Item 4a

Care Coordination:

Connecting Families Across Services

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Contents

Executive Summary

Five Early Childhood Collaboratives (Collaboratives) are funded by First 5 Monterey County (F5MC) as a strategic plan response to family request for more integrated, cohesive, and holistic service provision. The provision of care coordination is a key strategy for the integrated services provided by the Early Childhood Collaboratives. A consistent point person, or care coordinator, develops trusting relationships with families, creates a shared care plan, collaborates with a group of professionals to identify holistic and appropriate services, and supports families in accessing those services. Critical to the work is not only appropriate screenings and coherent service referrals, but ensuring families are consistently connected with services – making it easier for families to navigate the service system.

In 2020, F5MC contracted with Social Policy Research Associates (SPR) to explore outcomes related to care coordination services. This included exploring whether families experience referrals as better aligned with their unique needs and if they also have successful connection to services. F5MC also had an interest in understanding whether care coordinators participating in F5MC capacity building activities report increased capacity to deliver high quality services. Lastly, they were interested in determining whether cross-agency capacity building and care coordination play a role in strengthening alignment within early childhood development (ECD) systems in Monterey County.

To better understand these outcomes of interest, SPR conducted focus groups with care coordinators, Collaborative administrators, and families in care coordination; administered a survey to care coordinators, Collaborative administrators, and other organizations where families are frequently referred to; and analyzed administrative data.

Findings from this study are summarized below by each key outcome of interest.

Outcome 1: Better Coordination of Services

Care coordinators build and maintain relationships with service providers and families, while carrying out various activities that aim to help families navigate services and supports more easily and efficiently.

Findings below summarize the importance of these relationships and its impact on families.

Care coordinators build relationships with service providers to facilitate connecting families to their services

A care coordinator's job is heavily relationship-based. Their communication and connections with service providers help them identify resources and streamline the referral process for families. In fact, sixteen of the seventeen F5MC care coordinators and Collaborative administrators reported having at least one staff member in their Collaborative who is responsible for building and maintaining relationships with other programs and agencies. The agencies who receive frequent referrals also rated these relationships as very or extremely important to helping connect families to services.

Care coordinators develop trust with families to inform targeted, comprehensive supports

Care coordinators also strive to establish trusting relationships with families. Both care coordinators and families report that the approach to care coordination involves taking time to learn about families on a personal level and care coordinators remaining accessible to families over time. The relationships that coordinators establish with families are fundamental to the ability to understand the unique needs and priorities of each family in order to provide coherent and comprehensive referrals and connections to services.

Care coordinators provide intensive, broad and tailored support

Care coordinators connect families to a broad range of resources. For example, care coordinators referred families to service providers that support a child's development as well parents' own development and well-being. Data from the care coordinator and administrator surveys identify assessments, therapy (speech, behavioral, etc.), and early intervention as the top three referral services for families. Supports sometimes include helping families fill out CalFresh forms or helping with housing stabilization.

Families connect to resources with support from care coordinators

In addition to connecting families with service providers during the initial referral process, care coordinators regularly follow up with families and service providers to ensure services have been accessed by families. Every care coordinator and administrator rated following up with families as very or extremely important to helping families connect to services, and 94% reported following up with the service provider as very or extremely important. Additionally, all but one respondent indicated often or always following up with either the family or service provider. Families spoke about the favorable interactions they had with referral sites when they had the support of a care coordinator, especially when compared to their experiences trying to access those same services on their own prior to care coordination.

Families face structural barriers outside of care coordinator control that impede their ability to access resources

Despite the relationship building and activities that care coordinators carry out to streamline the referral process, there are still structural barriers that limit a care coordinator's ability to support families' access to services. Care coordinators reported challenges in their daily activities and responsibilities, which included capacity constraints at referral sites and limited ability to fully support families who speak languages other than English and Spanish. Notably, care coordinators and administrators reported families being put on a waiting list due to a lack of capacity from the service provider as one of the top two reasons preventing families from connecting to services. Meanwhile, families named three challenges that affected their ability to follow up on referral services: language barriers, poor organization and management at the referral organization (e.g., having to provide updated contact information multiple times), and navigating conversations with medical providers who are hesitant or unwilling to evaluate their child.

Outcome 2: Higher Levels of Quality

Care coordinators and administrators receive multiple opportunities for professional development, networking, and shared learning to support quality services. Findings below summarize how these offerings supported high quality care coordination services.

F5MC funded capacity building activities promoted greater care coordinator attunement with families

Care coordinators and Collaborative administrators consistently praised how the F5MC capacity building offerings, including a care coordination learning group, the Circle of Security trainings, and other sponsored trainings promoted mindfulness, reflection, empathy, and careful listening. Care coordinators expressed that F5MC trainings not only gave them knowledge and skills, but they also supported their own mental health which allowed them to serve families more effectively.

Care coordinators and administrators recommend repeating trainings for new staff and adapting trainings to better reflect indigenous cultures

Two primary suggestions to enhance F5MC trainings surfaced during the focus groups. One respondent suggested that F5MC regularly offer some of the foundational trainings that are core to how F5MC operates, such as the Facilitating Attuned Interactions (FAN) strategy, for new staff. Second, some respondents suggested that F5MC draw on more diverse trainers or fund the development of tools grounded in the unique communities served by the Collaboratives, including the indigenous communities in the County.

Outcome 3: Increased Alignment in ECD Systems

F5MC strives to encourage more frequent, structured, effective communication among practitioners and promote greater alignment of strategies for change among organizations. Below we delve into how the care coordination approach supports integrated systems.

The Collaborative approach supports improved communication

Collaboratives are designed to support increased connection among various service agencies as well as increased communication that supports the confidential sharing of information needed for successful services to families. Care coordinators meet regularly as part of the care coordinator learning group and other F5MC funded trainings. These meetings and trainings help them to co-develop common understandings and tools that support consistent approaches to families and services.

The Collaboratives share an alignment of strategies for change

While each Collaborative has their own strengths, challenges, and methods that are tailored to their particular client population, care coordinators agreed that the F5MC funded Collaboratives share a general foundation of empathy and common practices that shape how they work with families in fundamental ways and how they support their staff. For example, care coordinators agreed that providers within F5MC Collaboratives focus first on stabilizing families and building a relationship before jumping into referrals and developmental assessments. Care coordinators reported that other practitioners within the County do not always share this same approach. This divergence between the approach of the Collaborative and the approach of other service providers poses a particular challenge to care coordinators working with and supporting indigenous families, as they shared that most service providers do not have the cultural knowledge to support their clients.

Conclusion

The role of care coordination in the F5MC's funded Collaboratives appears to support families access to services through the development of deep, meaningful trusting relationships with families, identification of individualized and holistic services for families, and intentional connection of families with referred services within the County. It also occurs through the F5MC capacity building activities for care coordinators and increased communication that the Collaborative approach fosters, both which support a shared alignment of strategies for change. While the Collaboratives have a shared alignment of strategies, there might be additional opportunities to build alignment of strategies outside of the Collaboratives in support of families.

Introduction

Over the years, First 5 Monterey County (F5MC) has sought to adapt its investments to better support children ages birth to five and their families. During F5MC's strategic planning process for 2017-2023, "community members and service providers emphasized the need for a cohesive and navigable system of care and support for families."[1] In response, F5MC identified the goal of enhancing access to quality resources, programs, and services through coordination, collaboration, and integration in the 2017-2023 Strategic Plan.

In 2017, F5MC launched the Early Childhood Collaboratives (hereafter referenced as Collaboratives). Five organizations were selected and funded to lead the Collaboratives. The Collaboratives provide care coordination to help families navigate services more efficiently and receive more cohesive services for their needs. Collaboratives also offer various direct services to support families, including child developmental screenings and assessments, counseling, home visiting, playgroups, and parent classes. These various services and care coordination support an integrated and holistic approach to serving families. Exhibit 1 shows the locations of and services provided by the five Collaboratives.

Through care coordination, a consistent point person develops trusting relationships with families, creates a shared care plan, collaborates with a group of professionals to support holistic and appropriate services, refers families to service providers and supports families in accessing those services (see Appendix A for additional details about services offered by care coordinators).

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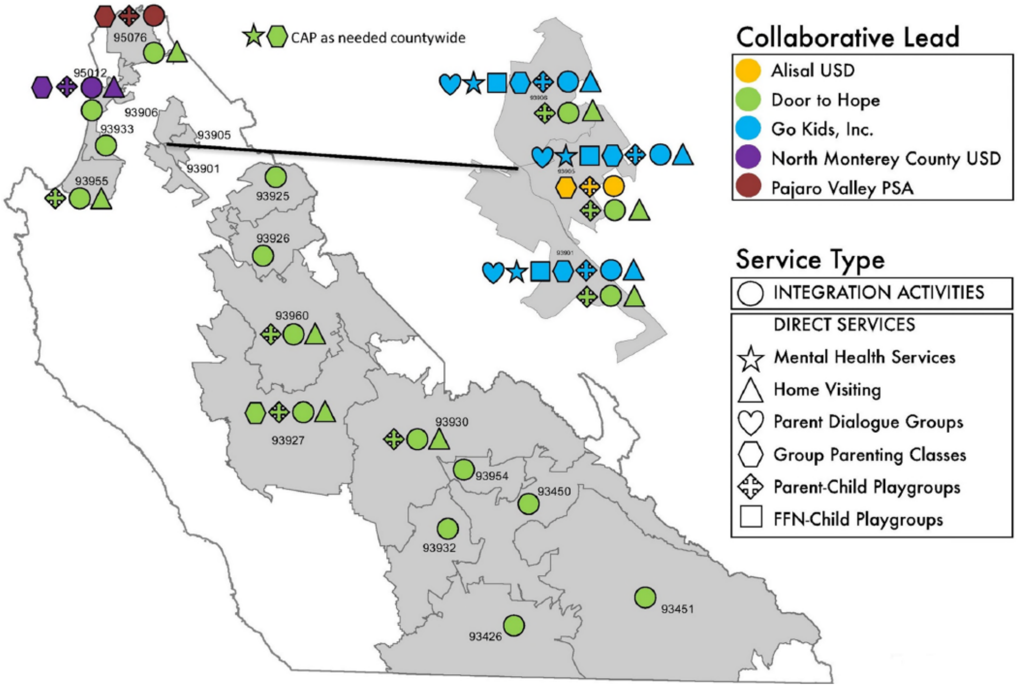
[1] Hamai, Tamara. (2018). *First 5 Monterey County Monitoring, Evaluation, Accountability, and Learning (MEAL) for Strategic Plan 2017-23.*

Exhibit 1. Location and Services Provided bv Collaboratives



In 2020, F5MC contracted with Social Policy Research Associates (SPR) to explore outcomes related to care coordination services. This included exploring whether families experience referrals as better aligned with their unique needs and have successful access/connection to services. F5MC also had an interest in understanding whether care coordinators participating in F5MC capacity building activities report increased capacity to deliver high quality services. Lastly, they were interested in determining whether cross-agency capacity building and care coordination play a role in strengthening alignment within the early childhood development (ECD) systems in Monterey County.

Overview of Data Sources

To better understand these outcomes of interest, we collected qualitative data from care coordinators, Collaborative administrators, and families in care coordination; administered surveys; and analyzed administrative data.

Findings detailed in this report are drawn from a variety of sources including:

1) **Two focus groups** with care coordinators and **one focus group** with Collaborative administrators
2) **Eight focus groups** with families who received care coordination services; five focus groups were held in Spanish, two in English, and one in Triqui

3) **Three short surveys** for care coordinators, Collaborative administrators, and partner agency staff, completed by 12 care coordinators, five administrators, and staff from 14 partner agencies
4) Individual-level **client records** from Persimmony, F5MC's client management system

Data collected from care coordinators and Collaborative administrators focused on their experience coordinating services for families and working with other service providers, their perspective on professional development opportunities offered by F5MC, the level of interaction among ECD professionals in the county, and their assessment of the alignment in best practices and approaches for serving families across the county. Focus groups with families explored their experience receiving care coordination, the impact of the service on their families, and their awareness of First 5 Monterey County. The survey to partner agencies asked about their experience working with F5MC Collaboratives and other agencies that refer families. Appendix B includes more information about the data sources and methodology used in this report.

Demographics of Families in Care Coordination

In this section we present high level demographics of families in care coordination that are relevant for understanding the findings presented in the rest of this report. Between July 2017 and June 2021, 909 families received care coordination through F5MC-funded Collaboratives.[2] These 909 families include 1,001 individual adults, 1,036 children ages 0-5, and 18 siblings over five years old.

Exhibit 2 provides a dashboard of demographics of families served by care coordination. As shown, the majority of families identified as Latino (80%) and primarily speak Spanish at home (55%). In addition, 17% of families speak an indigenous language from Mexico as their primary language. Additionally, 90% of families receiving care coordination live in one of F5MC's priority zip codes.

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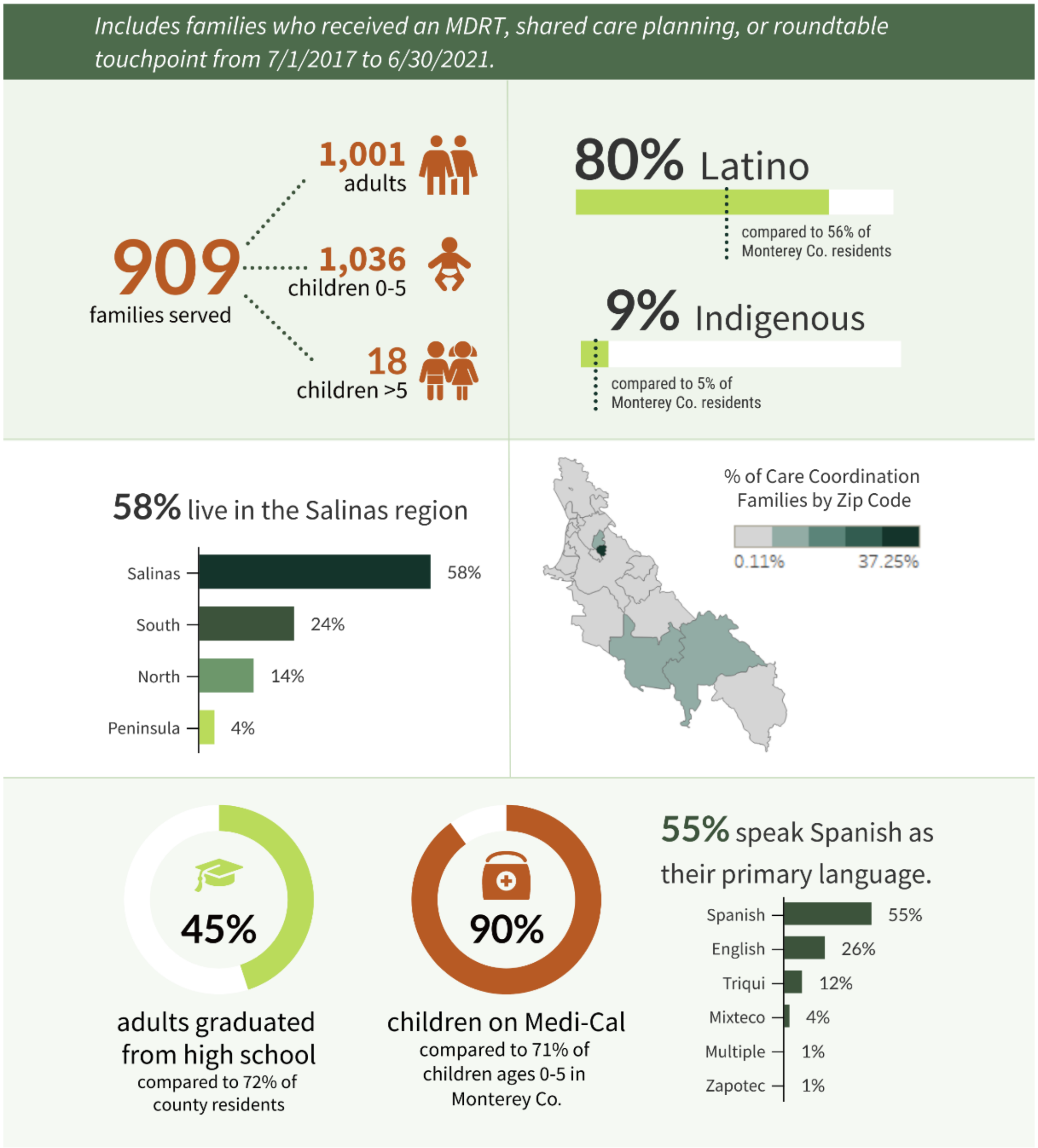
[2] This data comes from Persimmony, F5MC's client management system. We first began by looking at all families receiving services from the Collaboratives and found that 4,134 families were served by the Collaboratives between July 2017 through June 2021. Of those, 22% (909 families), had a record of receiving care coordination in Persimmony. For the purposes of this report, participation in care coordination means that the family was discussed in a multi-disciplinary round table (MDRT) meeting, a shared care planning meeting, or a roundtable meeting.

Exhibit 2. Demographics of Families Served by Care Coordination



Overview of this Report

This report describes how care coordination and the capacity building opportunities offered to care coordinators supports progress toward three key outcomes of interest. The report is divided into three sections, each covering one of these key outcomes:

- **Outcome 1: Better coordination of services** for families with young children. This section investigates the role that care coordination has played in making services for families more effective, easy to navigate, and responsive to their needs and preferences.

- **Outcome 2: Higher levels of service quality** reported by practitioners supporting families with young children. In the second section, we assess the extent to which care coordinators have developed self-awareness and stronger skills and practices through F5MC capacity building activities.
- **Outcome 3: Improved alignment of ECD systems** in Monterey County. The final section describes how the care coordination program helps partners engage in more frequent, structured, and effective communication and the extent to which their strategies for change are aligned.

We provide key findings in each outcome, and present recommendations from participants as well. We also integrate data from the varying data sources throughout the discussion. Please note to further protect confidentiality of participants, we generally do not highlight which quotes have been translated into English. However, in a few instances, we do provide a few quotes from the Triqui parent focus group to highlight some findings that were relevant for this community.

Outcome 1: Better Coordination of Services

Families receive a variety of services and supports through care coordination. Specifically, we found that:

Care coordinators regularly referred children to specialized services. Surveyed care coordinators and Collaborative administrators reported assessments, therapy (speech, behavioral, etc.), and early intervention as the top three referral services for families. This aligned with parents' experiences, as they discussed being connected to therapy for their child, behavioral and developmental specialists, and resources for children with special needs.

Care coordinators referred parents to child development services. Parents were provided resources and courses to help understand their child's development. For example, one parent was informed about a learning center that could provide her with specific information about down syndrome, which would help increase her understanding of and preparation for raising her child. Furthermore, another parent was guided on how to continue with her education through a GED program in an effort to advance her education and her family's financial opportunities.

Care coordinators connected families to immediate relief resources during the pandemic. For example, families described being connected to organizations providing basic needs (e.g., diapers, food, clothing, etc.), as well as food vouchers and rent relief programs. Families shared that these immediate resources alleviated financial stress they felt during the pandemic. As described by one parent:

> *"We got help two years in a row: diapers, farmers market [produce], therapy, getting my oldest [child] reconnected with MCSTART, getting my two youngest connected with Parents as Teachers, and really everything. I've called [my care coordinator] and she has always had a resource that I can utilize or knows who I can call. She's been a huge advocate for not just me and my kids, but [has helped me navigate] the situations I've struggled with [involving] my partner."*

This section of the report describes how care coordinators were able to better coordinate services for families, mainly by:

1) **developing relationships** with service providers and families to best meet a family's needs; and
2) **connecting families** to service providers.

In addition, we highlight some structural barriers that affect families' experience with care coordination and referral services. We also share recommendations and reflections from families on how to improve care coordination. Each finding is supported by data from the survey and focus groups. The findings are related to key indicators of interest developed by F5MC that capture whether families receive appropriate screenings and coherent service referrals and whether they more consistently connect with and perceive services to be more effective, easy to navigate and responsive to their needs. Additionally, the data aims to identify whether care coordinators have a greater number of connections with resources and relevant relationships with other practitioners and organizations, which can improve the coordination and services that families receive.

Finding #1: Care coordinators develop relationships to best meet a family's needs

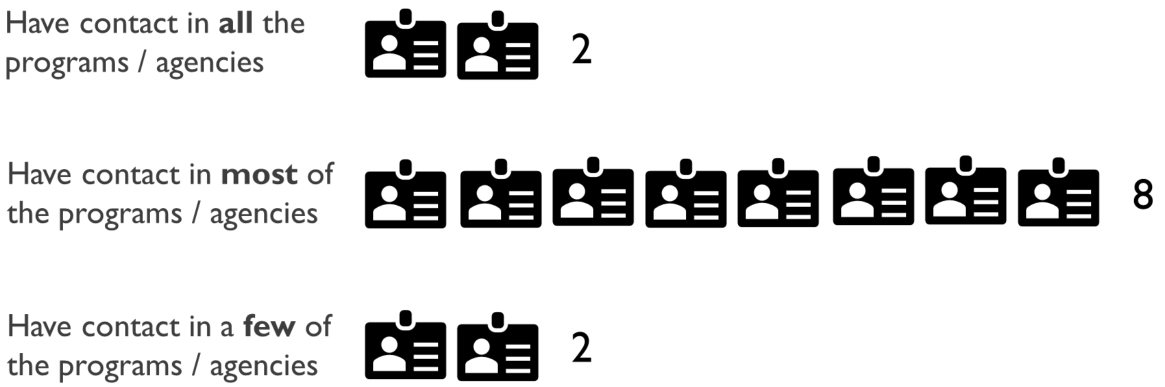
Care coordination is a complex relational job that includes helping families navigate services and supports. To do this, care coordinators serve as a consistent point person for families. They create a care plan that identifies the support and resources that families need, refer families to service providers that can offer such support and resources, and track and monitor a family's progress. Given this work, a care coordinator's job is heavily relationship-based, as they must build and maintain rapport with the families they are supporting, with service providers that they refer families to, and with one another. Below we describe how care coordinators build relationships with service providers and how they develop trust with families.

Care coordinators have relationships with service providers to facilitate connecting families to services

Care coordinators understand that strong relationships with service providers can streamline the referral process, which ultimately positions them to better serve and support families. Ten out of the twelve care coordinators surveyed indicated that they have a contact in all or most of the programs/agencies where they refer families (Exhibit 3).

Exhibit 3. Contacts across Programs/Agencies (n=12)

(Amount of contacts that care coordinators have in other program/agencies)



Because of their importance, most Collaboratives dedicate staff to maintaining these relationships. Across both the care coordinator survey and administrator survey, sixteen of the seventeen respondents reported having at least one person in their Collaborative who is responsible for building and maintaining relationships with other programs and agencies. Of these sixteen staff, fifteen rated these relationships as extremely or very important to helping connect families to services.

16 Care coordinators and their supervisors reported there is a person in their collaborative who is responsible for building and maintaining relationships with other programs/agencies.

11 reported they were extremely important

4 reported these were very important

1 reported they were somewhat important

Some care coordinators are the ones responsible for building these relationships for their Collaborative. Alternatively, they may be leveraging the connection and rapport that their colleague, such as their Collaborative administrator, has built with other agencies to support their families. Working with service providers is only one part of their job, as a significant portion of their role revolves around communicating and interacting with families.

Care coordinators develop trust with families to inform targeted, comprehensive supports

Care coordinators were intentional about developing trust with families because it is fundamental to their ability to learn about and respond to families' needs. Care coordinators also described how they can work in partnership with families once they have established a foundation of trust. One care coordinator noted that "after gaining their trust, they [families] really open up." Another care coordinator also spoke about the importance of maintaining the trust of families and mentioned that losing the trust of a family could mean they no longer come back for support. Worse, it could also erode the trust of other families in the community to work with care coordinators.

Parents and caregivers also described the ways that care coordinators purposefully developed trust with them. Parents reported that their care coordinator remembered everything they had discussed in the past, including personal details and would spend as much time as needed with families.

> *"[The care coordinator] cares about what's going on with you and your family, and [they] know exactly what to say and how [they] can help. [They] really listen to what you have to say." – Parent*

Because care coordinators took the time to get to know families on a personal level and remain accessible to families, parents and caregivers felt comfortable calling them and seeking support. In fact, one parent shared that the care coordinator is the first person she turned to when she had a question about child development. Others emphasized the importance of having someone to call when they faced a challenge or crisis. In one instance a parent even noted that she and the care coordinator "have cried together" and "have talked a lot." One parent described the impact of this personal touchpoint by stating:

> *"I appreciated that she [the care coordinator] always would remember what we talked about last time and would bring it up, and it just feels so much more personal when they remember what's going on in your life. I'm sure they have so many other people that they're dealing with, and I never felt like she was rushing."*

Care coordinators use their relationships with families to identify the most appropriate services. Additionally, it allows them to offer emotional support for family members, which influences whether the family connects to referral services and their experience with service providers.

Several care coordinators also reported seeing themselves reflected in the families they support because of their shared background, which helped them connect with families and makes their work more meaningful. As one coordinator articulated, "I see myself in their struggles, and then that is what I love about my job." It is through these connections that care coordinators connect families to services, which is the second key finding further detailed below.

Finding #2: Care coordinators connect families to service providers

Care coordinators work in partnership with families to determine the best course of action to meet families' needs. The data revealed clear examples of families being referred *and* connected to services because of care coordination.

Care coordinators provide intensive, broad, and tailored support

The intensity of care coordination services varies depending on the needs of individual families. For example, during their first year of care coordination, about 30% of families received at least 16 care coordination touchpoints, with 14% receiving over 25 touchpoints.[3] As shown in Exhibit 4, families tended to receive

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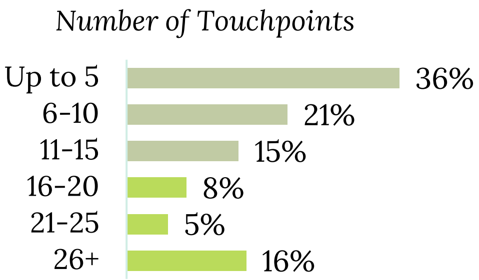
[3] A touchpoint is an individual service provided to a family, including contacts with families, referrals, and meetings between providers where families are discussed. The touchpoints are the sum of all touchpoints for a family, which could include separate touchpoints for a parent and child for the same service.

more touchpoints and services during the first 3 months of care coordination than at other points during their first year in care coordination.

Exhibit 4. Intensity of Care Coordination Touchpoints

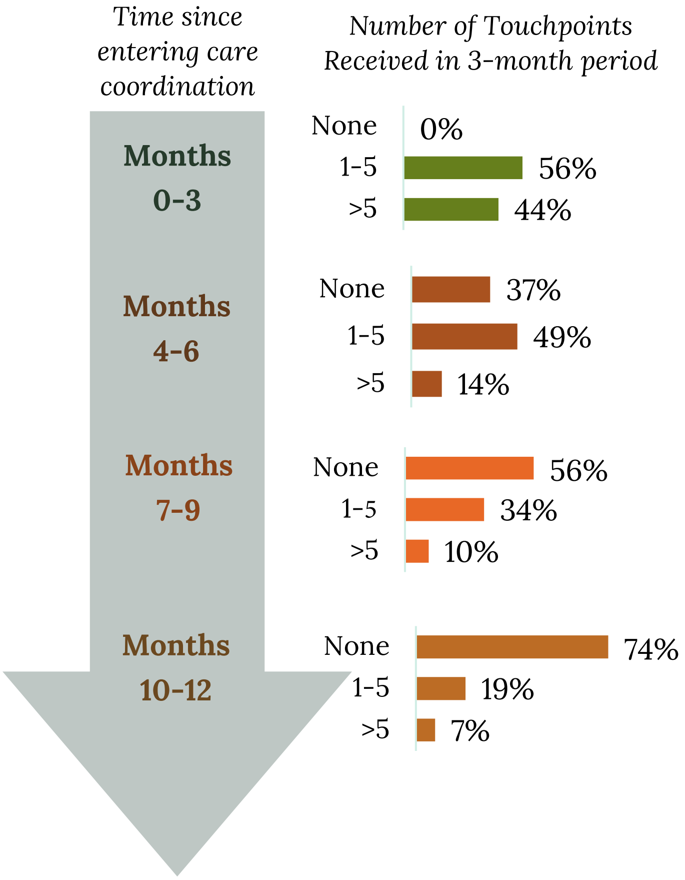
<u>30% of families received</u> <u>at least 16 touchpoints</u> in their first year in care coordination.



Families received a wide range of referrals:

- Individual and family therapy
- Speech therapy
- Behavioral and developmental specialists
- Peer advocate programs
- Parent education
- Rent relief
- Food vouchers
- GED and English language classes

Families tended to receive <u>more touchpoints in the first 3 months</u> of care coordination than at other points during their first year.



Care coordinators described how the support given to families is broad, in that they try to help families as needed – whether it be around housing, immigration support, or filling out CalFresh forms. Care coordinators helped parents fill out applications and understand how to access community resources. In some cases, they advocated for families to ensure they received the services for which they qualify.

To describe the intensity and broadness of the work, one care coordinator provided the story of a family with a young child in which an older sibling became involved with the Juvenile Probation Department. The care coordinator noticed that the parent and young child were being affected by the recent events involving the older sibling, as the parent was too overwhelmed to follow through with the services they were being referred to for their young child, who had notable changes in their behavior. Thus, the care coordinator's work expanded to support the entire family of this child. As the care coordinator reported:

> *"This became definite attention for the family. It was affecting the [young] kid… that we were serving. You could tell that the mother wasn't able to participate in the work that we were providing for them because of this tension. She didn't have a way to communicate with the system. The system was not responsive to her.* ***In this case, I remember very vividly our case manager walking or driving her…making an appointment, being her advocate, doing all of this work to try to get some resolve for the family so that we can re-engage [them].*** *It's not like I can say, 'Well, go to this other agency, they'll help you.' I don't have that resource.* ***The depth of the work, sometimes it's missed because we base it on count and volume****. And so, understanding what it took to get this family to a point where they could have peace of mind so that we could connect with them the way we want to connect with them and getting those barriers out of the way and resolved is so important."*

This example illustrates the intensive, broad, and tailored nature of the work. The case manager was focused on supporting the older sibling, helping the family navigate the Juvenile Probation Department, and driving the family to meetings, all in service of having the family get to a place where they could also provide support for their younger child. It demonstrates how care coordinators support families in ways that meet the needs of each family member and ensure families connect with resources.

Families connect to resources with support from care coordinators

Parents described struggling to access services prior to care coordination. For one, they were often unaware of the resources they qualified for and unsure of what services to seek when needing specialized attention for their children. A few parents who knew where to go, specifically for evaluations and assessments, expressed the difficulties they faced with trying to make an appointment and receive attention. They were often turned away from the organization, which claimed their child did not require an evaluation, or never managed to secure an appointment. Other parents struggled with language barriers that arose when attempting to navigate the medical system. Parents also expressed uncertainty when completing forms for services such as Medi-Cal.

Once parents began care coordination and were subsequently referred to service providers by their care coordinator, they spoke to the positive changes they saw in their interactions with referral sites. Two parents who previously had challenges with accessing therapy services on their own received immediate attention after being referred by their care coordinator. They described their experience by stating:

> *"Trying to get my four year old, on my own, into [a therapy service], I mean, a couple years went by and I never heard from them after the initial assessment. And then when [the care coordinator] sent the referral, it was immediate. So that comparison, again, it really helps having an advocate."*
>
> *"To get [my son] a therapist, before I had [the support of the care coordinator], I had tried so many times. He would be seen for just the first time, but then for follow-ups, they never really had appointments or they had them and then they would reschedule. So, with [the care coordinator] reaching out [to] the right person and getting me to the right therapist for him, it really made a big difference."*

Care coordinators also helped parents navigate conversations with medical providers who were reluctant to provide an evaluation. Specifically, parents reported receiving advice from care coordinators on how to advocate for their child and approach their doctor to request an evaluation. For example, two parents with concerns about their child's hearing and vision received support from their care coordinator to obtain a medical referral from their doctor for an ophthalmologist. Parents initially encountered pushback from their doctors, who did not deem the exam necessary despite the parents' concern. The parents were encouraged by their care coordinator to insist in their conversations with their pediatrician, which helped secure an exam for their children to receive appropriate care. They felt like they had taken the right step to advocate for their child, which alleviated parents' concern about the child's health. Parents in the focus group were appreciative of having care coordinators support them with navigating the healthcare system and medical situations, a sentiment that was especially felt among non-English speaking families.

In general, parents had more favorable interactions with service providers once they had the support and referral of a care coordinator. Even though families still often needed to wait to be seen by the service provider, they knew they could count on their care coordinator to be focused their family's experience.

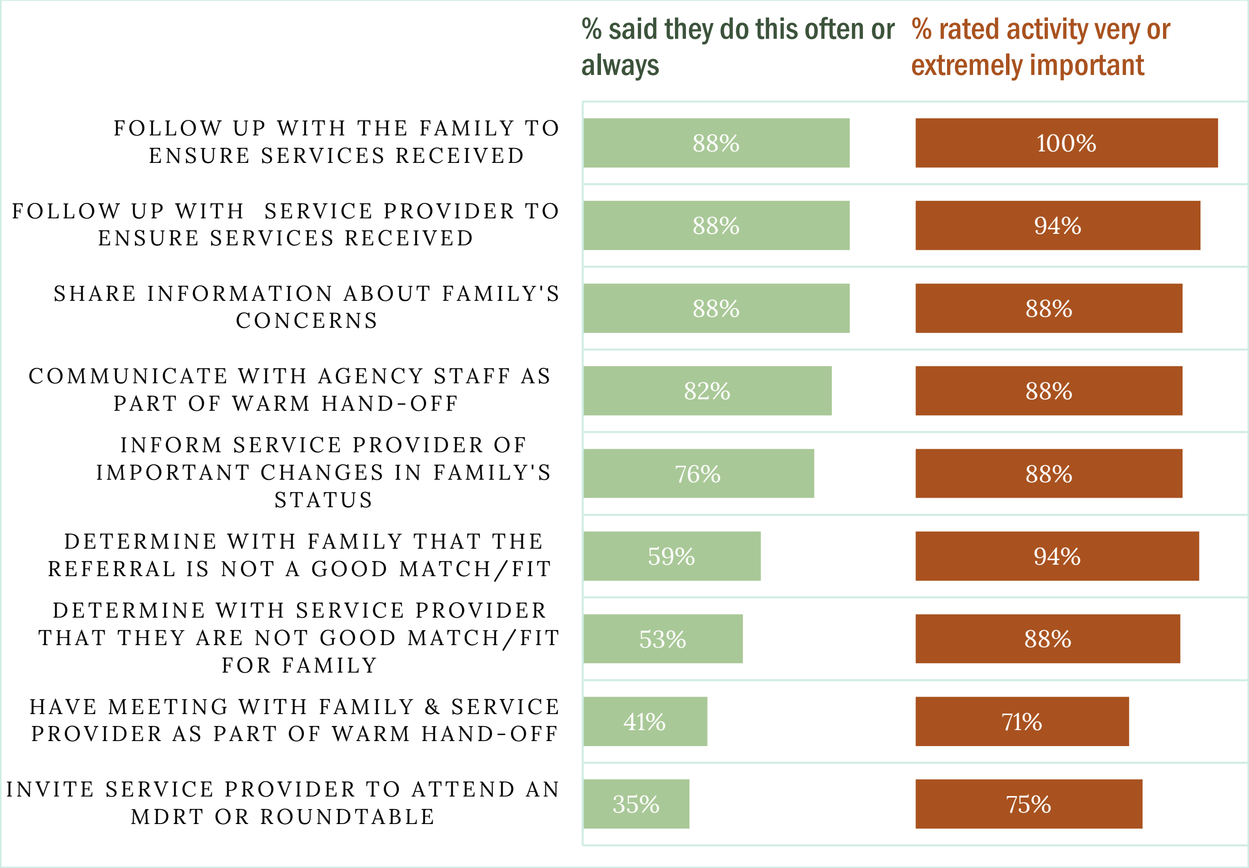
Care coordinators follow up to connect families with resources

During the referral process, care coordinators are intentional in their engagement with families and service providers to ensure families connect with services and supports. As one care coordinator described:

> *"There's a lot of connecting depending on...when a family is in crisis. There is...more being [done] with them. They need us to accompany [them] in some of these things...It's going to take much more of that warm hand-off to make that referral stick than to just give them a phone number to say, 'Here, go and call them.'"*

To understand the complexity of the referral process, in a survey, we asked care coordinators and administrators to rate how often they engaged in an activity during the referral process and then to rate how important that activity was to help a family connect to services. As seen in Exhibit 5, most (88%) care coordinators and administrators reported following up with families or service providers often or always during the referral process. Additionally, every care coordinator and administrator rated following up with families as very or extremely important to help families connect to services, and 94% reported following up with the service provider as very or extremely important. Notably, the activities with the highest frequency percentages – meaning 80% or more of the respondents engaged in these actions often or always – involved the care coordination staff communicating either with the family or the service provider, yet again demonstrating the relational importance of their role.

Exhibit 5. Importance and Frequency of Activities during the Referral Process (n=17)
(Care Coordinator/administrator assessment of how often they do the following activities and how important they are to supporting families)



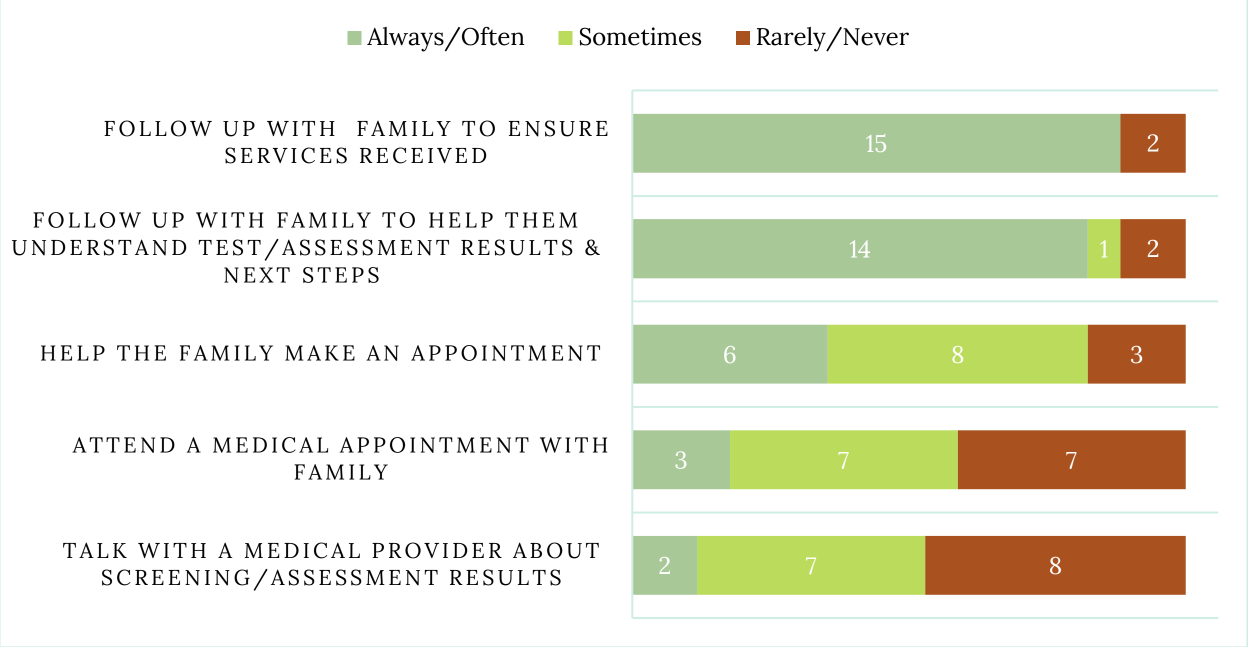
Interestingly, a few activities that were rated very or extremely important were reported to be done less frequently by care coordinators and administrators. For example, though respondents thought it was important to determine with the family or with the service provider that the referral site is not a good match (94% and 88%, respectively), only slightly more than half of respondents reported doing this often or always (59% and 53%, respectively). A potential explanation for this discrepancy could be that while care coordinators consider these actions as important, they only engage in conversations about match if the family or service provider initiate a conversation and raise a concern that they would like to discuss with the care coordinator. Alternatively, care coordinators could have interpreted this question to be about all types of referrals, including those to basic needs that do not require a conversation because all families can benefit from free basic needs.

Additional research with care coordinators could be useful in explaining these differences.

Given that we had heard some parents describe how critical care coordinators were in supporting their engagement with medical providers, we also asked care coordinators and administrators about the activities they engage in when referring a family to a medical provider (Exhibit 6). The majority of care coordinators and administrators reported following up with families "often" or "always" after having made a referral to a medical provider to ensure services were received. Respondents also reported that they sometimes help the family schedule medical appointments. A handful noted that they sometimes attend a medical appointment with the family or even talk to the medical provider about results. These varying answers may be dependent on language barriers, as care coordinators with non-English speaking families are more likely to provide interpretation throughout various steps in a medical referral process.

Exhibit 6. Frequency of Activities during the Medical Referral Process (n=17)

(Care coordinator/administrator assessment of how often they do the following activities)



Coordinators are intentional with their actions during the referral process because they are aware that their approach can streamline the process and better connect families to services. Even through all of the purposeful work that coordinators do, they and the families they serve still face challenges that can limit or negatively influence the referral experience.

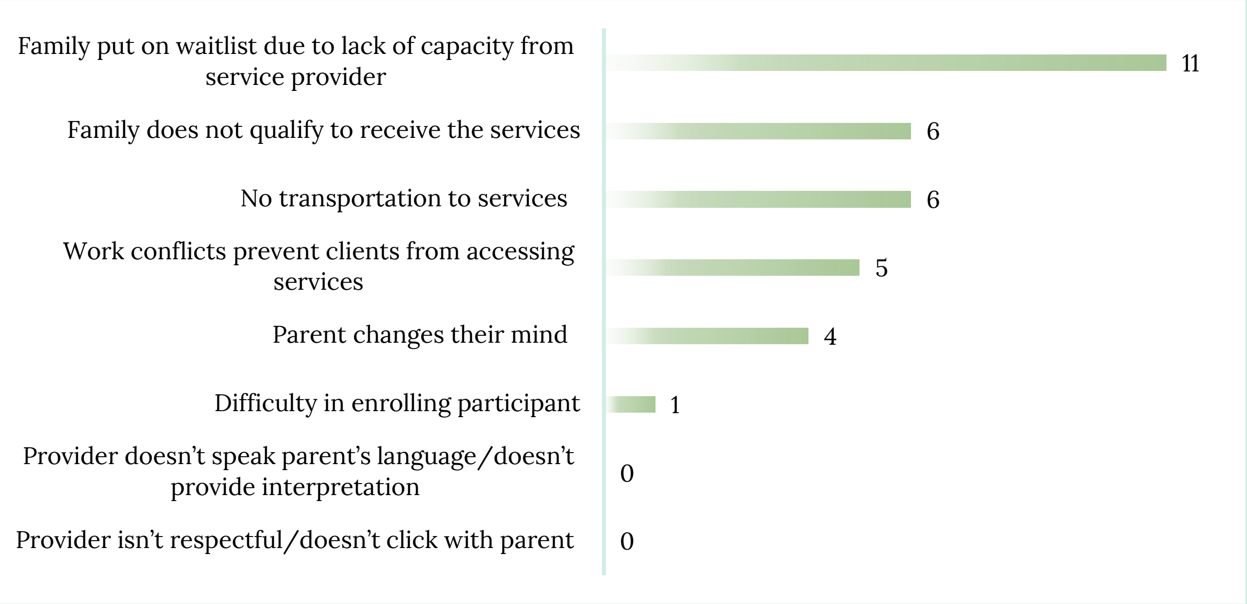
Finding #3: Families face structural barriers that impede their ability to access resources

Despite the relationship building and activities that care coordinators carry out to streamline the referral process, respondents described structural barriers that limit families' abilities to connect with services.

In the survey, care coordinators and administrators were asked to identify the top two challenges that prevent families from accessing and connecting to services in the county. Eleven out of seventeen respondents reported families being put on a waiting list due to a lack of capacity from the service provider as the most common barrier to families connecting to services (Exhibit 7). A family not qualifying for services, lacking transportation, or having a work conflict were also among the top barriers.

Exhibit 7. Top Two Challenges Preventing Families from Connecting to Services

(Care coordinator/administrator rating of top two challenges families face)



Below we elaborate on some of the challenges as discussed in focus groups.

Families end up on wait lists or deal with poorly organized referral sites

Despite noting an increase in referral sites, especially for behavioral and mental health and early language intervention, care coordinators still reported challenges with the lack of capacity at these sites. The capacity constraints at referral sites contributed to long waiting list experiences. While some parents were quickly seen by the referral site, others shared that they had a longer wait time particularly when it involved an evaluation or assessment for their child.

Beyond a longer wait time for referrals, families described delays in services caused by the poor organization and management of referral sites and organizations. One parent recalled their experience with a service provider that consistently called the wrong number in an attempt to reach the family, which continued even after the family provided the correct number on multiple occasions. Care coordinators also described challenges with the management of referral sites. One care coordinator shared their frustration about receiving delayed responses from referral partners and navigating staff turnover at referral sites, as they lose their point of contact. Another care coordinator spoke about outdated processes, such as having to send required paperwork for the referral process via fax instead of email, which made the process longer.

Families speaking indigenous languages need translation support

Care coordinators encounter language limitations when supporting families who speak languages other than English and Spanish. There are few coordinators who speak indigenous languages spoken in the community, such as Triqui, Mixteco, or Zapotec. Care coordinators who do not speak a family's native language have greater difficulty communicating, which affects the support they can provide. Additionally, the care coordinators who speak an indigenous language typically have a large caseload and limited capacity, which can also affect the support a family receives. This situation similarly carries over into referral sites that are unable to provide interpretation services to these families. Interestingly, however, in the survey, no care coordinator or administrator reported language barriers or lack of interpretation as one of the top two challenges.

In our focus group of Triqui families, they described barriers to accessing supports and services, especially for those families who do not speak English and know very limited Spanish. Triqui families shared that they often have difficulty scheduling time with the two care coordinators who speak Triqui. The parenting class activities that these care coordinators lead in Triqui quickly fill up, leaving families to attend Spanish language classes that they typically do not fully understand because of their limited Spanish. As one Triqui parent said,

> *"Sometimes [referral providers] try to communicate with their broken Spanish and it makes things difficult because I can't comprehend what they are trying to say. Sometimes we [try to communicate with basic] Spanish, and you get scold[ed for] saying 'yes' to something you don't even know."*

While a few care coordinators speak Triqui and often provide interpretation support for these families, parents felt these care coordinators face capacity constraints that prevent them from supporting all families in need of their language services and interpretation. While we did not hold focus groups with families who speak other indigenous languages, we would anticipate similar challenges regarding translation support for these families as well.

"We really need interpreters that speak Triqui. I have seen people that are provided Spanish interpretation but some of them don't understand Spanish. People need to have interpreters that can speak their own language. I have seen that people struggle when it comes to language, and having a Spanish interpreter is not enough." -Triqui Parent

Families struggled to navigate conversations with their child's medical provider

As noted earlier, on occasion, a child's physician would refuse to evaluate the child upon the parent's request (or provide a referral for a child to be evaluated). This was another challenge that families discussed in focus groups. Parents said that their concerns for their child's health and development were often questioned or dismissed by their pediatrician, which left them feeling uneasy. Parents truly appreciated having the support of their care coordinator, who listened fully to their concerns and talked with them about the best course of action to take. This often involved encouraging the parent to revisit the topic and conversation with their child's doctor and further advocate for the evaluation. Despite these challenges, families and care coordinators communicate closely to identify the best way to mitigate and overcome these obstacles, to ensure families receive the support they need.

Families reflect on how care coordination and Collaboratives can be improved

While families were overall content with care coordination services and resources provided to them and their children, during the focus groups, they were asked to provide recommendations on how coordination can be improved. While some suggestions are directly connected to care coordination, others are more specific to the additional services and resources they receive from the Collaborative. All suggestions, however, are based on their lived experience. While the number of focus groups that discussed a certain suggestion(s) is specified, it is important to remember that this was an open-ended question where parents spoke about what was most relevant to them in that moment, often based on their positionality and identities. As such, we cannot rank which is more or less important but offer them here as opportunities for reflection for F5MC and the Collaboratives.

1. **Families want care coordinators to provide the same information regarding immediate relief resources to all parents, particularly across different centers throughout the county.** Across two focus groups, some parents shared that their care coordinator informed them about locations where they could obtain free basic needs resources such as food, diapers, and baby wipes and apply for rent-relief. Other parents in those same focus groups were surprised to learn about these resources because their care coordinator had not informed them.[4] Parents were disappointed to learn that not all families were being provided with the same information. They felt that it was important to inform all families about the same support and resources, especially ones that all families can benefit from, regardless of the region they are in or the care coordinator managing their case. Moving forward,

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[4] Focus groups were held by each Collaborative. Therefore, parents would have participated in a focus group with only parents supported by that same Collaborative.

they suggest providing the same information to all families to avoid feelings of exclusion, which can affect how families come to view their coordinators.

2. **Families would like the virtual parent-child classes provided within the Collaboratives to be more engaging and interactive to foster the creation of community among one another.** When classes shifted to virtual settings because of the pandemic, parents in three focus groups felt that the activities they were supposed to do with their children were less engaging and fun compared to previous in-person classes. Part of this was due to parents' minimal interactions, as most participants had their camera off during class. Parents felt that facilitators could establish and encourage virtual classroom guidelines that help families interact with one another during classes held via Zoom. They also felt like it was helpful to see other parents apply the class lessons with their children. Establishing this community can help parents share best practices, tips, and resources with one another, especially since many face similar situations and challenges. One parent articulated this need for connection, "I'm always for peer groups, like people that are in the same situations are accessing the same services coming together and bouncing ideas off of each other or just sharing."
3. **Families want to better understand how care coordinators and other organizations and entities communicate with one another.** For example, parents connected to probation services wanted to know whether care coordinators and probation officers speak and, if so, how often these conversations take place, as this likely influences the services and support that families are referred to (from the case coordinator and the probation officer). Based on their lived experience, parents felt as though care coordinators can engage more frequently in conversation with other organizations. Interestingly, this differs from care coordinators, who described sharing information about families across referral sites. Parents also shared that they would like care coordinators to better inform parents of the collective effort to build their care plan.

> *"The same with all organizations in Monterey County that all share the same clients. How much do they really talk? Because I feel like so much more could be done for a person if all of the places they receive services talked to each other." - Parent*

4. **Parents want care coordination centers to receive additional funding to increase the reach and frequency of the services they already provide to Monterey County families.** Across four focus groups, parents agreed that providing more funding to Collaboratives and staff could result in more support that ultimately reaches and benefits families. With this additional funding, parents would like care coordinators to have smaller caseloads and thus provide families with more frequent and immediate support. They would also like additional educators who can lead parent/child classes, so more families can participate in the courses that currently reach enrollment capacity. They hope this funding can also extend the duration of home visits, which currently feel rushed and dispersed, as well as extend the operating hours across centers to accommodate for different schedules.
5. **Triqui families wanted more care coordinators who speak their language and additional interpretation services beyond Spanish.** As noted in the prior section, in the focus group with Triqui families, they discussed challenges in accessing supports and services because of the limited number of Triqui interpreters in the community. They also mentioned that having Spanish interpreters was often not enough language support.
6. **Families want care coordinators to inform them about and connect them with English language learning courses.** While families appreciated when care coordinators serve as interpreters during appointments, those from one focus group wanted to gain fluency in English to understand and communicate directly with providers, in order to best advocate for their children and themselves.

"I feel like we need more services such as helping those that want to learn English. I want to learn so that I can understand what providers are trying to tell me. The reason why I really want to learn English is because I don't to miss out anything they are telling me." -Parent

Outcome 2: Higher Levels of Quality

As part of F5MC support to Collaboratives, care coordinators and administrators receive multiple opportunities for professional development, networking, and shared learning to support quality services. F5MC convenes a Care Coordinator Learning Group, which meets several times a year to co-develop a shared understanding of best practices for offering strength-based, culturally responsive services to families. Collaborative staff also have had opportunities to be trained in the Facilitating Attuned Interactions (FAN)[5] and the Circle of Security[6] approaches to working with families.

Care coordinators reported receiving support from each other through Care Coordinator Learning Groups held six times a year and the Circle of Security learning group, both of which offer opportunities to discuss challenges and share promising solutions. [7] This support was especially helpful in the early months of the pandemic while they were trying to shift to working from home.

In addition to the learning group, many care coordinators connect with and learn from other early childhood development providers through F5MC's Infant-Family Early Childhood Mental Health (IFECMH) training series. IFECHM trainings bring providers from diverse ECD fields together and has allowed ECD professionals to learn various disciplines, bringing, in the words of one Collaborative administrator, a "multidisciplinary approach that has really benefited the work" and "trickles down to the families and their children in the county." Outcomes related to the IFECMH trainings have been extensively described in previous evaluation reports.[8] These

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[5] To learn more about FAN see https://www.erikson.edu/professional-development/facilitating-attuned-interactions/

[6] To learn more about Circle of Security see https://www.circleofsecurityinternational.com/circle-of-security-model/what-is-the-circle-of-security/

[7] All care coordinators are invited to attend the monthly learning group. Attendance is voluntary and not everyone attends all sessions. During the focus groups, three coordinators described opportunities to discuss with their peers in the Circle of Security learning group.

[8] See Tirado-Strayer, N. & Mathur-Kalluri, Monica. (2019). *Foundation of Infant-Family and Early Childhood Mental Health Training Program: Year 7*. San Francisco: WestEd.

Harkins, D.M. & Miller, J. (2016). *Foundations of Infant-Family and Early Childhood Mental Health Training Program: Year 4*. West Ed Center for Prevention & Early Intervention Retrieved from https://www.first5monterey.org/download/library/2015-2016-reports-and-publications/foundations-of-infant-family-and-early-childhood-mental-health-training-program-year-4-54.pdf studies have found that the program improved participants' foundational skills and knowledge and supported the sharing of new information, resources, and referrals among participants as well as with families served.

This section of the report describes how trainings supported care coordinators and administrators' ability to be attuned with families, as well as their reflections on how helpful F5MC supports were. We also provide recommendations from participants on the trainings.

Finding #1: Trainings promoted greater attunement with families

Care coordinators and Collaborative administrators consistently praised F5MC trainings as promoting mindfulness, reflection, empathy, and careful listening, as demonstrated below in this quote by a Collaborative administrator:

> *"With the mental health training, with the FAN training, and now the Circle of Security training, we're really getting that reflective practice piece. I don't get to see the day-to-day interactions with families, but I see the growth in all of our team members and how they're using reflective practice for themselves and for their own growth in their work."*

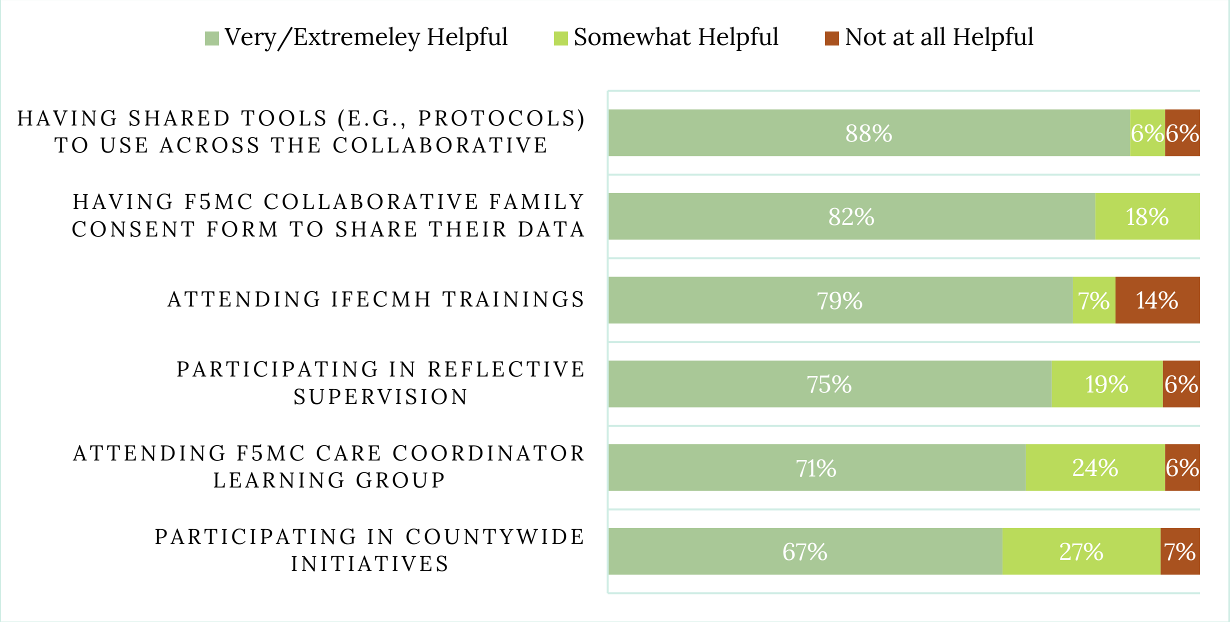
These practices allow care coordinators to have greater attunement with families. The FAN training was described as a helpful tool in encouraging providers to slow down and really listen to their families to build stronger relationships. For example, one respondent shared that in the last year or so, her agency has learned to slow down, focus on self-care, and incorporate reflective practices in their work, adding that she feels like "that's been a really huge impact on the way [her agency] has grounded itself to be able to serve [their] families."

Care coordinators expressed that F5MC trainings not only gave them knowledge and skills, but they also supported their own mental health which has allowed them to serve families more effectively.

> *"I try to attend everything that First 5 provides, and they've been a huge help especially this last year during the pandemic because it was a rollercoaster shifting, working from home. My sanity, I owe it to First 5 for providing all the resources for us, for ourselves and obviously to better support the families that we serve."*
> *-Care Coordinator*

Responses to our care coordinator survey further indicates that F5MC trainings support higher quality services, with most care coordinators and administrators indicating that each opportunity offered by F5MC was very helpful or extremely helpful in their role (Exhibit 8). Notably, although the care coordinators and administrators in our focus groups discussed the importance of reflective practice at length, a few care coordinators indicated on our survey that they had either not engaged in or were unaware of reflective supervision, countywide initiatives, or IFECMH trainings. The countywide initiatives were generally perceived as less helpful, and at least one supervisor rated almost all of the activities as not helpful. Other resources that have been helpful include trainings with the County Office of Education and the California Department of Education.

Exhibit 8. Perceived Helpfulness of F5MC-Funded Trainings and Activities
(Care coordinator/administrator assessments of how helpful activities are for their role)



Care coordinators and administrators reflect on how trainings can be improved

Overall, focus group participants expressed a great deal of respect for F5MC staff and the supports they have provided. Collaborative administrators agreed that F5MC staff seeks and responds to constructive feedback. F5MC has also been very responsive to the training needs identified by agencies. Two primary suggestions to enhance F5MC trainings surfaced during the focus groups, we offer them here as reflections for F5MC.

1. **An administrator suggested that F5MC regularly offer some of the foundational trainings that are core to how F5MC operates, such as the FAN strategy, for new staff.** It was noted that trainings sometimes backtrack when trainers spend time reviewing these concepts for new staff who have not received these foundational trainings that are core to how F5MC operates, such as the FAN strategy.
2. **Four respondents suggested that F5MC draw on more diverse trainers or fund the development of tools grounded in the unique communities served by the Collaboratives.** A couple of respondents also reflected that most of the trainings draw on a dominant white research framework that can feel disconnected from indigenous cultures. Similarly, four respondents found it difficult to take the concepts and translate them into a form that resonates with and is accessible to indigenous families that think about childhood and the role of parents differently. When bringing the child development principles that they have learned to families, these care coordinators sought a way to build on the cultural assets that indigenous families bring instead of challenging their cultural values and practices around raising children.

Outcome 3: Increased Alignment in ECD Systems

F5MC recognizes that a strong, effective, and resilient system of care is important to best serve children and their families. As such, one of their impact areas are integrated systems in which "the early childhood development system is comprehensive, cohesive, and navigable" (p9).[9] Specifically, F5MC strives to encourage more frequent, structured, effective communication among practitioners and promote greater alignment of strategies for change among organizations. Below we delve into how the care coordination model supports integrated systems.

Finding #1: The Collaborative approach and F5MC capacity building activities support improved communication

Focus group respondents identified two F5MC structures that encourage more frequent, structured, and effective communication within the ECD field in Monterey County. First, the Collaborative approach encourages partner agencies to communicate regularly, coordinate services, and draw on each other's strengths. Second, the Care Coordinator Learning Group and other capacity building trainings provide opportunities for ECD professionals from across the county to know one another and share best practices, ideas, and resources.

Focus group responses suggest that the Collaborative approach and the activities of care coordination have increased communication within participating agencies. Collaborative administrators praised the Collaborative approach for encouraging agencies with similar goals to collaborate instead of competing. Further, because F5MC brings care coordinators together in a learning group as well as through other capacity building trainings, care coordinators consistently reported feeling comfortable reaching out to each other if they are interested in a service that they provide or if a client moves to a different part of the county.

Care coordinators also discussed having open lines of communication with agencies they refer families to. For example, care coordinators shared that their partners communicate with them when they are unable to reach families so that

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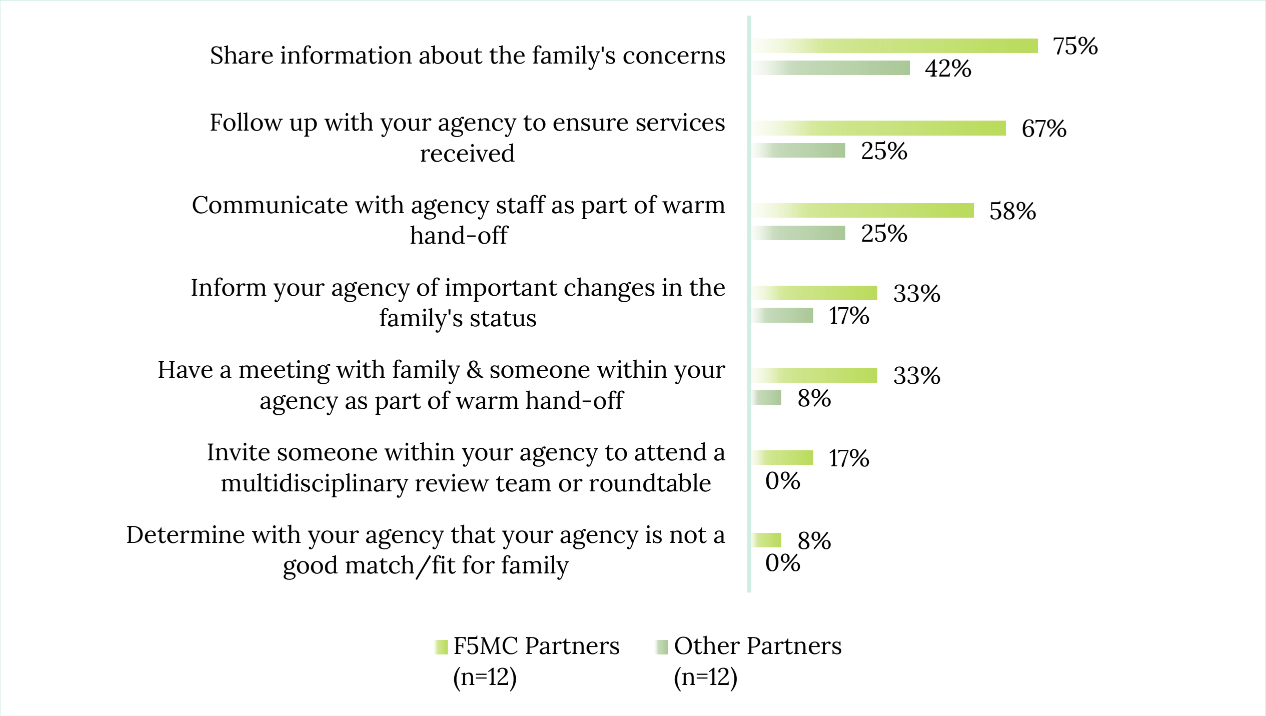
[9] Hamai, Tamara. (2018). *First 5 Monterey County Monitoring, Evaluation, Accountability, and Learning* (MEAL) *for Strategic Plan 2017-23*.

the care coordinator can follow up. As one explained, "there has been good open communication trying to help and find some resources to be able to support and help families."

Survey results further provide evidence of frequent communication across organizations. As mentioned above, care coordinators and administrators indicated on our survey how frequently they communicate with other practitioners during the referral process. The results (displayed in Exhibit 5) indicate that most respondents (88%) always or often follow up with service providers to ensure families receive the services and share information with service providers about the family's concerns when making a referral. In addition, about three quarters (76%) always or often inform service providers when a client's status changes after a referral is made.

Service providers, that were identified as frequent referral partners by care coordinators, also were surveyed to gather their perspective on communication with Collaboratives. These service providers reported that F5MC-funded Collaboratives communicate more during the referral process than other referral partners. For example, as shown in Exhibit 9, service providers that were sampled reported that F5MC Collaboratives were more likely to "always" or "often" share information about the concerns of the family they have referred, communicate with someone at the partner agency during a referral as part of a warm hand-off, and follow up to ensure families receive services, compared to their other partners.

Exhibit 9. Collaboratives Communicate More During Referral Process than Other Partners *(Percent of Service Providers[10] Reporting that Collaboratives Agencies Always or Often Do the Following, Compared to Other Partners)*



Although care coordinators and administrators indicated that F5MC's Collaborative approach and care coordination services play a role in encouraging communication among funded partners, the influence of F5MC in helping Collaborative agencies connect with partners not directly funded by F5MC is less clear. On the one hand, F5MC-funded agencies seem to be communicating more with their referral partners than other agencies. However, it was not clear in focus groups with care coordinators if communication and interaction with non-funded direct service providers had increased significantly over the previous five years.

Finding #2: The Collaboratives share an alignment of strategies for change

While each Collaborative has their own strengths, challenges, and methods that are tailored to their particular client population, care coordinators agreed that the F5MC-funded Collaboratives share a general foundation of empathy in how they

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[10] Service providers include the organizations that Collaboratives identified as their most important referral partners.

work with clients. Moreover, according to care coordinators in our focus groups, they also share common practices, such as reflective practice and the FAN strategy, that shape how they work with families in fundamental ways and how they support their staff. For example, care coordinators agreed that providers within F5MC Collaboratives focus first on stabilizing families and building a relationship before jumping into referrals and developmental assessments.

> *"One of the things that I really appreciate about this work through First 5 has been the incorporation of reflective practice, reflective supervision, and bringing that in to having a shared understanding and a shared model, a practice of slowing down, of really being intentional and thoughtful about our work."*
> *– Collaborative Administrator*

The care coordinator approach also ensures that Collaboratives are operating in a similar, integrated way where they draw on the strengths of other agency partners. As one Collaborative administrator shared, "It's been amazing and beautiful to see the team approach [of care coordination.] We all have different organizational pressures, but when it comes to this program, we're all operating in a clear, unified way." Another administrator reflected that the care coordination approach has encouraged agencies to "think outside of what [they] traditionally thought [early childhood education] was…and are now taking on housing, immigration, legal rights, and domestic violence."

On the other hand, care coordinators reported that other practitioners in the field do not always share the same approach, as demonstrated in the quote below:

> *"All of us under the First 5 umbrella are on the same page…We work from our heart where we offer empathetic, sympathetic approach, where we care about our clients and we want to assist. As far as other county agencies that are not a part of First 5, I don't really see often that they're sensitive to our families' needs. I hear that from the clients when they express, 'Oh, they treated me much different than the relationship that I have with you.'"*

This divergence between the approach of the Collaborative and the approach of other service providers poses a particular challenge to care coordinators working with and supporting indigenous families, who shared that most service providers do not have the cultural knowledge to support their clients. This feedback from Collaborative members suggests that the county may benefit from a wider adoption of the practices that F5MC promotes.

Summary and Conclusion

Input from families, care coordinators, and Collaborative administrators demonstrates the ways that F5MC's care coordination services have helped families access appropriate services to support the wellbeing of young children. As this report demonstrates, parents and caregivers reported that care coordinators develop trusting relationships with families, connect families to appropriate service providers, and provide follow-through to ensure that families can access their service referrals.

This report also concludes that cross-agency capacity building opportunities offered in conjunction with care coordination services, along with the Collaborative approach adopted by F5MC, supports attuned interactions between providers and families, stronger communication and partnership between Collaboratives, and common practices in how providers work with clients, such as prioritizing stabilizing families and supporting the whole family.

At the same time, structural barriers, such as long waiting lists for certain services, or poor management by service providers, still impede access to resources for some families. Moreover, both care coordinators and families reported that services are not always accessible or culturally appropriate for families speaking indigenous languages. Considering the findings in this report, we conclude with the following suggestions and considerations:

1) Periodically repeating foundational trainings for new staff;
2) Partnering with members of indigenous communities to adapt trainings to better reflect indigenous cultures;
3) Expanding access to translation services and English Language courses; and
4) Strengthening relationships and alignment of practices with service providers outside of the Collaboratives.

As demonstrated in this report, F5MC's care coordination approach supports many of the goals identified in its FY2017-2022 strategic plan, particularly, coordination of supports for families; with families appreciating the support they received that connected them to services and resources.

Appendices

Appendix A. Care Coordination Services

Specific care coordination services a family may receive are detailed below:

- **Screenings—**Each Collaborative implements outreach and screening activities for families with young children using appropriate screenings, such as the Ages and Stage Questionnaire (ASQ-3 and ASQ-SE2) for children and the Patient Health Questionnaire (PHQ) and the Edinburgh Postnatal Depression Scale (EPDS) for parents. All families receive follow-up information about the results of the screening. Collaborative screeners also ask questions to understand the family context and needs as part of the screening process. Screening or developmental assessment information may also be shared with the Collaborative directly from a community partner.
- **Triage** – Screening and/or assessment information is reviewed by the Collaborative team. Families may then be referred to specific services and resources or they may be assigned to more intensive care coordination services. A family's information may also receive more in-depth review through a Multidisciplinary Review Team or Roundtable (see below).
- **Shared Care Planning** – Care coordinators meet with the family to co-develop a shared care plan that is aligned with the family's identification of their most pressing needs, goals and activities. The plan includes appropriate resources and referrals, a realistic timeline for check-ins, and goals and milestones established by the family.
- **Multidisciplinary Review Team (MDRT)** – A team comprised of the care coordinator(s), a professional with expertise in early childhood development, a professional in early childhood mental health, and when possible, a professional with pediatric medical expertise, meets regularly to discuss the most complex family cases. Care coordinators follow up on the MDRT's recommendations for each family.
- **Roundtables** – A meeting focused on the needs of one family and is comprised of representatives of other agencies supporting the family. This may include a teacher, service provider, or representative from the regional center or special education. The meetings also may include the parent or

other family representative. This supports cohesive and consistent work among service providers.

- **Referrals and Referral Follow-up** –Care coordinators connect families to the most appropriate services and resources. Referrals for holistic family supports may include those that will meet basic needs (e.g., employment support; the Women, Infants and Children's nutrition program (WIC); and housing assistance) as well as referrals to specific services (e.g., mental health counseling, full developmental assessments for children, and early childhood care and education).

Collectively, these services and activities aim to provide a series of holistic supports to families and young children tailored to their needs. Critical to the work is not only appropriate screenings and coherent service referrals, but ensuring families are consistently connected with services – making it easier for families to navigate the service system.

To understand family experiences in care coordination, we analyzed the services received by families who entered care coordination between July 1, 2019 through June 30, 2020.[11] Persimmony records indicate the first data entry point by Collaboratives for 90% of families receiving care coordination was a screening, triage, or care coordination touchpoint.[12] The recorded touchpoint for the remaining ten percent of families were parent-child playgroups, home visiting services, and/or parent engagement/education services with their Collaborative.

As shown on the following page, most families had data touchpoints for a shared care planning meeting while only 12% had a touchpoint for a roundtable meeting. While in care coordination, 88% of families received at least one screening touchpoint that was recorded by the Collaborative.[13] Although all families in care coordination should have went through triage, 60% of families had a triage

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[11] The analysis includes 210 families whose first care coordination touchpoint, including assessments, triage, referrals, shared care planning, roundtable, or MDRT touchpoints, occurred between 7/1/2019 and 6/30/2020. Therefore, all families in this analysis had at least one year to participate in care coordination.

[12] A touchpoint refers to a recorded service in Persimmony.

[13] Screenings or full assessments conducted by an organization that referred the family are shared with the care coordination team but are not entered into Persimmony and may explain why not all families are recorded as having received a screening.

touchpoint recorded in Persimmony. About two-thirds of families received a referral to an outside service/agency by their care coordinator.

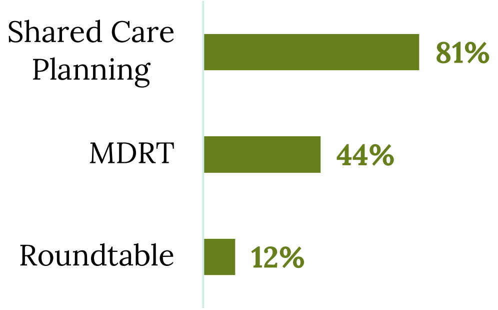
Exhibit 10. Persimmony Touchpoints Recorded for Families in Care Coordination

88% of families received at least one **screening**.

60% of families went through **triage**.

66% of families were **referred to community services and resources**.

Families were more likely to participate in shared care planning than MDRT or roundtable meetings.



Appendix B. Methodology

Instrument Development

Focus group protocol development

F5MC was interested in learning about the benefits of care coordination for families and the alignment of early childhood professionals in the county. To investigate this, we conducted focus groups with care coordinators, Collaborative administrators, and families to gather their experiences with care coordination, connecting with resources in the community, and exploring how families with young children can be better supported through care coordination. More specifically, care coordinators and Collaborative administrators were asked about their interactions with families when coordinating services, their experience with professional development opportunities, their perception of interactions among ECD professionals in the county, and their reflections on the alignment of best practices and approaches for serving families in the county. Meanwhile, families were asked about their experience with care coordination, their interactions with their care coordinators, the impact of these services and support on their family, and their understanding of F5MC's mission and work.

The focus group protocols were developed in summer 2021 with feedback obtained from F5MC staff (see Appendix C for a copy of the protocols). Protocol development included several rounds of iteration and refinement to ensure the protocol would properly address the research questions, outcomes, and relevant indicators. F5MC staff translated both protocols to Spanish to offer future participants an opportunity to discuss these questions in their preferred language. In addition, F5MC worked with a consultant to translate the parent focus group into Triqui.

Survey instrument development

The survey component of this evaluation was designed to unpack if systems are better aligned in ECD by exploring if Collaboratives and partners engage in more frequent, structured, and effective communication. To explore systems alignment, care coordinators, Collaborative administrators, and other partner agencies were asked questions about the practices of care coordinators. These partner agencies included service providers and agencies that had existing Memorandum of

Understanding (MOUs)[14] with the Collaboratives to ease sharing of family data, as well as service providers identified by care coordinators as frequently referred to families.

The survey asked care coordinators and administrators about their experience working with other service providers as part of the referral process (see Appendix D for the survey instruments). Meanwhile, partner agencies were asked about their experience working with F5MC funded partners and other agencies that refer families. The survey complements the data that was collected through focus groups with care coordinators and administrators.

The survey instrument was developed in fall 2021 after the qualitative data collection ended, which also informed the development of items. Similar to the qualitative data protocols, survey development included several rounds of iteration and refinement with F5MC to ensure it addressed research questions and relevant indicators. It also included making slight modifications to the survey questions and answers that were most appropriate for each group being surveyed. F5MC helped translate the survey into Spanish to ensure potential respondents completed the survey in the language they felt most comfortable with.

Sample

Focus group sample

All care coordinators and Collaborative administrators were invited to participate in the focus groups. There was a total of two focus groups with care coordinators, one in English and one in Spanish, and one focus group with Collaborative administrators in English, all of which were facilitated by SPR staff. A total of six care coordinators and six Collaborative administrators attended focus groups.

Similarly, F5MC was interested in including many family perspectives from across the county. Using administrative data from Persimmony, parents were identified who had participated in care coordination over the past year. The SPR research team randomly sampled parents from the identified parents and care coordinators

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[14] Collaborative agencies are required to join the F5MC MOU among diverse service agencies and use the related family consent process to support communication as well as appropriate confidentiality among referral partners. Comprehensive information about a family's strengths and needs is carefully developed and coordinated through this process of sharing multiple perspectives.

then reached out to sampled families to invite them to participate in a focus group. A total of 26 parents from across the county participated across eight focus groups.

The number of parent participants per focus group varied from two to eight. Five of the eight focus groups were conducted in Spanish, two in English, and one in Triqui. F5MC identified a consultant who translated the focus group protocol into Triqui, led the focus group in Triqui, and provided a translated summary of the conversation. The remaining seven focus groups were conducted by SPR staff.

Given COVID-19, all focus groups were conducted virtually on Zoom. Focus groups were between 45 to 60 minutes and conducted at times convenient to participants. Participants received a $20 electronic gift card after the focus groups, which was sent to their email address, in appreciation of their participation. A select number of parents preferred to receive a physical gift card, which was sent to an address that they provided SPR staff at the end of the focus group.

Survey sample

All care coordinators and Collaborative administrators were invited to complete the survey. F5MC first reached out to care coordinators and administrators via email to inform them of SPR's upcoming outreach. The survey was then administered between November 2021 and January 2022 using an email campaign through Alchemer. Each participant received a unique survey link. To increase response rates, several reminders were sent to non-respondents with the most receiving 6 reminders throughout this timeframe. Twelve of the 13 care coordinators completed the survey (92% response rate), while 5 out of 6 administrators completed the survey (83% response rate).

As noted above, SPR surveyed F5MC partners, which included staff from MOU and non-MOU organizations that were nominated by care coordinators or identified by F5MC. Similar to care coordinators, F5MC reached out to partners via email to inform them of SPR's upcoming outreach. An initial group of 14 partners received the survey in December 2021 using an email campaign through Alchemer. Each participant received a unique survey link. A few weeks after the initial launch date, F5MC asked SPR to send the survey to an additional three partners, who received the survey in January 2022. The survey closed for all individuals in early February 2022. Fourteen of the 17 total participants completed the survey for an 83% response rate.

Analysis

Qualitative data

Qualitative data analysis was informed by grounded theory.[15] The focus groups were recorded and transcribed. We used an iterative process for analysis of the data. We began by coding each focus group by question in the protocol, as each question represented different areas of interest we wanted to capture. We summarized recurring patterns and themes across focus groups. We then shared emerging findings with F5MC staff, the Evaluation Advisory Committee (EAC), and care coordinators.

This iterative engagement with the data informed the synthesis of emerging findings presented here by supporting interpretation of the findings, highlighting areas for clarity, providing opportunities to have findings interrogated externally from the SPR analysts, and ensuring that the findings are relevant and reasonable. While replicability of qualitative analysis is not feasible or appropriate, we recognize the importance of ensuring our findings are transparent and trustworthy. [16] As such, we share quotes throughout the report to both illuminate key findings and to present evidence of our findings. As with all our quotes, we only include those that allow us to protect confidentiality of respondents. We also provide additional quotes in Appendix E to further illustrate our findings.

Survey data

The survey data was downloaded from the survey platform (Alchemer). SPR imported the data into Stata, where staff ran initial frequencies for each survey question. SPR used those frequencies to create visuals in Excel and report the data findings for each group. Given the relatively small sample sizes, care coordinator and administrator responses were combined for the purposes of analysis and interpretation. A breakdown of the data for each specific group can be found in Appendix F.

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[15] Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

[16] Pratt, M.G., Kaplan, S., & Whittington, R. (2020). The tumult over transparency: Decoupling transparency from replication in establishing trustworthy qualitative research. *Administrative Science Quarterly*, (65)1, 1-19.

Administrative Program Data

This report drew on administrative program data entered in Persimmony, the databased used by care coordinators to record client demographics, intake information, and services. We used these records to understand the demographics of families participating in care coordination, learn about the services they received and how they flowed through those services. Specifically, this analysis drew on the following data exports from Persimmony:

- Clients—includes client identifiers, demographic information, and intake data for clients and ECE providers served by F5MC since FY2008-2009.
- Services—includes client identifiers and a record for each service a client participated in with a F5MC Collaborative. This includes the type of service received, the date of the service, and the amount of time spent in the service. We exported service data from July 1, 2017 through June 30, 2022. This does not include services provided by partner organizations and referral agencies.
- Assessments—includes client identifiers, the type of assessment conducted, and the date of the assessment.

To create our analysis file, we began by:

1) **Merging** the client demographic data, the services data, and the assessment
2) **Replacing** F5MC client and family identifiers with study IDs and dropping personally-identifying information, such as dates of birth, from the analysis file.
3) **Creating** family-level dummy variables for each service below to indicate if anyone in the family had received that service:
    - Care Coordination – Multidisciplinary Care
    - Care Coordination – Roundtables
    - Care Coordination – Shared Care Planning

Since care coordination is focused on the supports provided to a family, we wanted to focus the unit of analysis on the family unit. As such, we created a file with the following family-level variables that would provide information on the services received by the family:

- Number of touchpoints per family
- First day of service within family

- Last day of service within family
- First type of service family received during analysis period
- Date of first care coordination service for anyone in the family
- Number of touchpoints for anyone in the family within the first year after entering care coordination, within the first three months after entering care coordination, and within the following periods: four to six months after entering care coordination, seven to nine months after entering care coordination, and ten two twelve months after entering care coordination

We were also interested in learning more about family demographics. Specifically, we wanted to create a series of demographic variables about the families: highest level of parental education, ethnicity, insurance access, and special needs status. To develop, family level demographic data we did the following:

- Highest level of parental education—we chose the highest level of education identified by any parent in the family
- Ethnicity—we created a "multiracial household" category if members of a family selected different ethnicities
- Insurance—we used the child's insurance
- Special needs—defined as yes if any child in the family was identified as having special needs

We then dropped individual-level variables to end up with a data file with one record per family.

After taking these steps, we ended up with 4,134 families who were served F5MC Collaboratives between July 1, 2017, when the program first started and the current strategic plan was implemented, through June 30, 2021; for four fiscal years. We created a variable that identified families who received care coordination. In discussions with F5MC, we defined a family of having been in care coordination if they received any of the following touchpoints: an MDRT meeting, a shared care planning meeting, or a roundtable discussion. We dropped client records for the other families, leaving 909 families that participated in care coordination during that time. We used this group of 909 families when presenting the demographics of families.

Because care coordination service data was entered differently in the first two years of the program (FY2017-2018 and FY2018-2019), we excluded families who started receiving services during that time in the analytic sample we used to investigate the services families received. We further limited this analysis to families who had participated in care coordination for at least a full year during the analysis period by dropping families who entered care coordination after July 1, 2020. Ultimately, the analysis on services received included 202 families who had entered care coordination between July 1, 2019 through June 30, 2020.

Limitations of this study

Although this report provides detailed information from the perspective of families and care coordinators, limitations of the Persimmony data restricted our ability to understand how all families flowed through care coordination services. These limitations include the inability to comprehensively track referrals in the database; inconsistency in how care coordinators tracked certain services, such as triage meetings; and the fact that services performed by partners, such as screenings, are not always entered into Persimmony. Therefore, while we are able to capture the voices of care coordinators who describe supporting families as they navigate referrals, and of families who say they connect with services, we do not have administrative data to further support (or refute) these claims.

Another limitation deals with the relatively small survey sample sizes. Even though we sampled all care coordinators and Collaborative administrators, they represent a small population, similar to the partner survey respondents. Additionally, our analysis compares how each group responded to the frequency and importance of certain activities, but due to the small sample size we are unable to conduct additional statistical analyses amongst groups. Finally, the survey captures respondents' opinions and perspectives from a specific point in time, which may only represent one aspect of the communication and collaboration that takes place among Collaboratives and partners as part of care coordination.

Despite these limitations, we still gathered rich data across focus groups and the surveys, and the study data demonstrate the progress F5MC and the Collaboratives have made in progressing toward F5MC's key outcomes of interest.

Appendix C. Focus Group Protocols

Care Coordinator Focus Group Protocol

Introduction

1. How long have you worked in early childhood and what is your favorite part about working in this field?

Coordination of Services

2. Think about the organizations and resources that you know and trust to refer families to. Has that number changed over the past five years? If so, tell us more about that.
3. How satisfied are you with the range of organizations and resources that you can refer families to?
4. From your perspective, have there been any changes over the last five years in the likelihood that families connect with the resources that you refer them to? If so, what has contributed to that?
5. What challenges do families face when connecting to the resources that you refer them to? What would help families overcome those challenges?

Capacity Building

6. Please tell us how long you have been involved in any First 5 trainings or other capacity building and how this support has been the most helpful to your work. (If doesn't come up, ask specifically about IFECMH) Does the IFECMH influence your work as a care coordinator? How so? How about the care coordinator learning group)?
7. Are there any practices that have been a focus of First 5 trainings that you haven't been able to implement? Why do think that is? (*Intent: understand where there are systems gaps e.g., they have the knowledge and tools to implement but there are other barriers getting in the way*)

ECD System Alignment

8. What other resources or trainings in the community have supported you as an early childhood development professional? How did you find those resources?
9. We are interested in learning more about the ways that early childhood development professionals interact with one another in the county. Please share some of the ways that you interact with other professionals outside of your organization.
    a. How satisfied are you with the opportunities you have to interact with others?

   b. Have you seen a change in how you interact with others in your field (or how early childhood professionals interact with each other) over the last five years?
   c. In what ways?
   d. What has contributed to these changes?
10. To what extent do you feel that you and your colleagues in your Collaborative have a shared understanding of best practices and a common approach to serving for families?
    a. To what extent do you think early childhood professionals across the county have a shared understanding of best practices or common approach to serving families?
    b. How has this alignment changed over the last five years? What, if anything, has helped the professionals across the county adopt a common approach to serving families?
11. We understand that there have been many conversations with First 5 about gaps in services in the county. Are there any other obstacles that you have faced when supporting children and their families? What, if anything, helped you overcome those obstacles? What additional support would help? [*To what extent has F5MC's investment shifted conditions that are holding problems in place in the early childhood field?*]

Family Focus Group Protocol

Introduction

1. Please tell us your name, how old your children are and an activity that your family likes to do together.

Guiding Questions

The next set of questions asks more specifically about your experience working with [insert names of relevant care coordinators] to support your young children, those five and under.

2. How were you first connected to [name agencies relevant for this focus group]? How did you hear about that service?
3. Please tell us about your experience with your care coordinator. Did you receive the help that you were looking for?
   a. *Probe*: How, if at all, did your care coordinator help you support your child's development?
   b. *Probe*: Tell us about how your care coordinator has supported you as a parent and an individual, if at all.

    c. *Probe*: Tell us about the services that your care coordinator helped you find. How did they go about connecting you to those resources?
    d. *Probe*: I'd like you to think about some of the meetings that you have had with your care coordinator. How do you feel while you are meeting with your care coordinator?
4. What obstacles or challenges have you faced following up on the resources that your care coordinator referred you to? How long does it usually take you to get the services that your care coordinator refers you to?
5. What challenges, if any, did you face getting care and services for your child before working with your care coordinator?
    a. Probe: What was your experience like connecting with the resources your care coordinator referred you to? How, if at all, was your experience getting care and services different when you worked with your care coordinator?
    b. Can you think of anything that you gained or learned from working with your care coordinator that will help you find or connect to resources in the future? If so, please tell me more.
6. Every family is unique and has their own approach to parenting. To what extent do you feel that your care coordinator understood your family and what is important to you when they connected you with services? Is there a volunteer who can share an example of when you felt like your care coordinator really understood your family and your priorities as a parent?
7. Do you have any suggestions for how a care coordinator could provide better services or improve the way they help a family?

Closing

Lastly, we'd like to hear your perspective on First 5.

8. What do you know about First 5? Have you heard other families talk about First 5? Do you think First 5 is well known among families?
9. Thank you for sharing so much about your experience with your care coordinator and with First 5 in general. After reflecting on the discussion today, is there anything else you'd like to share about your experience with care coordinators or First 5 Monterey County?

Appendix D: Surveys

Care Coordinator Survey

1. How long have you been working as a Care Coordinator in your agency?
    Less than a year
    1-2 years
    3-5 years
    more than 5 years

The next series of questions are about your experience with agencies that you often work with as part of care coordination.

2. Do you have a contact person for the referrals you make as part of care coordination?
    I have a contact in **all** the programs or agencies I make referrals to.
    I have a contact in **most** of the programs or agencies I make referrals to.
    I have a contact in a **few** of the programs or agencies I make referrals to.
    I don't have a contact **in any** of the programs or agencies I make referrals to.

3. We are interested in learning more about the programs or agencies that your Collaborative refers families to and reaching out to them to ask them to complete a short survey. In your role as a Care Coordinator, what are the 3 most frequent programs or agencies that your Collaborative refers families to? Please also provide at least one contact name per program/agency so that we can reach out to them directly to complete the survey. If you don't have a contact, please write in "No Contact."
    _Program/Agency 1__________
    _Program/Agency 2__________
    _Program/Agency 3__________

4. What type of support does AGENCY 1 provide to your families?

5. What type of support does AGENCY 2 provide to your families?

6. What type of support does AGENCY 3 provide to your families?

7. Thinking of your clients for care coordination, when you refer a family, how often do you do the following as part of the referral process? (Scale: Always, Often, Sometimes, Rarely, Never)

    Share information about the concerns of the family you have referred

Communicate with someone in the agency during a referral as part of a warm hand-off
Have a shared meeting (virtual or in-person) with family/client and the new service provider as part of a warm hand-off
Follow up with the service provider to ensure families received services
Inform the service provider of important changes in the client's status
Invite the service provider to attend an MDRT or roundtable
Follow up with the family to ask about and ensure they received services
Determine with the service provider that they are not a good match/fit with the families
Determine with a family that the referral is not a good match/fit

8. Thinking of your clients for care coordination, when you refer a child for an appointment with a medical provider, how often do you do the following? (Scale: Always, Often, Sometimes, Rarely, Never)

Help the family make an appointment
Attend a medical appointment with a family to support access to services
Talk with a medical provider about the results of a screening or full assessment
Follow up with the family to ensure they received services
Follow up with the family to help them understand results of tests or assessments and next steps

We want to learn about the importance of different activities in connecting families with resources during the referral process.

9. How important are the following activities in helping families to receive the services they need? (Scale: Extremely Important, Very Important, Somewhat Important, Not Important)

Sharing information about the concerns of the family you have referred
Communicating with someone in the agency during a referral as part of a warm hand-off
Having a shared meeting (virtual or in-person) with family/client and the new service provider as part of a warm hand-off
Following up with the service provider to ensure families received services
Informing the service provider of important changes in the client's status
Inviting the service provider to attend an MDRT or roundtable
Following up with the family to ask about and ensure they received services
Determining with the service provider that they are not a good match/fit with the families

Determining with a family that the referral is not a good match/fit

10. How helpful are the following to the success of your work as a care coordinator? (Scale: Extremely Helpful, Very Helpful, Helpful, Not at all Helpful, I've never done this/Not sure what it is)

    Participating in reflective supervision
    Having the F5MC Collaborative consent form from families allowing us to share their data
    Having shared tools (e.g., protocols) to use across the Collaborative
    Attending IFECMH trainings
    Attending the F5MC Care Coordinator learning group
    Participating in countywide initiatives (e.g., Bright Beginnings advisory groups, maternal mental health task force)
    Other, please specify

11. Please indicate any challenges or barriers related to being successful in your role.

12. Is there someone in your agency, such as your supervisor, who is responsible for building and maintaining relationships with other programs/agencies?
    Yes
    No

13. How important have those relationships been in helping you connect families with services throughout the county? (Scale: Extremely Important, Very Important, Somewhat Important, Not Important)

14. What are the top 2 reasons that families aren't able to connect to services? Select only two.
    No transportation to services
    Family put on waitlist due to lack of capacity from service provider
    Work conflicts prevent clients from accessing services
    Parent changes their mind
    Provider isn't respectful/doesn't click with parent
    Provider doesn't speak parent's language/doesn't provide interpretation
    Family does not qualify to receive the services (e.g., health insurance doesn't cover, diagnosis or need did not meet the criteria for services, didn't qualify for subsidies)
    Other (Please describe)

Care Coordinator Survey - Spanish

1. ¿Cuánto tiempo ha estado trabajando como coordinadora de servicios en su agencia?

Menos de un año
Entre 1 y 2 años
Entre 3 y 5 años
Más de 5 años

La siguiente serie de preguntas es acerca de su experiencia con los programas o agencias con las que trabaja a menudo.

2. ¿Cuenta con una persona de contacto para a las remisiones que hace como parte de la coordinación de servicios?

Tengo un contacto en **todos** los programas o agencias a los que hago remisiones.
Tengo un contacto en la **mayoría** de los programas o agencias a los que hago remisiones.
Tengo un contacto en **algunos** de los programas o agencias a los que hago remisiones.
No tengo ningún contacto en **ninguno** de los programas o agencias a los que hago remisiones.

3. En su función como coordinadora de servicios, ¿cuáles son los 3 programas o agencias más frecuentes a los que su Colaborativa remite a las familias?

_Programa/Agencia 1__________
_Programa/Agencia 2__________
_Programa/Agencia 3__________

Estamos interesados en aprender más sobre los programas o agencias a los que su Colaborativa remite a las familias, y nos gustaría contactar a dichos programas o agencias para pedirles que completen una breve encuesta. Por favor indique el nombre de por lo menos una persona para cada programa/agencia a quien podemos contactar para completar la encuesta. Si tiene varios contactos, por favor use una coma (,) para separar los nombres. Si no tiene un contacto, por favor escriba "No tengo contacto."

4. ¿Qué tipo de apoyo ofrece [AGENCY 1] a sus familias?

5. ¿Qué tipo de apoyo ofrece [AGENCY 2] a sus familias?

6. ¿Qué tipo de apoyo ofrece [AGENCY 3] a sus familias?

7. Pensando en sus clientes de coordinación de servicios, cuando remite a una familia, ¿con qué frecuencia hace lo siguiente como parte del proceso de remisión? (Escala: siempre, Con frecuencia, Algunas veces, Rara vez, Nunca)

Compartir información sobre las preocupaciones de la familia que ha remitido
Comunicarse con alguien de la agencia durante una remisión, como parte de una cálida transferencia del caso
Reunirse (de manera virtual o en persona) con la familia o cliente y el nuevo proveedor de servicios, como parte de una cálida transferencia del caso
Hacer seguimiento con el proveedor de servicios para asegurarse de que las familias reciban los servicios
Informar al proveedor de servicios sobre cambios importantes en el estado del cliente
Invitar al proveedor de servicios a asistir a una mesa redonda o a un MDRT (cita del Equipo de Revisión)
Hacer seguimiento con la familia para preguntar y asegurarse de que hayan recibido los servicios
Determinar con el proveedor de servicios que los servicios no cubren ni se ajustan a las necesidades de las familias
Determinar con una familia que la remisión no cubre ni se ajusta a sus necesidades

8. Pensando en sus clientes de coordinación de servicios, cuando remite a un niño a una cita con un **proveedor médico**, ¿con qué frecuencia hace lo siguiente? (Escala: siempre, Con frecuencia, Algunas veces, Rara vez, Nunca)

Ayudar a la familia a programar una cita
Asistir a una cita médica con una familia para apoyar el acceso a los servicios
Hablar con un proveedor médico sobre los resultados de un examen o evaluación completa
Hacer seguimiento con la familia para asegurarse de que recibieron los servicios
Hacer seguimiento con la familia para ayudarlos a comprender los resultados de las pruebas o evaluaciones y los próximos pasos

Deseamos conocer la importancia de las diferentes actividades para conectar a las familias con los recursos durante el proceso de remisión.

9. ¿Qué importancia tienen las siguientes actividades para ayudar a las familias a recibir los servicios que necesitan? (Escala: Extremadamente importante, Muy importante, Algo importante, Nada importante)

Compartir información sobre las preocupaciones de la familia que ha remitido

Comunicarse con alguien de la agencia durante una remisión, como parte de una cálida transferencia del caso
Reunirse (de manera virtual o en persona) con la familia o cliente y el nuevo proveedor de servicios, como parte de una cálida transferencia del caso
Hacer seguimiento con el proveedor de servicios para asegurarse de que las familias reciban los servicios
Informar al proveedor de servicios sobre cambios importantes en el estado del cliente
Invitar al proveedor de servicios a asistir a una mesa redonda o a un MDRT (cita del Equipo de Revisión)
Hacer seguimiento con la familia para preguntar y asegurarse de que hayan recibido los servicios
Determinar con el proveedor de servicios que los servicios no cubren/no se ajustan a las necesidades de las familias
Determinar con una familia que la remisión no cubre/ no se ajusta a sus necesidades

10. ¿Qué tan útiles son las siguientes actividades para el éxito de su trabajo como coordinadora de servicios? (Escala: Extremadamente útil, Muy útil, Algo Útil, Nada útil, Nunca lo he hecho/No estoy segura de qué se trata)

Participar en la supervisión reflexiva
Tener el formulario de consentimiento de las familias, que nos permite compartir sus datos
Tener herramientas compartidas (por ejemplo, protocolos) para usar en toda la Colaborativa
Asistir a las capacitaciones de IFECMH (Salud Mental Infantil-Familiar y de la Primera Infancia)
Asistir al grupo de aprendizaje de la coordinadora de servicios de F5MC
Participar en iniciativas en todo el condado (por ejemplo, grupos asesores de Bright Beginnings, grupo de trabajo de salud mental materna)
Otro, especifique _________________

11. Indique los desafíos u obstáculos relacionados con el éxito de su función:

12. ¿Hay alguien en su agencia, como su supervisor/a, que sea responsable de establecer y mantener relaciones con otros programas/agencias?

Sí
No

13. ¿Qué tan importante han sido esas relaciones para ayudarla a conectar a las familias con los servicios de todo el condado? (Escala: Extremadamente importante, Muy importante, Algo importante, Nada importante)

14. ¿Cuáles son las 2 razones principales por las que las familias no pueden conectarse a los servicios? Sólo elija 2 opciones. Si quiere cambiar una de sus selecciones, tendrá que hacer clic en la opción que quiere deseleccionar antes de elegir una nueva.
    No hay transporte a los servicios
    Se coloca a la familia en lista de espera debido a falta de capacidad por parte del proveedor de servicios
    Los conflictos laborales impiden que los clientes accedan a los servicios
    Los padres cambian de opinión y no desean los servicios
    El proveedor no es respetuoso/no se vincula con los padres
    El proveedor no habla el idioma de los padres/no se brinde el servicio de interpretación
    La familia no califica para recibir los servicios (por ejemplo, no hay cobertura del seguro médico, el diagnóstico o la necesidad no cumple los criterios para recibir los servicios, no califica para recibir subsidios)
    Otro (describa)

Collaborative Administrator Survey

1. How long have you been working in your agency?
    - Less than a year
    - 1-2 years
    - 3-5 years
    - more than 5 years

The next series of questions are about the experience your staff has with agencies they often work with as part of care coordination.

2. What are the 3 most frequent programs or agencies that your Collaborative refers families to?
    - _ Program/Agency 1__________
    - _Program/Agency 2__________
    - _Program/Agency 3__________

3. What type of support does AGENCY 1 provide to your families?

4. What type of support does AGENCY 2 provide to your families?

5. What type of support does AGENCY 3 provide to your families?

6. Thinking of your clients for care coordination, when a care coordinator refers a family, how often do they do the following as part of the referral process? (Scale: Always, Often, Sometimes, Rarely, Never, Unsure)

    Share information about the concerns of the family you have referred
    Communicate with someone in the agency during a referral as part of a warm hand-off
    Have a shared meeting (virtual or in-person) with family/client and the new service provider as part of a warm hand-off
    Follow up with the service provider to ensure families received services
    Inform the service provider of important changes in the client's status
    Invite the service provider to attend an MDRT or roundtable
    Follow up with the family to ask about and ensure they received services
    Determine with the service provider that they are not a good match/fit with the families
    Determine with a family that the referral is not a good match/fit

7. Thinking of clients for care coordination, when a care coordinator refers a child for an appointment with a medical provider, how often do they do the following? (Scale: Always, Often, Sometimes, Rarely, Never, Unsure)

   Help the family make an appointment
   Attend a medical appointment with a family to support access to services
   Talk with a medical provider about the results of a screening or full assessment
   Follow up with the family to ensure they received services
   Follow up with the family to help them understand results of tests or assessments and next steps

We want to learn about the importance of different activities in connecting families with resources during the referral process.

8. When a care coordinator refers a family to an agency, how important are the following activities in helping families receive the services they need? (Scale: Extremely Important, Very Important, Somewhat Important, Not Important)

   Sharing information about the concerns of the family you have referred
   Communicating with someone in the agency during a referral as part of a warm hand-off
   Having a shared meeting (virtual or in-person) with family/client and the new service provider as part of a warm hand-off
   Following up with the service provider to ensure families received services
   Informing the service provider of important changes in the client's status
   Inviting the service provider to attend an MDRT or roundtable
   Following up with the family to ask about and ensure they received services
   Determining with the service provider that they are not a good match/fit with the families
   Determining with a family that the referral is not a good match/fit

9. How useful has the following been in your job as an administrator/supervisor? (Scale: Extremely Helpful, Very Helpful, Somewhat Helpful, Not at all Helpful, I've never done this/Not sure what it is)

   Participating in reflective supervision
   Having the F5MC Collaborative consent form from families allowing us to share their data
   Having shared tools (e.g., protocols) to use across the Collaborative
   Attending IFECMH trainings
   Attending the F5MC Care Coordinator learning group
   Participating in countywide initiatives (e.g., Bright Beginnings advisory groups,

maternal mental health task force)
Other, please specify

10. Is there someone in your agency, including yourself, who is responsible for building and maintaining relationships with other programs/agencies?
    Yes
    No

11. How important have those relationships been in helping care coordinators connect families with services throughout the county? (Scale: Extremely Important, Very Important, Somewhat Important, Not Important)

12. As a supervisor, how do you build and maintain relationships with other agencies?

13. What are the top 2 reasons that families aren't able to connect to services? Select only two.
    No transportation to services
    Family put on waitlist due to lack of capacity from service provider
    Work conflicts prevent clients from accessing services
    Parent changes their mind
    Provider isn't respectful/doesn't click with parent
    Provider doesn't speak parent's language/doesn't provide interpretation
    Family does not qualify to receive the services (e.g., health insurance doesn't cover, diagnosis or need did not meet the criteria for services, didn't qualify for subsidies)
    Other (Please describe)

Partner Survey

The first couple of questions ask about your background.

1. What is your role within your organization?
    Case Manager
    Supervisor/Administrators
    Other please specify______________

2. How long have you been in your organization?
    Less than a year
    1-2 years
    3-5 years
    More than 5 years

3. What type of support does your organization provide to families?

The next series of questions are about your experience with organizations that you often work with.

4. Thinking of referrals from First 5 Monterey County's (F5MC) Collaborative services to children and families (*i.e., Alisal Family Resource Center, Castro Plaza Family Resource Center, MCStart/Door to Hope/Monterey County Probation Department, New Possibilities/Nuevas Posibilidades/GoKids, Pajaro Valley Prevention & Student Assistance*-PVPSA), when a F5MC funded partner refers a client how often do they do the following as part of the referral process? (Scale: Always, Often, Sometimes, Rarely, Never)

    Share information about the concerns of the family they have referred
    Communicate with someone in your agency during a referral as part of a warm hand-off
    Have a shared meeting (virtual or in-person) with family/client and someone within your agency as part of a warm hand-off
    Follow up with your agency to ensure families received services
    Inform your agency of important changes in the client's status
    Invite someone within your agency to attend a multidisciplinary review team or roundtable (a special meeting to discuss the needs of the family with the relevant agencies providing support to the family)
    Determine with your agency that your agency is not a good match/fit with the families
    Determine with a family that the referral is not a good match/fit

5. In general, thinking of non-First 5 funded agencies, when an agency refers a client how often do they do the following as part of the referral process? (Scale: Always, Often, Sometimes, Rarely, Never)

   Share information about the concerns of the family they have referred
   Communicate with someone in your agency during a referral as part of a warm hand-off
   Have a shared meeting (virtual or in-person) with family/client and someone within your agency as part of a warm hand-off
   Follow up with your agency to ensure families received services
   Inform your agency of important changes in the client's status
   Invite someone within your agency to attend a multidisciplinary review team or roundtable (a special meeting to discuss the needs of the family with the relevant agencies providing support to the family)
   Determine with your agency that your agency is not a good match/fit with the families
   Determine with a family that the referral is not a good match/fit

We want to learn about the importance of different activities in connecting families with resources during the referral process.

6. When an agency refers a family to you, how important are the following activities in helping families receive the services they need? (Scale: Extremely Important, Very Important, Somewhat Important, Not Important)

   Share information about the concerns of the family they have referred
   Communicate with someone in your agency during a referral as part of a warm hand-off
   Have a shared meeting (virtual or in-person) with family/client and someone within your agency as part of a warm hand-off
   Follow up with your agency to ensure families received services
   Inform your agency of important changes in the client's status
   Invite someone within your agency to attend a multidisciplinary review team or roundtable (a special meeting to discuss the needs of the family with the relevant agencies providing support to the family)
   Determine with your agency that they are not a good match/fit with the families
   Determine with a family that the referral is not a good match/fit

7. What are the top 2 reasons that families aren't able to connect to services provided by your agency or program?

No transportation to services
Family put on waitlist
Work conflicts prevent clients from accessing services
Client changes their mind
Your agency determines it wasn't a good fit with the family
Your agency isn't able to provide services in the client's language
Family not qualified to receive the services (e.g., health insurance doesn't cover, diagnosis or need did not meet the criteria for services, didn't qualify for subsidies)
Other (Please describe)

Appendix E: Additional Quotes

Below we provide additional quotes to illuminate the report findings above. As with all our quotes, we only include those that allow us to protect confidentiality of respondents and that provide depth and are illustrative of the theme. As such, the quotes we provide vary across themes. Additionally, some quotes have been translated from Spanish to English by SPR staff, and some have been translated from Triqui to English by a consultant.

Outcome 1: Better Coordination of Services for Families

Finding #1: Care coordinators develop relationships to best meet a family's needs

Care coordinators develop trust with families to inform targeted, comprehensive supports

"I appreciated that she always would remember what we talked about last time and would bring it up, and it just feels so much more personal when they remember what's going on in your life. I'm sure they have so many other people that they're dealing with, and I never felt like she was rushing. Even if she told me right before she was meeting with me, 'Oh, I have to leave for a home visit,' she would still take the time, and it would even drag on probably longer than it was supposed to. But she didn't seem rushed. She's really good." – Parent

"I appreciated that [the care coordinator] was always trying to get me to find a solution and in a way that was almost my idea. She had a way of getting you to think about what you can do. 'What do you think you need to do?' And I liked that because I know what I need to do." – Parent

"[My care coordinator] does help a lot. She helps with anything that I need. I'm grateful for what she does. I trust her with anything especially when it comes to my children. My child is falling behind, and she helps me with any need. She also follows up with any services that she sends you to, such as therapy. She's the only one that I trust. I don't trust anyone that easily." – Parent

"It was nice to have someone to work on stuff [with]. I'm always working on myself. I'm such a work in progress…It's hard to pull your life back together and…Yeah. Having someone to guide you and even just bounce thoughts off of and then, like I said before, you sometimes come up with a solution on your own." – Parent

"I've liked that when I have a doubt or question, she really helps me figure out what to do. If she doesn't know something, she looks for and gives me that information." – Parent

Finding #2: Care coordinators connect families to service providers

Care coordinators provide intensive, broad, and tailored support

"To be honest my child has speech problems and [the care coordinator] has been able to help me to send my child to therapy and now my child is able to talk more."
– Parent

"[The care coordinator] connected me with [a resource that] has been very helpful for me and my child because my child wouldn't behave and wouldn't listen to me. That person she connected me with recommended that whenever my child is throwing a tantrum that I should not pay attention until the child calms down…Now my child is behaving well, but he does have issues communicating. He'll be seen for more evaluation and will have a provider present to help my child with speech." – Parent

"She has referred [me] to many specialists. For example, my child was falling behind and was not acting age appropriate. She referred my child to a specialist to help my child and [me] on how to communicate with my child." – Parent

"When I told [the care coordinator] that my one-year-old child didn't really move his hands, she gave me these small balls and explained how to use these toys so that he could start reaching and playing, so he had more movement. [The care coordinator] told me to let her know if I didn't see more movement, so that she could make a referral for evaluation, but he's doing great." – Parent

"For me, personally, [the care coordinator] has helped me in knowing how to handle the situations with my child when they are in an emotional crisis and more than anything, during the pandemic they helped a lot. [The care coordinator] was giving a lot of advice and she was working even from her personal phone and sometimes I would ask her for advice and she helped us a lot. She also taught me how to calm myself and to be controlled in those situations. She's taught us a lot and it's good to be learning because it helps us in the future and with our children." – Parent

"The advice that they give and the support they offer helps a lot. They really help us as a family, especially when sometimes you don't have that much experience…I personally called [the care coordinator] when I had questions and doubts about anything." – Parent

"I have a child with down syndrome. I didn't know what it meant or what it was. I also didn't know what support existed. So, [the care coordinator] helped me fill out an application because I didn't know what I needed to do. She was the one who told me, 'We will fill this out. We will do it.' That helped me, in addition to other programs that I wrote down I didn't know were offering support to children with down syndrome. So,

because of her, I've found out about many things and because of her I've been informed about what it means to have down syndrome and the resources that exist. I sincerely appreciate her for all of the support that she's offered us." – Parent

Families connect with resources with support from care coordinators

"I have been referred to a provider who has helped me with my child. We needed therapy and that's where they sent us. Me and my child needed therapy on how to communicate with each other and that has been beneficial for both of us…[The care coordinator] referred me to a therapist, and the therapist would recommend what to do when she [the child] becomes angry. Now we both communicate well with each other and that's thanks to [the care coordinator] and therapy [that] has helped us both." – Parent

"As far as getting a response [from a service provider] once the referral was done, it was pretty immediate. And same with the other stuff. I was able to get in with [the therapist]…that week or the next week, and that was right when COVID started too. So yeah, I think especially taking COVID into consideration, having that direct referral helps to be able to get these services." – Parent

Care coordinators follow up to connect families with resources

"[The care coordinator] so frequently would check-in with me…even when things were going good and I wasn't reaching out to her. She would regularly [reach out], 'Oh, I haven't heard from you,' whether it was an email or a phone call. I like that she's still someone that I can go to, and she takes that time." – Parent

"[A service provider] always told me, 'No, your child does not qualify, they are too old.' There was a time when my child was diagnosed, so I called [the service provider] and they told me that my child did not qualify because she was past the age limit. Once I found First 5, they helped me and told me, 'No, your child does qualify for [the service provider].' So [the care coordinator] got in contact with the staff at [the service provider site] and she helped me [so my child could be seen]." – Parent

"I like [care coordination] because they're very nice and attend well. They helped me the last time I went, and I didn't have an appointment. They call you when you forget about your appointment. They look out for you, and for how your child is doing. I like that they are attentive to how the children are doing, and to us as well." – Parent

Finding #3: Families face structural barriers impede their ability to access resources

Families speaking indigenous languages need translation support

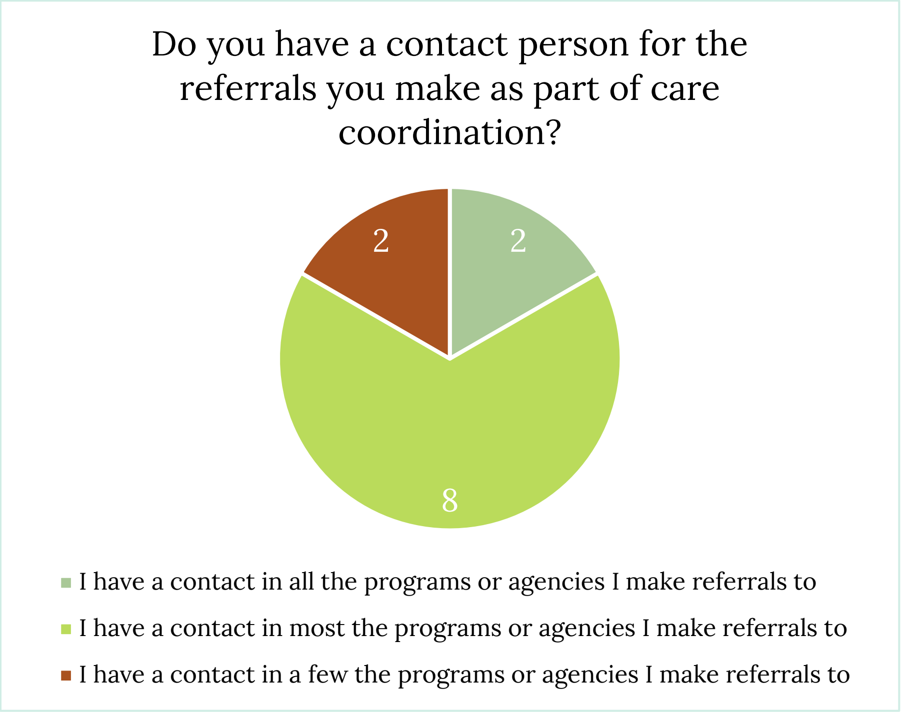
"Before getting services through [care coordination], it was very challenging for me. I had just arrived to the U.S. I got pregnant, and I didn't know who could help with the documentations. My first child needed a lot of help and needed to be seen by a specialist, but I didn't know who to reach out to. It was very difficult for me. Also, when you go to the clinic and the doctors speak to you in Spanish, you don't know what to respond sometimes or when it comes to Medi-Cal documentation, you don't know who to reach out to that can answer all your questions. When I found out [the care coordinator] help[ed] people, and that was years later, I was able to connect with her, [and] that made me feel relief." – Parent

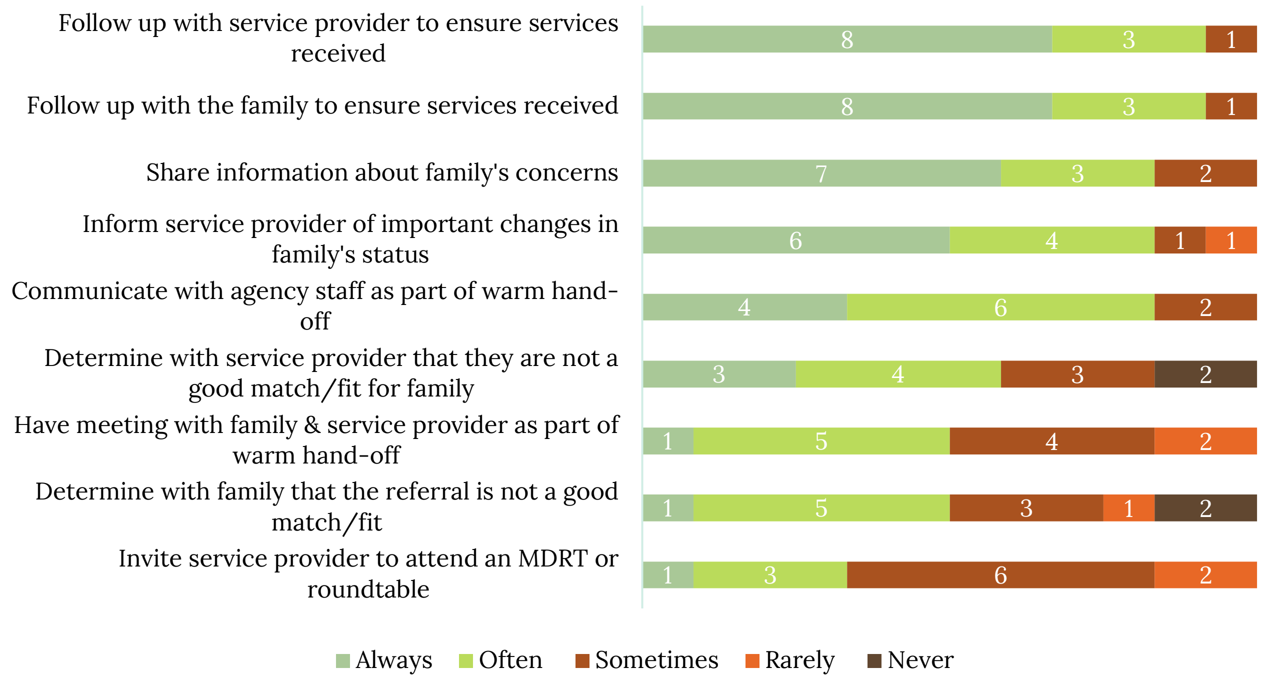
"Triqui interpreters are really helpful when it comes to a medical decision. For example, when I went to have a baby, I was in pain, and I was told that I needed a C-Section. I was firm with the providers and told them that I didn't want a C-section. I wanted to have a normal delivery. I was told they didn't have anyone that speaks Triqui at the moment. I said that I didn't care if I had to wait and it didn't matter if it was over the phone, I really wanted the providers to know how I felt about having a C-Section but in my own language. Moments later they were able to get me someone who spoke Triqui and I told the interpreter I didn't wanted a C-Section and the interpreter transferred that message to the providers and I didn't end up with a C-Section. You must be very careful when it comes to making a medical decision." – Parent

"It is difficult when you don't know anyone that can help you. Especially during your first pregnancy, and the problem is that you don't know if the symptoms you are having is because of the pregnancy or not…It's difficult when you can't communicate or make appointments for yourself too. I asked others on how to make appointments and how to receive benefits and all of them recommended I go to [the care coordinator]. [The care coordinator] would help you; she will also go with you to your appointments. She would help you fill out documents that you need for Medi-Cal, because Medi- Cal is very important and that's the first thing they ask for during pregnancy." – Parent

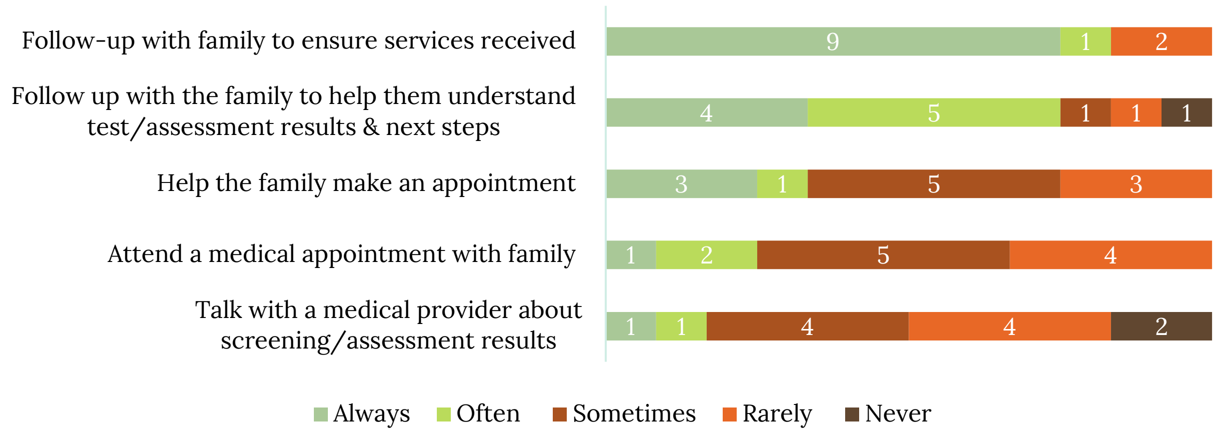
Appendix F: Survey Responses

Care coordinator survey responses

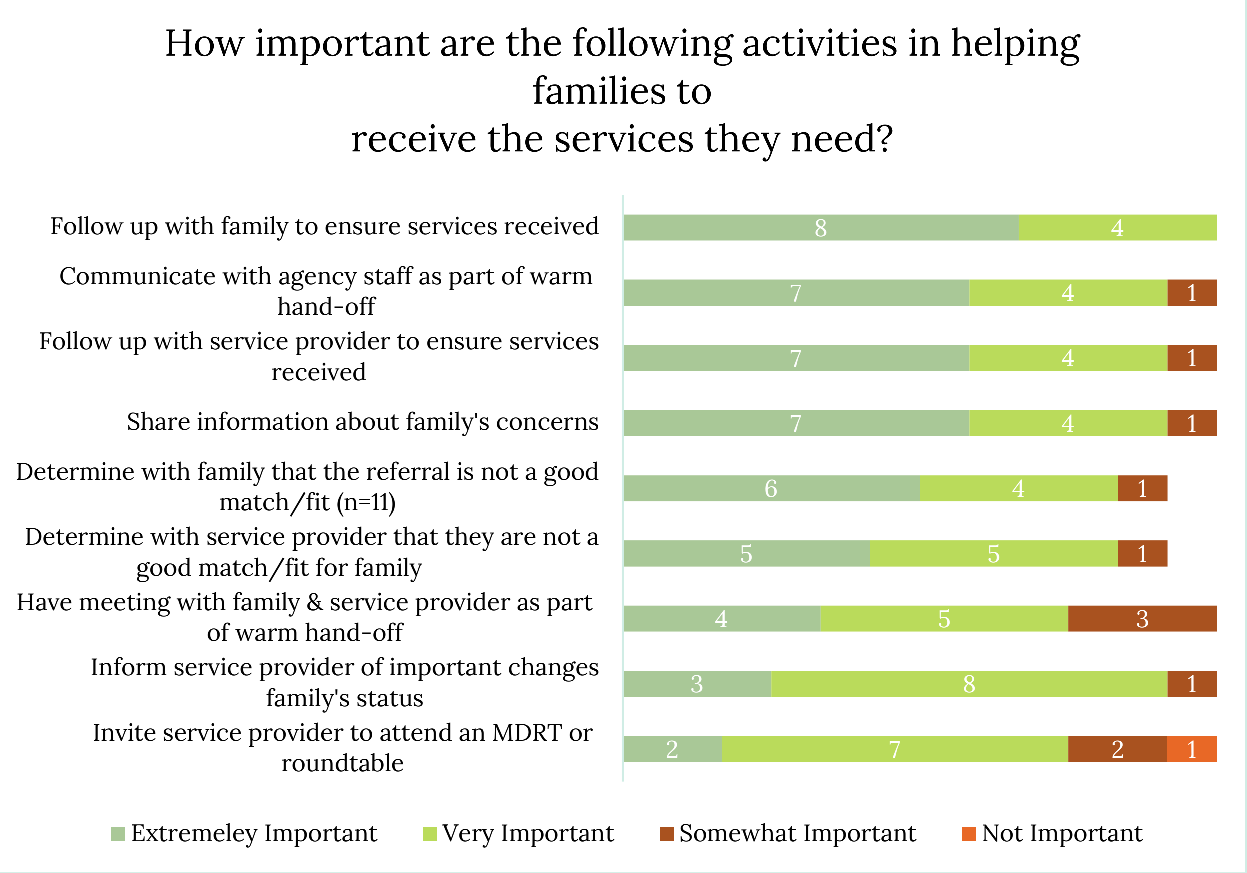


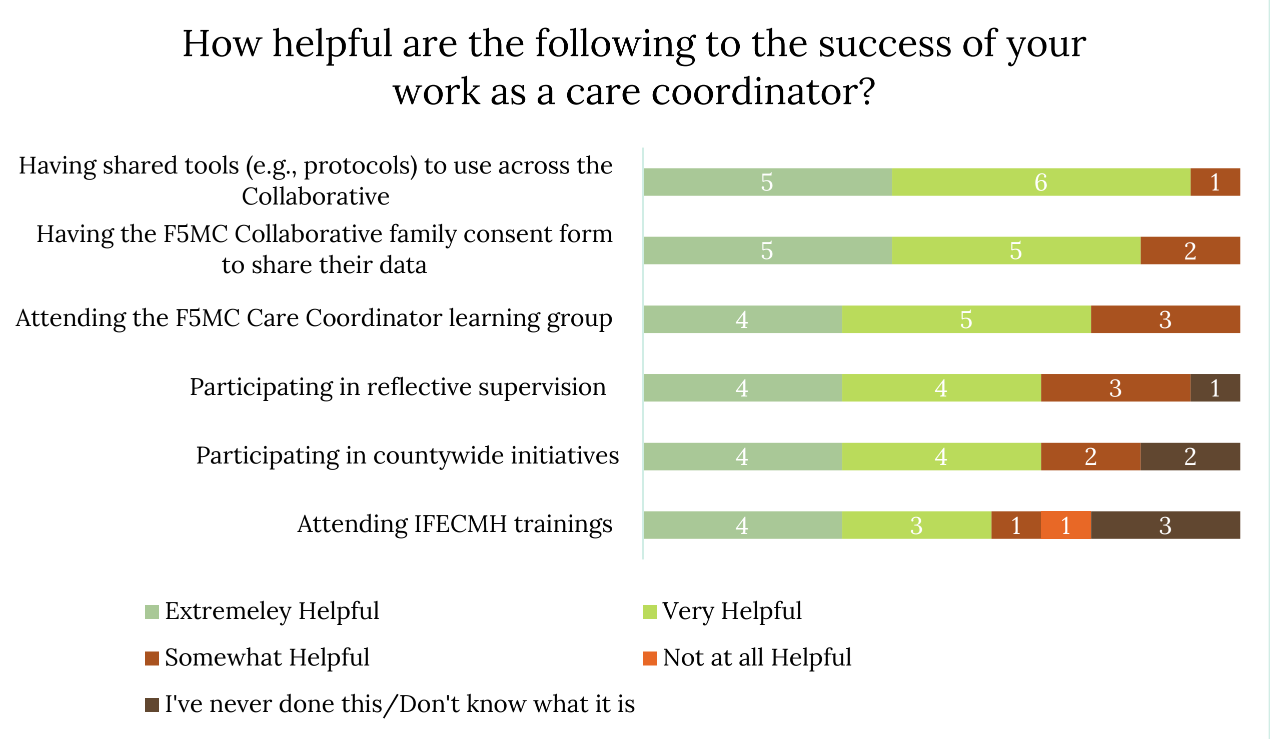


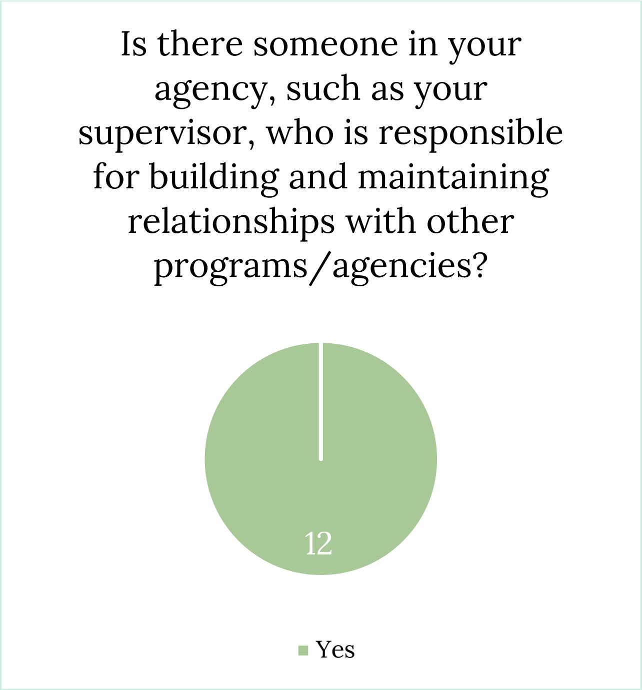
How often do you do the following as part of the referral process?

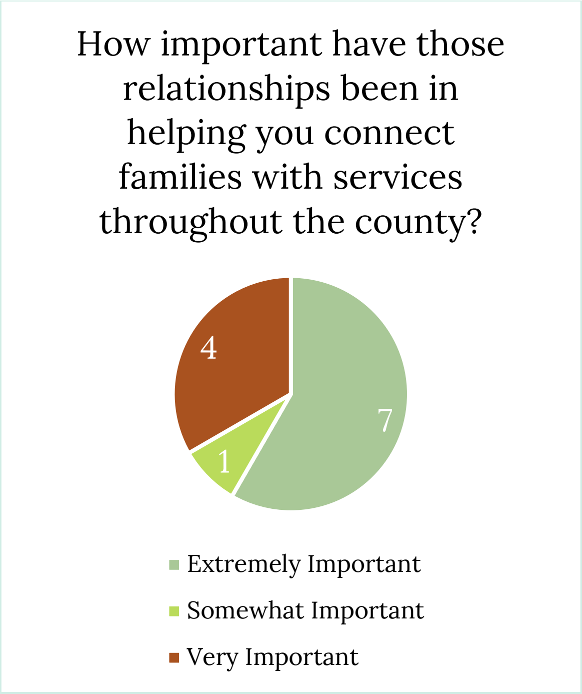


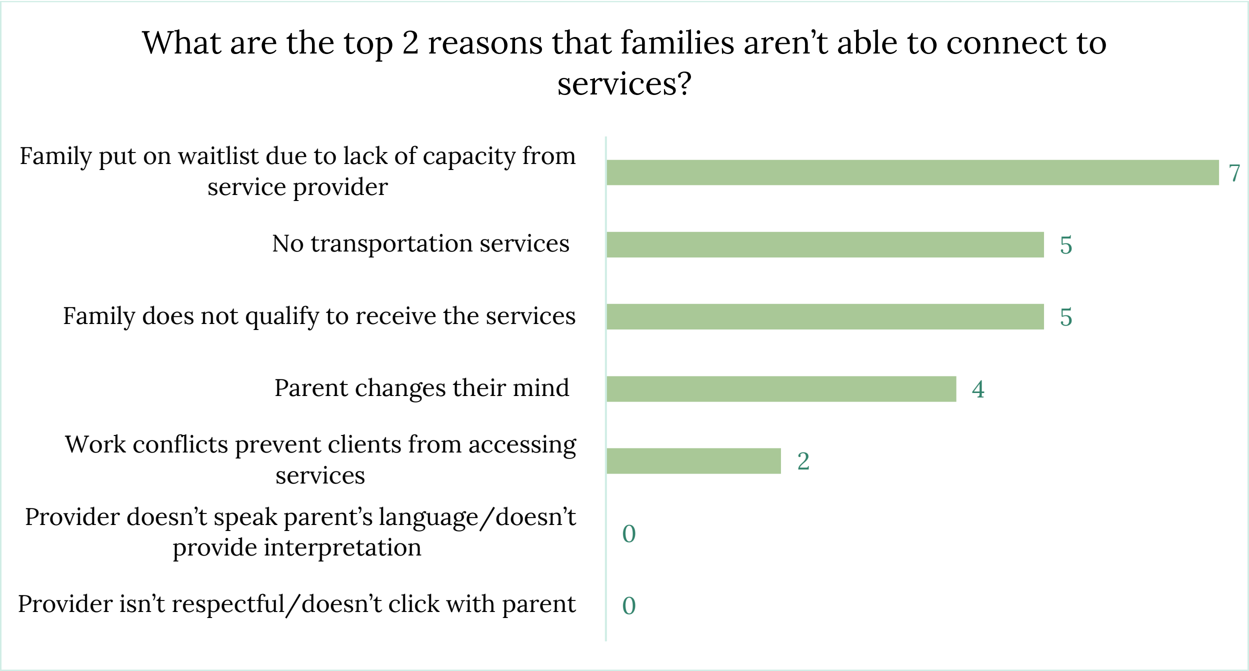
When you refer a child for an appointment with a medical provider, how often do you do the following?


How important are the following activities in helping families to receive the services they need?
Follow up with family to ensure services received
8
4
Communicate with agency staff as part of warm hand-off
7
4
1
Follow up with service provider to ensure services received
7
4
1
Share information about family's concerns
7
4
1
Determine with family that the referral is not a good match/fit (n=11)
6
4
1
Determine with service provider that they are not a good match/fit for family
5
5
1
Have meeting with family & service provider as part of warm hand-off
4
5
3
Inform service provider of important changes family's status
3
8
1
Invite service provider to attend an MDRT or roundtable
2
7
2
1
Extremeley Important
Very Important
Somewhat Important
Not Important

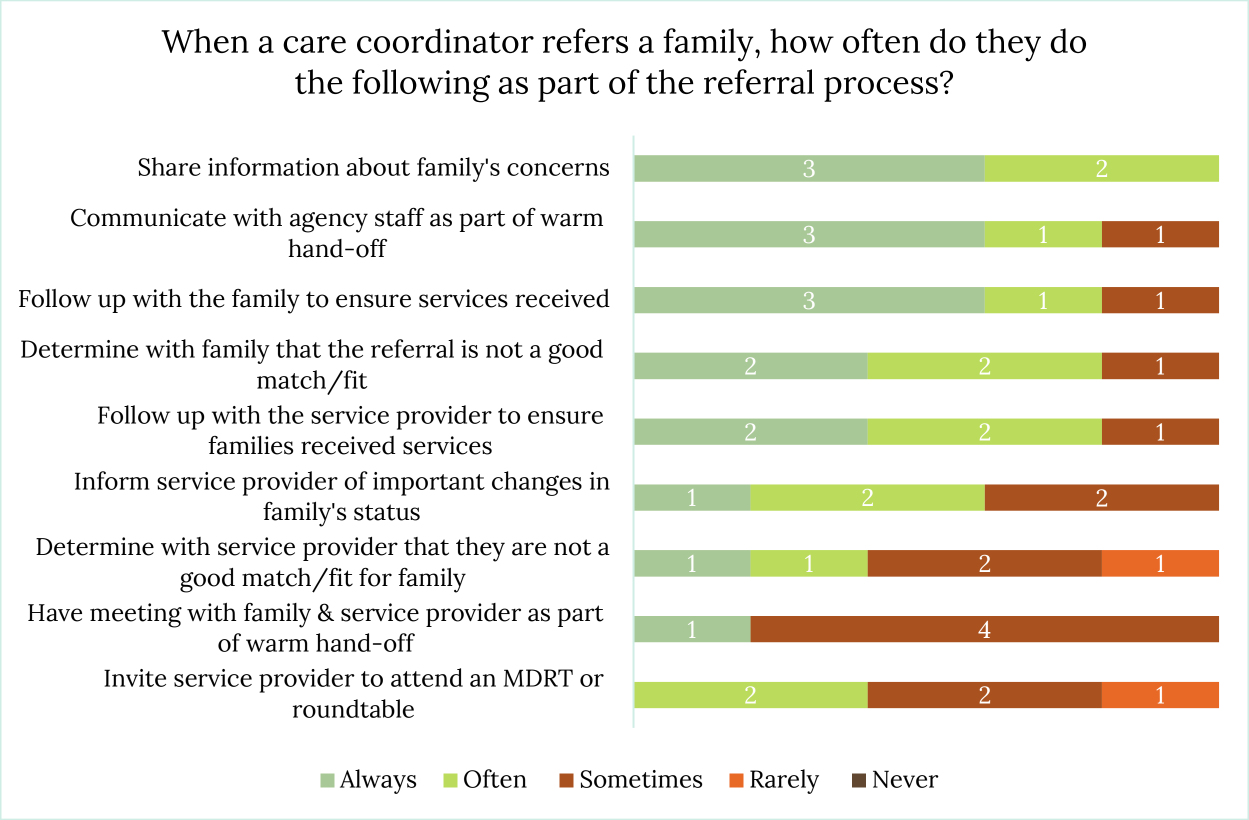

How helpful are the following to the success of your work as a care coordinator?
Having shared tools (e.g., protocols) to use across the Collaborative
5
6
1
Having the F5MC Collaborative family consent form to share their data
5
5
2
Attending the F5MC Care Coordinator learning group
4
5
3
Participating in reflective supervision
4
4
3
1
Participating in countywide initiatives
4
4
2
2
Attending IFECMH trainings
4
3
1
1
3
Extremeley Helpful
Very Helpful
Somewhat Helpful
Not at all Helpful
I've never done this/Don't know what it is

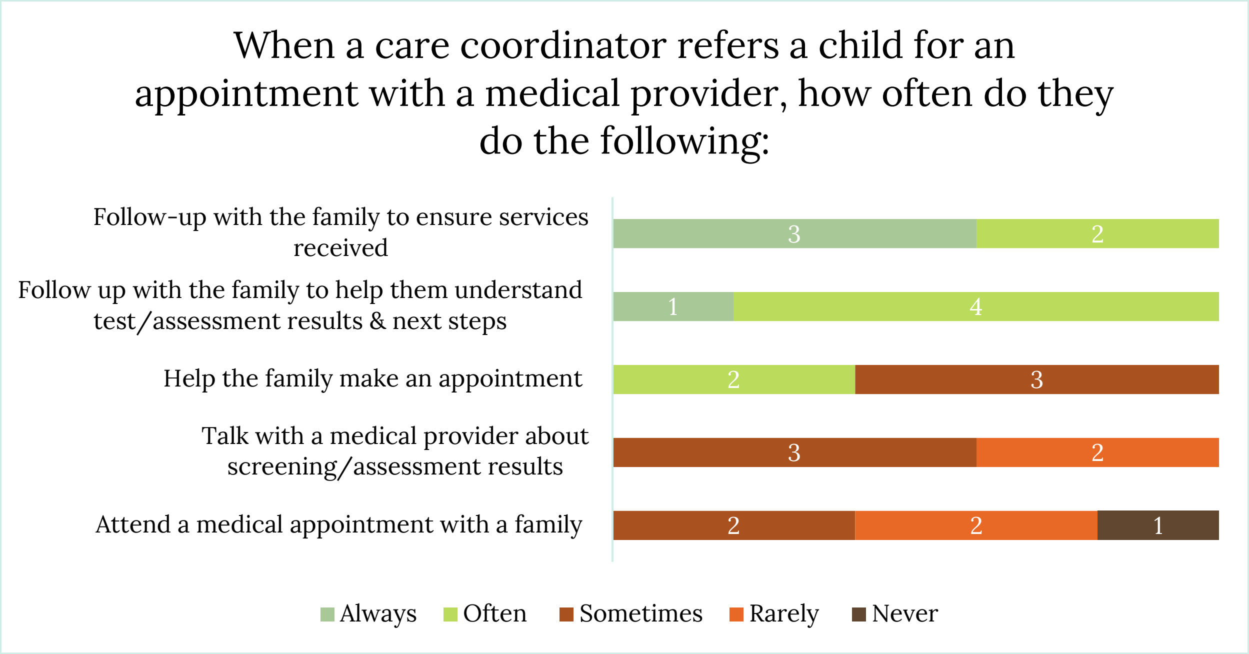

Is there someone in your agency, such as your supervisor, who is responsible for building and maintaining relationships with other programs/agencies?

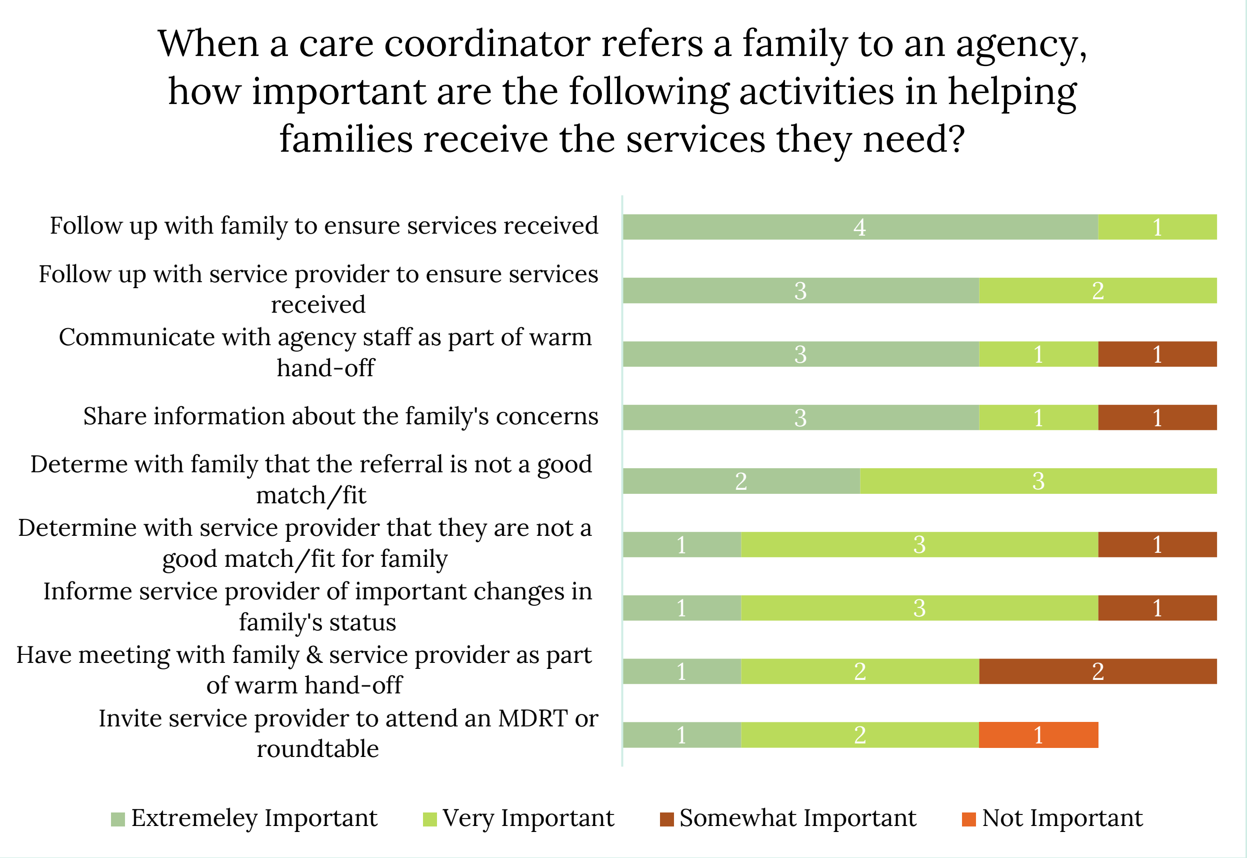

How important have those relationships been in helping you connect families with services throughout the county?

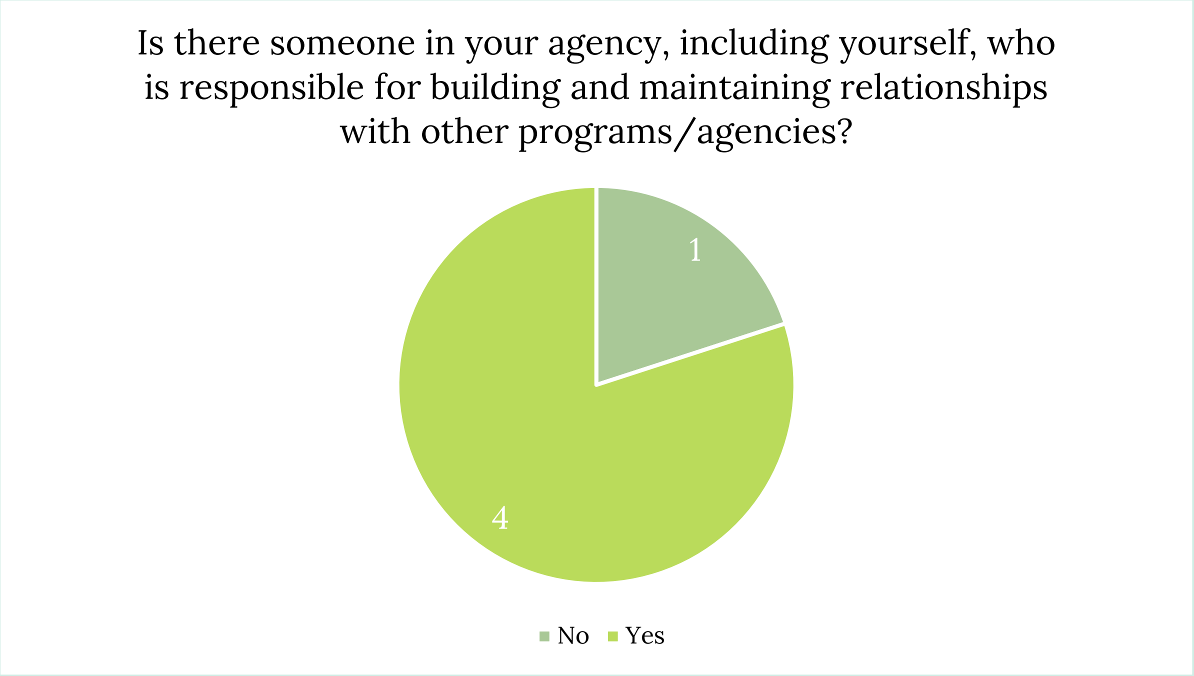

What are the top 2 reasons that families aren't able to connect to services?

Administrator survey responses

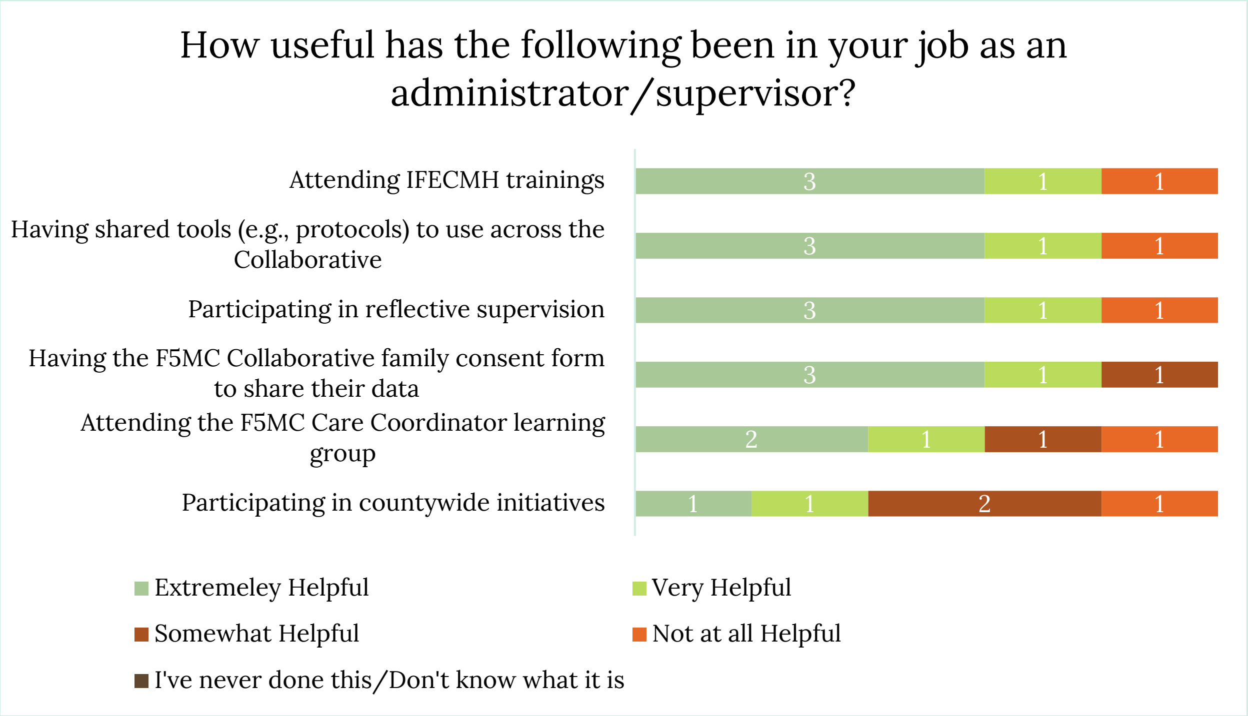

When a care coordinator refers a family, how often do they do the following as part of the referral process?


When a care coordinator refers a child for an appointment with a medical provider, how often do they do the following:

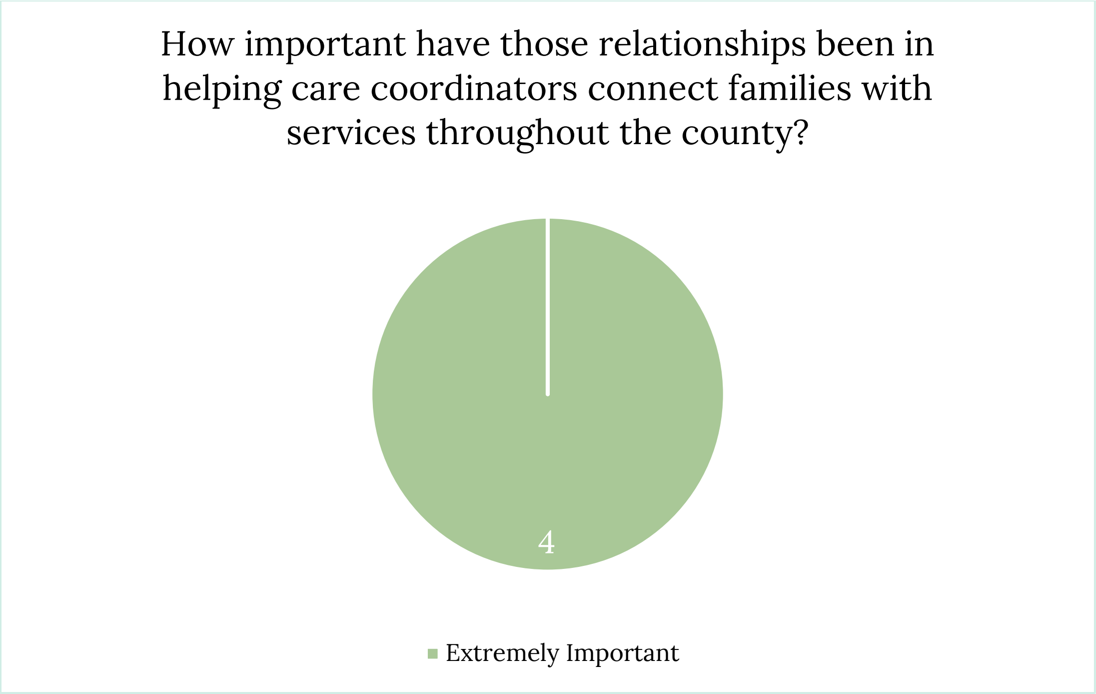

When a care coordinator refers a family to an agency, how important are the following activities in helping families receive the services they need?
Follow up with family to ensure services received
4
1
Follow up with service provider to ensure services received
3
2
Communicate with agency staff as part of warm hand-off
3
1
1
Share information about the family's concerns
3
1
1
Determe with family that the referral is not a good match/fit
2
3
Determine with service provider that they are not a good match/fit for family
1
3
1
Informe service provider of important changes in family's status
1
3
1
Have meeting with family & service provider as part of warm hand-off
1
2
2
Invite service provider to attend an MDRT or roundtable
1
2
1
Extremeley Important
Very Important
Somewhat Important
Not Important

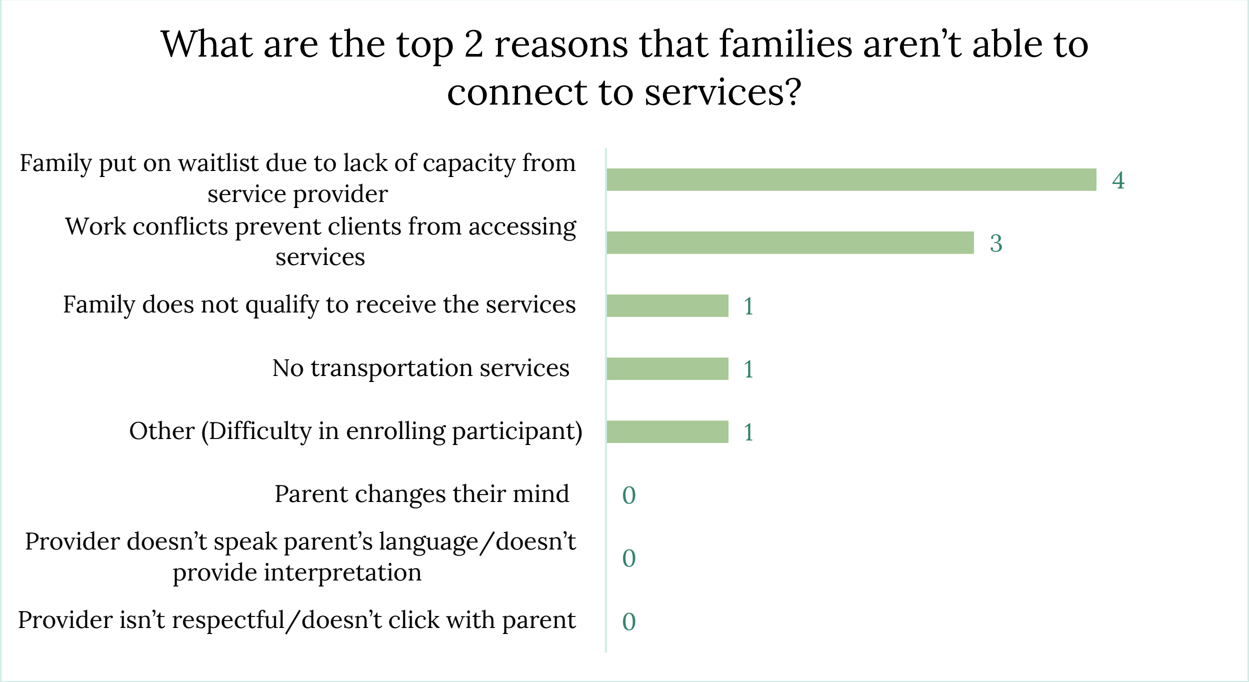


Is there someone in your agency, including yourself, who is responsible for building and maintaining relationships with other programs/agencies?

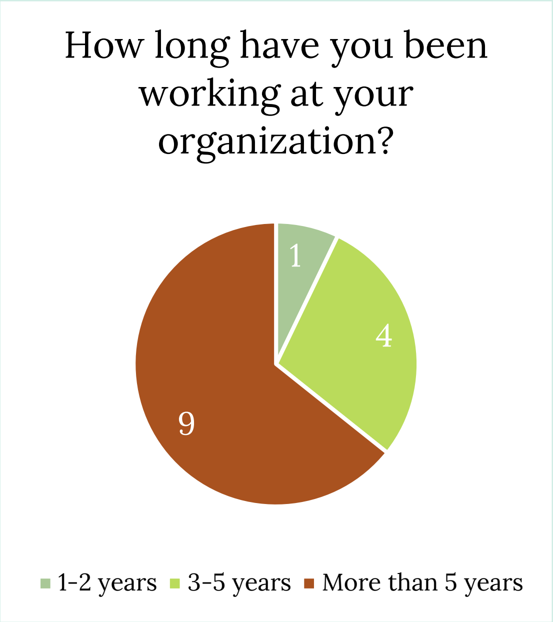


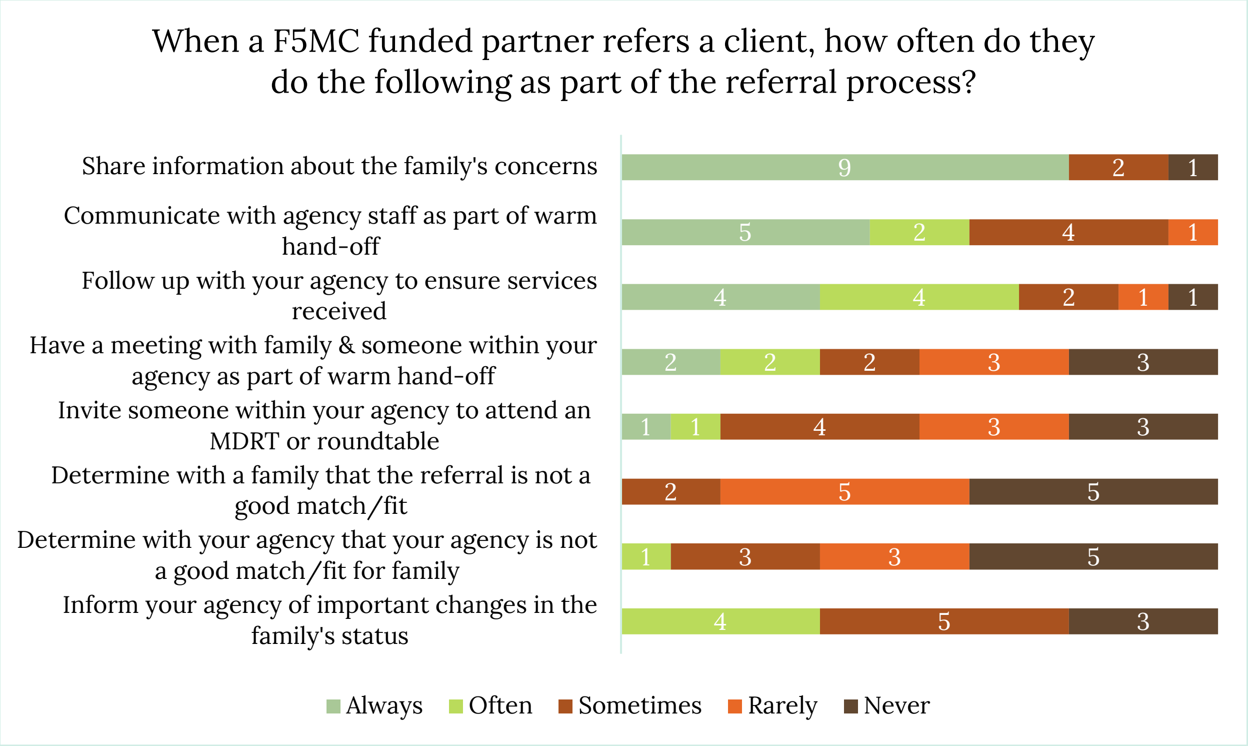
How useful has the following been in your job as an administrator/supervisor?

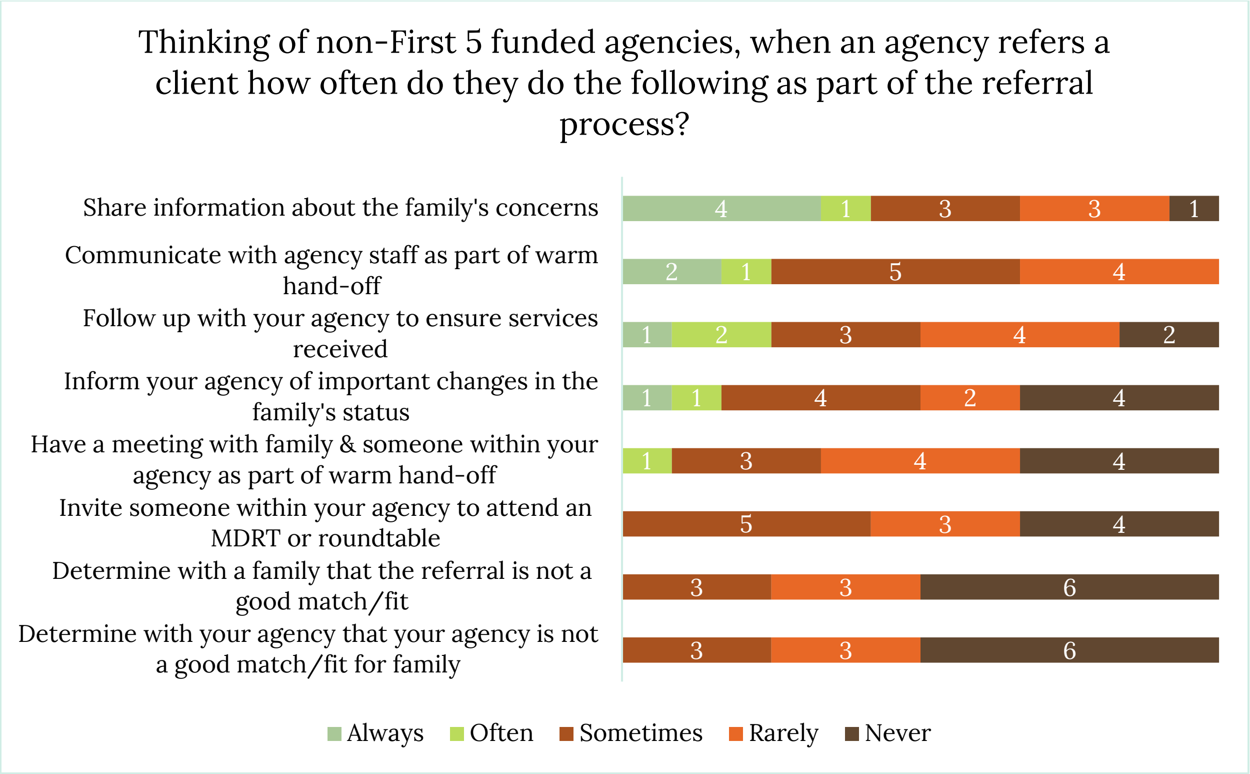

How important have those relationships been in helping care coordinators connect families with services throughout the county?

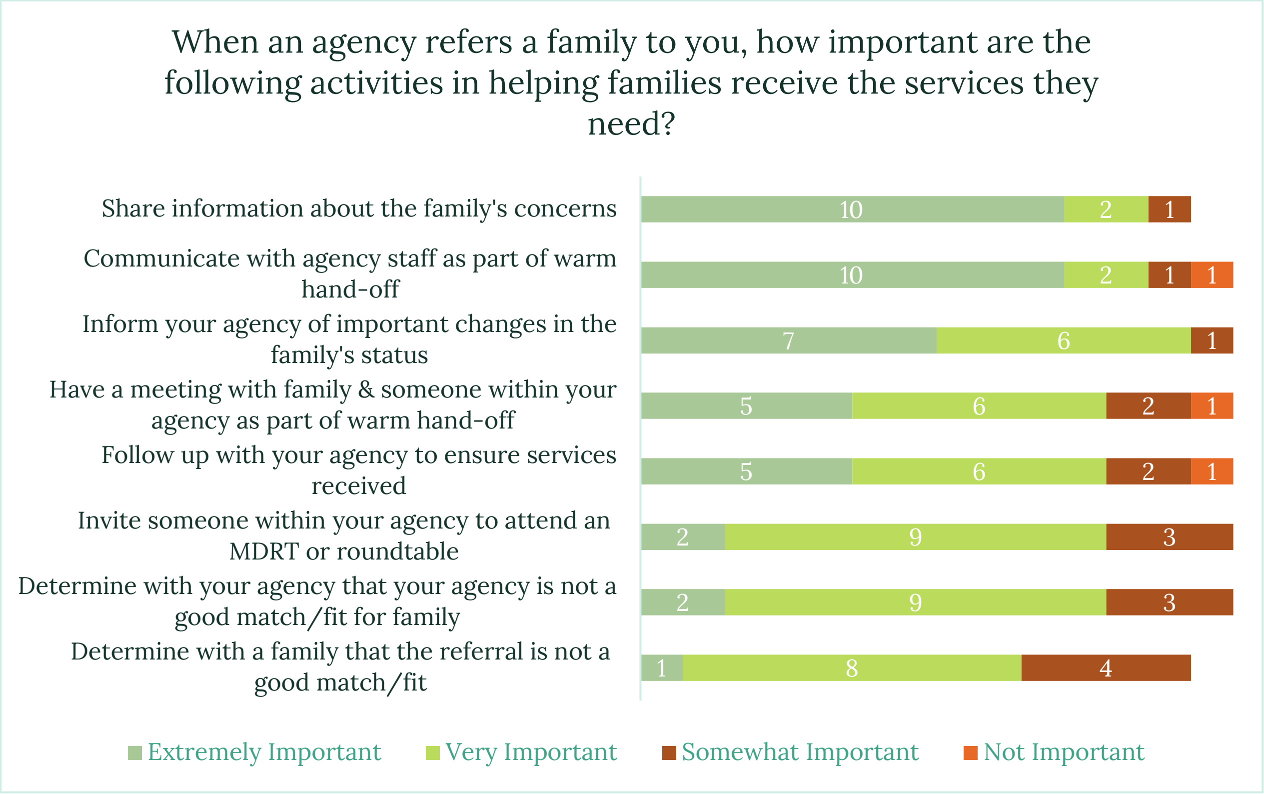

What are the top 2 reasons that families aren't able to connect to services?

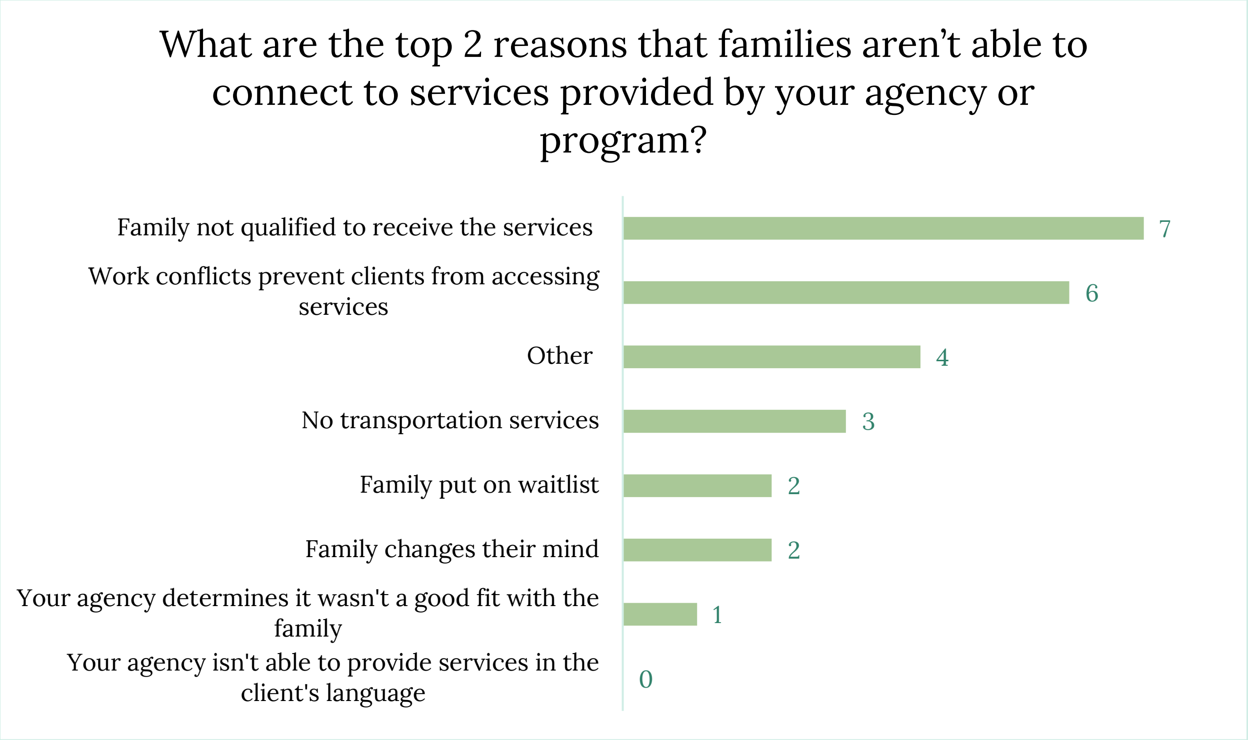
Partner survey responses






Thinking of non-First 5 funded agencies, when an agency refers a client how often do they do the following as part of the referral process?
Share information about the family's concerns
4
1
3
3
1
Communicate with agency staff as part of warm hand-off
2
1
5
4
Follow up with your agency to ensure services received
1
2
3
4
2
Inform your agency of important changes in the family's status
1
1
4
2
4
Have a meeting with family & someone within your agency as part of warm hand-off
1
3
4
4
Invite someone within your agency to attend an MDRT or roundtable
5
3
4
Determine with a family that the referral is not a good match/fit
3
3
6
Determine with your agency that your agency is not a good match/fit for family
3
3
6
Always
Often
Sometimes
Rarely
Never


When an agency refers a family to you, how important are the following activities in helping families receive the services they need?
Share information about the family's concerns
10
2
1
Communicate with agency staff as part of warm hand-off
10
2
1
1
Inform your agency of important changes in the family's status
7
6
1
Have a meeting with family & someone within your agency as part of warm hand-off
5
6
2
1
Follow up with your agency to ensure services received
5
6
2
1
Invite someone within your agency to attend an MDRT or roundtable
2
9
3
Determine with your agency that your agency is not a good match/fit for family
2
9
3
Determine with a family that the referral is not a good match/fit
1
8
4
Extremely Important
Very Important
Somewhat Important
Not Important


What are the top 2 reasons that families aren't able to connect to services provided by your agency or program?
Family not qualified to receive the services
7
Work conflicts prevent clients from accessing services
6
Other
4
No transportation services
3
Family put on waitlist
2
Family changes their mind
2
Your agency determines it wasn't a good fit with the family
1
Your agency isn't able to provide services in the client's language
0