Child FIRST's current Central Program Office budget. Going forward Child FIRST will continue to need national

philanthropy especially to support investments in selecting and preparing new states for replication. We anticipate that philanthropy will be a more prominent source of funding during this growth phase, potentially making up 25-50% of Central Program Office revenue by FY15.

- State and local philanthropy: Today, Child FIRST funds 12% of its Central Program Office budget with support from the Grossman Family Foundation, a recently established family foundation focusing primarily on Fairfield County in Connecticut. However, sites are also relying on state and local philanthropy to fund a portion of their implementation cost. Child FIRST's experience in Connecticut suggests that local philanthropy is an important source of support in the early years of replication. Therefore, it will be increasingly important for Child FIRST to coordinate with local sites in cultivating local and state philanthropy, so that the Central Program Office does not compete with funding for the local sites.

Child FIRST Central Program Office projected revenue sources

Funding Source		Projected Revenue (FY13)	% of Total Projected Revenue (FY13)	% of Future Revenue (FY15)
Federal government:				
Agency fees funded by federal grants	$	529,920	35%	5-20%
State government	$	456,481	30%	25-40%
Agency fees (steady-state)	$	72,000	5%	5-10%
Philanthropy	$	472,953	31%	25-50%

Start-up and implementation costs

Child FIRST is a complex and intensive program model. Launching Child FIRST in a new state will require significant upfront investment in preparation and training. In addition, delivering the program hinges on a state's investment in professional staff (90% of program cost). As described above, Child FIRST's Central Program Office will collaborate with prospective state partners to develop the resources required for implementation and to identify sustainable sources of funding for the long term.

Implementing Child FIRST requires investment in three areas:

1. Program delivery at the agency level: Agencies implementing Child FIRST will need to hire or assign full time staff to deliver and oversee the program. A typical agency would include four Clinician/Care Coordinator teams and a full time Clinical Director. Some support by agency leadership and administrative support is also required. In addition, agencies will incur rent, office operations, and travel costs (for team visits to families in their homes). For a state implementing Child FIRST in three agencies (each in a different geographic area) with four teams each (for a total of 12 teams serving over 300 children and their families), annual program delivery costs will be approximately $1.84M; or approximately $150,000 per team.

2. Training, consultation, and ongoing support for implementing agencies:

a. Pre-launch. The Child FIRST Central Program Office provides guidance and support as agencies hire new staff and prepare for the Learning Collaborative. For each new state this amounts to $77K.

b. Year One. In the first year of implementation, the Central Program Office staff and new staff dedicated to each state (Child FIRST State Program Office) conduct the 12 month Learning Collaborative, support specialty training and topical conferences on a quarterly basis, host an Annual Conference, and provide weekly to biweekly reflective consultation to all agency staff. The Central and State Program Offices also provide data analysis of Metrics and cross-site outcome data with feedback to the sites, monthly convenings of Clinical and Executive Directors of implementing sites, and ongoing technical assistance. For states implementing in three agencies and 12 teams, support from the Child FIRST Central Program Office will cost $257K for the first year.

c. Steady state. Once the program is established, the Central Program Office and Child FIRST State Program Office provide ongoing training, hold monthly convenings of Clinical Directors and agency Executive Directors, provide technical assistance, guide quality improvement through Metrics and outcome analysis, monitor fidelity, and conduct certification. For three agencies and 12 teams, these supports cost $106K per year. Child FIRST expects to recoup these costs through a number of sources: agency fees, direct support from states and philanthropy.

3. State-wide support and infrastructure: Implementing Child FIRST across a state requires extensive preparation at the state level and ongoing capacity to develop resources and oversee implementation. The Child FIRST Central Program Office directs the pre-launch work; the Child FIRST State Program Office leads these efforts in steady state.

    a. Pre-launch. A number of investments are required to prepare states to successfully implement Child FIRST. This includes: convening state agencies; researching funding options; advising states on agency selection; establishing technological infrastructure for data collection and quality improvement. These investments total $163K prior to launch.

    b. Steady state. Implementing and sustaining the Child FIRST program across a state requires ongoing attention of the State Program Office team to maintain relationships with state agencies and funding sources, ensure integration with the existing system of care, and ensure financial sustainability. This costs $99K in the first year, and $106K in steady state.

In addition, states may assign a government administrator to support implementation, particularly the management and administration of funding streams and grant programs. A summary of the costs to prepare for and implement the program in three agencies and 12 teams is included below.

Child FIRST start-up and implementation costs for a new state

	Pre-launch	Year 1	Steady-state
Program delivery by agencies	$ -	$ 1,838,583	$ 1,838,583
Child FIRST Program Office support to agencies	$ 77,258	$ 256,607	$ 106,504
Child FIRST Program Office support to state	$ 163,318	$ 98,889	$ 106,469
Child FIRST Program Office support subtotal	$ 240,576	$ 355,496	$ 212,973
State agency management costs	$ -	$ 33,413	$ 33,413
Total	$ 240,576	$ 2,227,492	$ 2,084,968

Once pre-launch is completed, Child FIRST Program Office support accounts for only 14% of total costs of program delivery and this falls to just 9% from year 2 onwards; effectively, this equates to a very low indirect rate.

For implementing agencies at steady-state, these investments above amount to a cost per family that ranges from $5,100 to $7,100 dependent on the local cost structure for salaries and other expenses[2].

A number of variables—such as the concentration of Child FIRST's target population, the complexity of issues facing the populations in need, Medicaid reimbursement options, agency receptivity to web-based training and consultation, and Clinician and Care Coordinator salaries—will influence cost per family and cost of launch for prospective states. Child FIRST's state launch and cost per family calculators can aid prospective funders in understanding the unique cost of launching and implementing Child FIRST in their state.

Long-term growth

Child FIRST is building capacity for growth and a revenue model that assumes continued growth to fund its operations. It has projected a growth rate that it believes to be sustainable over the plan period. While the current excitement about home visiting and early childhood may push Child FIRST to grow faster, it will be judicious about doing so, as building more capacity for growth will commit the organization to continued growth at a higher rate.

While Child FIRST is committed to steady growth in the next three years, it is not committed to this pace in perpetuity. Child FIRST will use the next three years to grow and learn, specifically with an eye towards:

- Time and resources required to replicate in a new state and secure sustainable funding streams;
- Testing the assumption that state-wide scale leads to sustainable funding and that replication in new states will inspire broader adoption of Child FIRST principles and approach;

[2] Cost per family includes 4 teams per site, as well as all programmatic costs and agency fees paid to Child FIRST. Cost per family ranges reflects regional variation in cost of living.

- Testing the true interest of national philanthropy for ongoing support of Central Program Office investments in growth and scaling.

At the end of this period, Child FIRST will revisit its strategy and set the course for the following three years accordingly, including: the pace of future growth, required activities, and funding model.

MEASURING PERFORMANCE

Child FIRST will define success over the next three years by the extent to which it (a) continues to replicate the program in Connecticut with fidelity and strong positive outcomes, (b) launches the program in at least two new states, (c) builds infrastructure that can sustain replication and continuous quality improvement, and (d) develops sustainable funding for the program.

Child FIRST has developed interim measures against which to measure progress in implementing its 2012-2015 plan. Key measures of the organization's performance will include:

Families served:

- Child FIRST program is delivered to over 700 families in CT in FY13; by FY15 it will grow to serving over 1050 families annually per year in CT and over 324 per state in new states according to the current growth proposal.

Family outcomes:

- Decreased involvement in child protective services
- Improved child mental health
- Improved child language, cognition, and executive function
- Decreased maternal depression and other mental health problems
- Decreased emergency health care utilization and decreased hospitalization
- Increased access to community services and supports

Certification:

- Certification of agencies serving the 15 CT DCF Area Offices with all demonstrating full fidelity to the model: six agencies by FY13, ten agencies by FY14, and 15 agencies by FY15.
- Certification of three agencies in a new state in FY15.

Replication:

- Child FIRST program is implemented in at least two new states with model fidelity.

System of care:

- Participation in an active early childhood system of care with a broad array of providers referring to and receiving referrals from Child FIRST
- Existence of a functioning community Child FIRST Executive Committee.

Central Program Office infrastructure:

- Staff hiring and other process milestones from implementation plan achieved on schedule

Program refinement:

- Continuous improvement of the Child FIRST model and its outcomes, especially for the most challenging populations, with ongoing refinement of training using the latest technology.

Funding:

- Sustained government funding in Connecticut through DCF, Medicaid, and other funding sources

- Confirmation of funding for at least two years in new states, from public or philanthropic sources

BUSINESS PLAN IMPLEMENTATION

Child FIRST has created a detailed implementation plan for 2012-2015 to guide its progress towards achieving its priorities. This plan identifies activities, actions and milestones in ten operational areas: building out Child FIRST team, refining training method, refining quality improvement and certification approach, securing funding, supporting implementing agencies, building relationships with prospective state partners, engaging new states, building awareness, conducting RCT, and forming a separate organization. A subset of these areas and associated milestones is illustrated below.

Child FIRST Implementation Plan Milestones Summary
Date Updated: 10/2/2012

					X	Milestone					
						2012					
	Sub-priority	Build out Child FIRST team	Start	End	Status	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Build Child FIRST program office	Milestone	Associate Clinical Director begins at Child FIRST	Nov-12	Nov-12	On track					X	
	Milestone	CT Program Director begins at Child FIRST	Nov-12	Nov-12	On track					X	
	Milestone	Office Manager begins at Child FIRST	Nov-12	Nov-12	On track					X	
	Milestone	Second CT Clinical Consultant begins at Child FIRST	Nov-12	Nov-12	On track					X	
	Milestone	Care Coordination Consultant begins at Child FIRST	Jan-13	Jan-13	On track						
	Milestone	Contract signed by CHDI and CF for quality assurance activitites	Nov-12	Nov-12	On track					X	
	Milestone	State 2 Program Office staff begin	Oct-13	Oct-13	On track						
	Sub-priority	Refine training method									
	Milestone	Provide Clinical Directors with pre-LC prep materials	Dec-12	Dec-12	On track						X
	Milestone	Finalize Clinical Director modules	Dec-12	Dec-12	On track						X
	Milestone	Carry out first Clinical Directors Mini-Training for Cohort 3	Dec-12	Jan-13	On track						X
	Milestone	Formally integrate CPP and Circle of Security into training schedule	Dec-12	Dec-12	On track						X
	Milestone	Roll-out specialty trainings (COS)	Mar-13	Mar-13	On track						
	Milestone	Roll-out specialty trainings (CPP)	May-13	May-13	On track						
	Milestone	Launch technology-based training platform/modules	Sep-13	Sep-13	On track						
	Milestone	Roll-out specialty trainings (Other)	Jun-13	Jun-13	On track						
	Sub-priority	Refine quality improvement and certification approach									
	Milestone	Finalize certification process	Jan-13	Jan-13	On track						
	Milestone	Finalize approach to supporting agencies that require improvement plan	May-13	May-13	On track						
	Milestone	Launch cross-site database	Jun-13	Jun-13	On track						
	Milestone	Launch data collection and continuous improvement processes	Jan-13	Jan-13	On track						
	Milestone	Publish and communicate adjustments to CF model	Jun-13	Jun-13	On track						
	Milestone	Deliver data to DPH	May-13	May-13	On track						
	Milestone	Deliver data to DCF	Mar-13	Mar-13	On track						
Fundraising	Sub-priority	Secure funding									
	Milestone	Secure funding for RCT	Jun-13	Jun-13	On track						
	Milestone	Secure additional funding for the Program Office	Dec-13	Dec-13	On track						
	Milestone	Obtain new federal funding streams	Sep-13	Sep-13	On track						
Implement a quality state-wide Child FIRST network	Sub-priority	Support implementing agencies									
	Milestone	Cohort 2 finished start-up training	Jun-13	Jun-13	On track						
	Milestone	Conduct Clinical Director training	Dec-12	Jan-13	On track						X
	Milestone	Cohort 3 finished start-up training	Dec-13	Dec-13	On track						
	Milestone	Cohorts 1 and 2 certified	Apr-13	Apr-13	On track						
	Sub-priority	State business development									
	Milestone	Confirm DCF funding commitment for FY14	Jun-13	Jun-13	On track						
	Milestone	Confirm required timing of RCT	Nov-12	Nov-12	On track					X	
	Milestone	Cohorts 1 and 2 certified	Apr-13	Apr-13	On track						
	Milestone	Sites bill Medicaid	Jul-13	Jul-13	On track						

RISK MANAGEMENT

In implementing the priorities in this business plan, several types of risks and plans to mitigate those risks have been identified.

- Operational risks:

    - *Building the team*: Child FIRST's success in the coming years depends upon its ability to fill and retain critical positions in the Central Program Office, especially those individuals who will be posted outside Connecticut. Failing to find the right individuals will severely impede its ability to execute its strategic priorities. To manage this risk, Child FIRST plans to devote significant Leadership Team time in the first months of FY 13 to building the team in Connecticut, and in FY14 and 15 to building the team in replication states. Should the key positions not be filled on the expected schedule, Child FIRST will postpone its investments in other priorities (likely replication) until the team is in place.

    - *Compliance with fidelity*: Should the implementing agencies fail to attract and retain high-quality staff, implement the model with fidelity, and fall short of outcome expectations, the program will not achieve its goals for impact and will jeopardize its reputation as a high-quality and effective intervention. Child FIRST has plans to assess carefully the abilities of new clinical staff at the sites in order to tailor its training to address significant skill gaps and to support sites with improvement plans. In addition, it will deny certification to sites that are not able to achieve realistic improvement goals. Child FIRST will also communicate the importance of fidelity compliance to its state partners so that they may assist in this effort.

- Financial risks:

    - *No-growth scenario*: If due to federal or state cuts, public funding for home visiting should be significantly less than expected and philanthropic funding is not available, Child FIRST will not be able to grow as planned. Should such conditions emerge, Child FIRST would curtail replication in new states and slow or halt new hires to support expansion. Instead, it would focus on preserving its presence in Connecticut through strong advocacy and marketing and increased investment in cultivating private funding sources. Further, Child FIRST will work to mitigate the impact of possible reductions in public funding by establishing strong relationships with funders in the states in which it operates. Close partnerships can increase the likelihood that alternative funding streams may be identified.

    - *Fee recovery projections*: Child FIRST's financial sustainability depends on the extent to which it can recover its costs from agencies and states. Should it discover that agencies and states are unable to cover the costs of implementing the model, Child FIRST would need to support partners in their pursuit of public and private funding.

- Market risks:

    - *Competition*: Funders and state partners will have finite resources to invest in home visiting and early childhood programs. As such, Child FIRST will continue to be compared with other home visitation programs. As discussed, Child FIRST is unique in addressing the needs of very high risk children and families. Child FIRST

Leadership would work to help a state determine if the challenges in their population could be best served by Child FIRST. In addition, Child FIRST will focus on making the model as cost-effective as possible and communicating its cost-effectiveness to stakeholders.

- *Meeting demand*: As of October 2012, Child FIRST had received attention and inquiries from 16 states interested in learning more about how to implement Child FIRST in their communities. Should Child FIRST not have capacity to respond to strong leads in a consistent and timely fashion, the organization may lose credibility in the early childhood and home visiting fields. To mitigate demand risks, Child FIRST will develop and communicate a checklist of commitments that a state or community must secure before Child FIRST would consider replication there.

- Outcome risks:

  - *Challenges of families served:* Child FIRST's commitment to serving the most vulnerable children and families in new communities could impact outcomes, as these vulnerable populations are often the hardest ones with which to succeed. Child FIRST will commit to conducting calculated adjustments to effectively adapt its model to serve new populations with a diverse set of challenges and circumstances unique to the new replication communities.

APPENDIX A: SUMMARY OF CHILD FIRST RANDOMIZED CONTROLLED TRIAL AND RESULTS

SAMHSA Starting Early, Starting Smart–Prototype

In 2001, Child FIRST was one of five sites nationally to receive a federal Starting Early, Starting Smart - Prototype grant from the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, to support a randomized controlled trial of the Child FIRST model. A randomized controlled trial is considered the highest level of scientific evidence of the effectiveness of an intervention. This is one of the few randomized controlled trials to test the effectiveness of an integrated home-based, psychotherapeutic, family intervention embedded in an early childhood system of care with young, vulnerable children from high risk families.

Children between the ages of 6 and 36 months were identified through screening at the Bridgeport Hospital Pediatric Primary Care Center and the Bridgeport Health Department's Women, Infants, and Children (WIC) Nutrition program. Ethnic breakdown showed 59% Latino, 30% Black, and 7% Caucasian. Risk factors were extremely high with 93% receiving public assistance, 64% unemployed, 53% without high school diploma or GED, 67% unmarried, 54% with depression, 44% with a family history of substance abuse, and 25% with a history of homelessness.

Seventy-eight (78) children were randomly assigned to the "Child FIRST Intervention" or the treatment group, while seventy-nine (79) children were randomly assigned to "Usual Care" or the control group which received the normal standard of care for children in the absence of Child FIRST. The results of this trial described below are the basis of a peer-reviewed article published in the January/February 2011 issue of the journal Child Development[3].

Results of the Randomized Trial

The study found clinically and statistically significant impact on child and family outcomes:

- ***Children's mental health***: Children in the Child FIRST Intervention were significantly less likely to have externalizing symptoms (meaning aggressive, defiant, disruptive, or hyperactive behavior) than children in Usual Care at 12 month follow-up, using the Infant-Toddler Social-Emotional Assessment. (Odds ratio = 4.7, moderate effect size)

- ***Language delays***: Children in the Child FIRST Intervention were significantly less likely than those in the Usual Care group to have language problems at 12-month follow-up. (Odds ratio = 4.4), using the CT Infant-Toddler Developmental Assessment Language Scale. Among those with baseline language problems, competent language was observed in 80.0% of Child FIRST Intervention compared with 36.4% of Usual Care children. Examination of language problems at 12 months, stratified by the presence or absence of language at baseline, suggests that the effect observed in the logistic regression reflects both remission of existing problems and prevention of new problems in families in Child FIRST, compared with Usual Care.

- ***Maternal mental health***: Mothers' mental health was evaluated along dimensions of overall mental health, depression, and parenting stress. Mothers in the Child FIRST

[3] Lowell, D.I., Carter, A.S., Godoy, L., Paulicin, B., Briggs-Gowan, M.J. (2011). A Randomized Controlled Trial of Child FIRST: A Comprehensive, Home-Based Intervention Translating Research Into Early Childhood Practice. *Child Development, 82*(1). 193-208.

Intervention were significantly less likely than mothers in the Usual Care group to report scores in the clinical range for mental health issues at 12 month follow-up, using the Brief Symptom Inventory. (Odds ratio = 4.0) The pattern of findings suggests that this reflects both a reduction in maternal symptoms and a prevention of new symptoms among mothers in Child FIRST, relative to Usual Care. Mothers in Child FIRST had significantly lower depressive symptoms than those in Usual Care at 12 month follow-up, using the Center for Epidemiology Scale-Depression (CES-D). Mothers in the Child FIRST Intervention were less likely to report high Difficult Child Parenting Stress at six month follow-up and less likely to have a Parenting Stress Index score in the clinical range at 12 months (Odds ratio = 3.2).

- ***Involvement in Child Protective Services***: The Usual Care group was significantly more likely than the Child FIRST Intervention group to be involved with protective services during the 12 month follow-up period (Odds ratio = 4.1 for parental self-report). The Usual Care groups was also significantly more likely to be involved with protective services at three year follow-up (Odds ratio = 2.1 based on child protection records).

- ***Access to services***: The Child FIRST Intervention group had 91% of service needs met at 12 month follow-up, compared with only 33% in Usual Care group (with a large effect size). A mean of 15 services were accessed by Child FIRST families.

Within the Child FIRST Intervention:

- ***Parent satisfaction***: Parents reported very high satisfaction with services received, with a mean score of 4.60 on a scale of 1.0 to 5.0.

These results obtained in the SAMHSA randomized trial are conservative estimates of the actual impact of the current Child FIRST model for two reasons. The analysis of the data from the randomized trial utilized the very rigorous “intention to treat” model, to prevent any sample bias. Therefore, the results of the trial underestimate the effects that would be expected with community implementation. Furthermore, since the randomized trial was completed in 2005, the Child FIRST model has continued to strengthen based upon experience in the field and continuous quality improvement.

APPENDIX B: CHILD FIRST LOGIC MODEL

Challenges

Family
- Poverty
- Domestic violence
- Substance abuse
- Maternal depression; mental health problems
- Homelessness or unstable housing
- Poor health
- Unemployment
- Lack of education
- Illiteracy
- Lack of parenting and child development information
- Child welfare involvement
- Food insecurity
- Parents with cognitive limitations
- Teen parents
- Single parents
- Uninvolved fathers
- Isolation
- Incarceration
- Undocumented status
- Multiple challenges

Child
- Developmental delay or learning problems
- Social-emotional or behavioral problems
- Health problems
- Exposed to "toxic stress" without buffering of strong attachment relationship
- Abused or neglected
- Inadequate health care of lack of Medical Home
- Low quality child care

Community
- Fragmentation in service system
- Gaps in services
- Community violence

Inputs

Child FIRST: Evidence-Based Home Visiting Model
- Strong positive outcomes in child mental health, language, maternal mental health, and connection to services
- Decreased child welfare involvement
- Master's level Mental Health/Developmental Clinicians
- Bachelor's Care Coordinators
- Team approach
- Multicultural/multilingual staff
- Learning Collaborative with intensive training
- Weekly reflective supervision
- Highly experienced staff
- Children prenatal to 6 years
- Multiple children per family

Funding:
- Child welfare
- MIECHV
- Medicaid reimbursement for in-home services
- Philanthropic support
- Federal (SAMHSA) support

Strong Collaborative Early Childhood System of Care
- Early care and education
- Local Education Associations
- Pediatrics in hospitals & FQHCs
- Family Resource Centers
- Shelters
- Domestic violence agencies
- Courts
- Home visiting: PAT, NFP, EHS
- Care Coordination (SOC)
- Early childhood, school-based mental health consultation
- Health Department
- IDEA Early Intervention
- Adult mental health and substance abuse providers
- Child mental health providers

State Policy and Advocacy
- Commission on Children
- Home Visiting Advisory Group
- EC Education Cabinet
- State agency commitments

Activities and Services

Identification, Assessment, & Planning

Screening and Referrals:
- Training of community providers
- Screening for developmental, social-emotional, parent risk
- Broad referrals from early childhood and adult providers

Community-Based Assessment & Consultation:
- Early care and education

Comprehensive Home-Based Assessment:
- Child development
- Child & adult health
- Child mental health
- Parent-child relationships and attachment
- Parental challenges esp. mental health
- Family service needs

Development of Individualized Child & Family Plan of Care:
- Family-driven, reflecting culture, priorities, needs
- Comprehensive, integrated plan
- All family members receive services
- Child/family specific meetings as needed
- Seamless, efficient, and effective services

Service Delivery

Home-Based Intervention:
- Engagement of very hard to reach families
- Parent guidance
- Parent-child dyadic psychotherapeutic intervention (adapted from CPP)
- Two generation approach
- Team approach
- Weekly individual and group reflective supervision

Case Coordination / Case Management:
- Hands-on connection to community services and supports
- Average of 12 referrals per family
- Access to over 80% of services desired

Transition Planning:
- Family strengthened and stabilized
- Engagement in community services and informal supports

Fidelity and Certification:
- Cross-site data system
- Process and outcome analysis
- Monitoring of fidelity
- CQI process
- Annual certification

Outputs

- Increased identification of multi-risk families
- 15 Child FIRST programs in CT serving 1,050 children and families
- Replication of model in at least two other states, each starting with 3 sites

Intermediate Outcomes

Service System:
- Increased identification
- Increased community consultation

Family Access to Services:
- Effective partnership with primary health provider and increased connection to Medical Home
- Increased access to home-based parenting and therapeutic services
- Increase connection to early care and education
- Increase usage of dental services
- Increased utilization of multiple other community resources
- Decreased use of ER
- Decreased hospitalization

Family Health:
- Reduced stress
- Decreased maternal depression
- Increased involvement of fathers
- Increased family support

Decreased Child Welfare involvement
- Decreased CW referral
- Decreased substantiation for abuse/neglect
- Decreased foster care

Longer Term Outcomes

Child Outcomes:
- Decrease in child emotional and behavioral problems with residential or hospital treatment
- Improved executive functioning
- Decrease in developmental and learning problems with special education
- Improved child physical health

Family Outcomes:
- Parenting behavior that provides nurturing, promotes optimal development, and fosters attachment
- Family safety
- Income security
- Housing security

Parent Outcomes:
- Decrease in maternal mental health problems
- Decreased incidence of domestic violence
- Increased education and literacy
- Improved health
- Increased employment

Service System Outcomes:
- Parent and provider satisfaction
- Utilization of data for service improvement
- Medicaid funds accessed for home-based services
- Increase in Medicaid reimbursement rate
- Expansion of Medicaid (EPSDT) funds for "medical necessity" and onsite consultation
- Increased community collaboration with seamless system of services and supports