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ORIGINAL PAPER

California Essentials for Childhood Case Study: Collective Impact Through Strategic Opportunities

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Abstract

This case study describes the formation, process, and implementation of the California Essentials for Childhood (EfC) Initiative. Major successes and challenges of the EfC Initiative are highlighted, as well as lessons learned and future directions. Grounded in a collective impact organizing model, the EfC Initiative brought a public health lens to addressing child maltreatment in California with an emphasis on primary prevention and social determinants of health. The public health perspective allows for broader policy and systems change approaches that can have population-level impacts. This perspective was embraced by partner organizations in ways that will have lasting influence and help to align cross-sector efforts to promote safe, stable, nurturing relationships and environments. The EfC Initiative was also successful in developing new Childhood Adversity and Resilience metrics for Kidsdata.org and local dashboards that provide actionable data for local partners. However, it was challenging to operate under a collective impact structure in a state as geographically and demographically diverse as California. The lessons learned will inform the next steps for the EfC Initiative.

Keywords Child abuse · Child neglect · Child maltreatment · Prevention · Collective impact · Policy · Systems change · Social norms

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Introduction

The California Essentials for Childhood (EfC) Initiative, funded by the Centers for Disease Control and Prevention (CDC), was a joint effort of the California Departments of Public Health and Social Services. The five-year project focused on promoting safe, stable, nurturing relationships and environments for all children and families to prevent child maltreatment (CM) and promote child, youth, family, and community well-being across the state of California. The EfC Initiative was structured based on a collective impact organizing model, and provided a forum for diverse stakeholders convened under a shared agenda to undertake mutually reinforcing activities on behalf of children and families. This case study describes the formation, process, and implementation of the EfC Initiative. Major successes and challenges of the EfC Initiative are highlighted, as well as lessons learned and future directions.

Demographic Context

At the time of the initial California Department of Public Health (CDPH) EfC grant application, California was (and still remains) the most populated state in the nation, with an estimated 2013 population of over 38 million people. It was also the most diverse state with a non-majority population split between whites (40%) and Hispanics/Latinos (38%), and for children under 18 years of age Hispanics/Latinos are the majority (California Department of Public Health 2018). As a state, however, California had the highest proportion of children living in poverty. The California Poverty Measure showed a 2013 child poverty rate of 23.6%, with around 5.0% of children in deep poverty (Bohn et al. 2017). The California Poverty Measure is a more comprehensive measure of poverty, since it incorporates changes in the standards of living that have occurred since the creation of the federal poverty measure. Furthermore, there were disparities in poverty for the year 2013 among different racial/ethnic groups. The percentage of Hispanics/Latino children in poverty was 32.6%, more than double that of Asian (15.1%) and white (12.4) children. The percentage of children who were food insecure in 2013 was 9.9% (Coleman-Jensen et al. 2014). These data demonstrated that prosperity and scarcity were not evenly distributed across California's populations and that these inequalities negatively impact the well-being of children and families.

For the baseline year of 2013, there were 40.3 substantiated CM reports per 1000 children in the state of California (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau 2015). This was slightly less than the national rate of 42.9 reports per 1000 children (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau 2015). For California, the breakdown of CM reports by race (per 1000 children) was 6.8 for whites, 20.1 for Blacks, 8.6 for Hispanics/Latinos, 1.7 for Asians, 14.0 for American Indian/Alaska Natives, 7.5 for Pacific Islanders, and 6.2 for Multiracial (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau 2015). There were also socioeconomic disparities with regard to CM in racial/ethnic groups. For example, when poverty indicators are considered within each racial/ethnic group, the differential rates of CM across racial and ethnic groups are

substantially reduced (Putnam-Hornstein et al. 2013). This highlights the strong and complex intertwined nature of the relationship between not only racial and ethnic groups and socioeconomic standing, but also with Child Protective Services involvement. These data demonstrated that CM was and is a significant problem in the state of California and that disparities exist across income levels and racial and ethnic groups.

The CDPH data from the Behavioral Risk Factor Surveillance System (BRFSS) showed that for the year 2013, 27.4% of adults in California reported having three or more Adverse Childhood Experiences (ACEs) as children, and 16.8% of adults reported having four or more ACEs as children (California Department of Public Health 2016). Numerous studies have shown that high numbers of ACEs are strongly correlated with emotional and behavioral problems during young adulthood, and chronic conditions in adulthood such as asthma, cardiovascular disease, chronic obstructive pulmonary disease (Anda et al. 2008; Brown et al. 2006; Center on the Developing Child at Harvard University 2018; Felitti et al. 1998). Overall, baseline data indicators suggest that California's families and children faced multiple structural, socioeconomic, cross-sector, and family-related challenges that have the potential to affect the long-term health and well-being of our children.

Social Context

Prior to and during the implementation of EfC Initiative, California has had democratic majorities in both houses of the legislature and a Governor from the Democratic party. After the 2008 recession, California's policy dialogue was about the budget (i.e., balanced budgets, rainy day funds, how to restore the safety net), rather than about whether to reduce public services. The majority of state General Funds for the Health and Human Services Agency were and continue to be allocated toward direct service delivery. For the 2015–2016 fiscal years, approximately $892 million of total state funds were allocated to CDPH under the California Health and Human Services Agency (HHSA) budget umbrella (California Department of Finance 2015). The California Department of Social Services (CDSS), on the other hand, was allocated approximately $8 billion under the same umbrella primarily to provide funds for a safety net of human services (California Department of Finance 2015). CDPH allocated its state and federal funds to existing or federally targeted priorities, which meant that relatively few prevention initiatives received financial support.

By the time of the EfC Initiative cooperative agreement, state government had enacted the Affordable Care Act and was working to expand the state Medicaid program. There were also several funded organizations engaging in child and family well-being work relevant to the EfC Initiative. At the time, the First Five California program had been in place for over a decade, since voters passed Proposition 10 in 1998 adding a 50-cent tax to each cigarette pack sold in California. The majority of the funds generated through this excise tax are allocated to local First Five Commissions in each of the 58 counties to engage in prevention and intervention activities. In 2007, the CDSS Office of Child Abuse Prevention (OCAP) began using the Strengthening Families framework (Center for the Study of Social Policies 2018) and was providing funds for local services through a series

of child welfare programs. Multiple home visiting programs were also in place locally and through the CDPH, Maternal Infant and Adolescent Health program that received funds through the federal Maternal, Infant, and Early Childhood Home Visiting program. Although state funds allocated to CDPH for child death review were eliminated in 2008, many larger counties in California maintained their local Child Death Review Teams (CDRT) and the CDPH Fatal Child Abuse and Neglect Surveillance program continued to provide CDRTs with access to the National Center for Fatality Review and Prevention's Case Reporting System.

Another existing priority for CDPH when our EfC Initiative application was submitted was the creation of the Let's Get Healthy California (LGHC) Task Force. The Task Force was created in 2012, under the Governor's Executive Order B-19-12, with the goal of making California the healthiest state in the nation by 2022 (Let's Get Healthy California Task Force 2012). There were six major goal areas for LGHC: healthy beginnings, living well, end of life, redesigning the health system, creating healthy communities, and lowering the cost of care. Thus, there were multiple opportunities to align various initiatives at CDPH under the LGHC goals.

There were also well-established networks of child abuse prevention councils, family resource centers, early childhood education organizations, and parents and teachers promoting child welfare services, pre-school, and increased support for schools. However, as the data summarized above demonstrate, California still faced major challenges to providing safe, stable, nurturing relationships and environments for all families and children.

California Essentials for Childhood (EfC) Initiative Overview

The primary reason that the CDPH Safe and Active Communities Branch (SACB) applied for the EfC grant was to strengthen the public health voice in the child welfare and early education domains to promote upstream primary prevention strategies, policies and practices. SACB believes that public health offers the potential to inform the dialogue through data, the promotion of evidence-based practices, and most importantly, a focus on broader policy and systems approaches to address the primary economic and other social determinants of CM. However, expectations for the Initiative were moderated by the size of the state, the magnitude and complexity of the social problem, and the large number of organizational players involved.

Although prevention was often mentioned, the overwhelming need for more immediate and concrete services for children and families dominated the policy dialogue. In addition, we were aware of the powerful role that social norms played in shaping the media, public, and policy agendas on how CM was addressed. The dominant social norm for CM was and continues to be that it is primarily a family matter, with attribution at the level of individual responsibility. However, there is also a growing body of research and practice that highlights the importance of how educational messages promoting early childhood education, as well as violence prevention, are framed. For example, the 1998 First Five California voter initiative successfully re-framed early childhood education messages to focus on shared community responsibility to support California's youngest residents, and

therefore, benefit all of society. Thus, we hoped not only to promote a more primary prevention focus, but also to raise the salience of broader policy and systems solutions in California.

Methods

This case study was designed to help assess the successes and challenges of the California EfC Initiative in its implementation of a collective impact process to prevent CM. In preparing this case study, we reviewed our meeting agendas and summaries, data and progress reports, compiled our own recollections, and conducted 15 semi-structured interviews with key stakeholders in the EfC Initiative. This case study is not intended as a comprehensive evaluation of the EfC Initiative, but rather more as a general description and set of personal insights into how this effort was perceived by our major partners. We hoped to identify some of our foremost accomplishments, major challenges, and strengths and weaknesses of our efforts to date. The ultimate goal is to apply the lessons learned to improve the next phase of our efforts.

In addition to our archival review, we conducted a series of 15 semi-structured qualitative interviews with key state and local stakeholders with expertise and knowledge in CM. We adapted and developed our in-depth semi-structured qualitative questionnaire based on the questionnaire developed by the EfC Colorado evaluation team. We piloted the questionnaire with backbone agency partners at the CDSS OCAP. The questionnaire asked about the informant's role and understanding of the EfC Initiative common agenda, highlights of their involvement, their perceptions of the collective impact process, challenges and lessons learned, and the degree of EfC success (e.g., accomplishments). The list of potential key informants included those involved in various parts of the EfC Initiative, serving on the Steering Committee, as a part of the larger membership body, or in specific workgroups. The actual selection and completion of the interviews represented a purposive convenience sample of those who were heavily involved with the EfC Initiative and available within our time frame. All interviews were conducted from June to September 2018. We obtained informed consent from all participants and participants were told that they could stop their interview at any time without explanation. The interviews ranged from 30 to 60 min in length. We provided participants with a copy of the questions if requested. With permission, interviews were recorded using digital recording software and interviews were transcribed by a professional transcriptionist. We analyzed the transcripts to help identify and illuminate major themes most relevant to the assessment of the EfC Initiative.

In describing the process of implementing the collective impact approach to the EfC Initiative, we identified themes and use quotes from the stakeholder interview transcripts to add depth to the description of the EfC Initiative's progress. The interview transcripts highlight various levels of involvement with the EfC Initiative, and represent a diverse set of perspectives and associated takeaways from state and local informants. These perspectives are organized around the five central components of the collective impact framework (i.e., common agenda, backbone, mutually reinforcing activities, continuous communication, and shared metrics).

Results

Common Agenda

Based on the four CDC goals, the California EfC Initiative developed a common agenda with a vision, mission, and governance structure (Fig. 1).

In our experience, creating the common agenda was a relatively quick and easy process for the EfC Initiative. The entire process was completed within three meetings. The relatively small and diverse set of stakeholders that convened for the EfC Initiative chose to create a rather broad common agenda because participants already shared a well-grounded understanding of the problem and current situation. Although multiple sources of data were made available, there was little desire to discuss their details at this point in time because the goal was to develop a shared action plan and to avoid "paralysis by analysis". The intended purpose of creating this broad common agenda was to ensure widespread buy-in across multiple professional and public sectors.

The structure for the EfC Initiative collective impact organization addressed 10 goals to target selected intermediate determinants of child well-being (Fig. 1). These identified goals were of primary significance to the EfC Initiative and motivated partner involvement.

Interviewed stakeholders conveyed a good understanding of the goals of the EfC Initiative. Stakeholders acknowledged the need for a widely shared vision for change

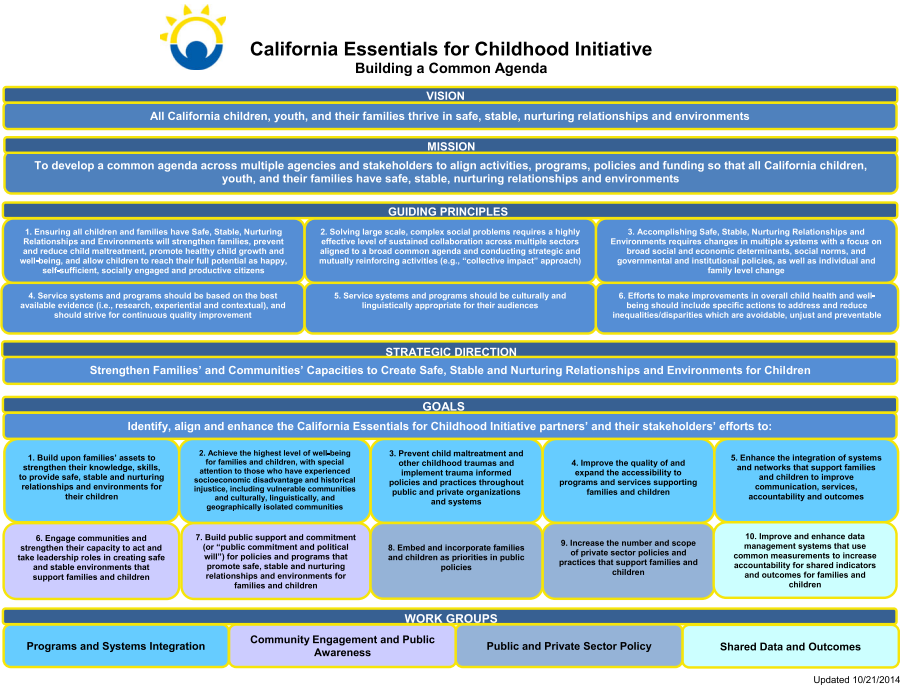

Fig. 1 California EfC Initiative Common Agenda

and embraced the collective impact approach for solving this complex social problem. For example, one participant stated:

> There was definitely more…conversations surrounding creating a shared agenda to tackle child abuse [and] maltreatment and prevention, and I think that…you can measure success in so many different ways, but I feel like certainly it put… trauma-informed care, resiliency, safe, stable, nurturing environments, it put all of that on the radar for a lot of people that I think would have not necessarily had that as a part of their shared agenda.

There was also a consensus that the public health model was useful in framing the EfC Initiative efforts. Interview participants shared how the public health approach was valuable for engaging in CM prevention work. The interviewees highlighted that the public health approach emphasizes systems-level change from a prevention lens, and offers an opportunity to engage multiple state agencies in thinking about determinants of health and well-being. As these two stakeholders shared:

> Everybody was aligned that taking the public health approach was important for this project and that really it's the most impactful way to address these problems… to focus on the systems perspective [and] to identify and change barriers that families and communities encounter. So, I feel like it was a valued and kind of universally accepted that this is like the best way to approach it.
>
> My understanding is that the public health approach adopts a broad prospective to address children's health and well-being, and it recognizes that a coordinated approach is best across agencies and organizations to ensure that systems and policies are in place that support children and youth… The public health approach is really the best one. It's the most effective to way to promote healthy communities and environments to address issues like poverty, drug use, violence, that threaten optimal health and well-being. I think that significant lasting improvements require this system-level type change.

Stakeholders also commented on the innovative nature of using a social determinants of health perspective in thinking about CM prevention. Participants shared how this was one of the first cross-agency initiatives at the state-level to approach CM from this framework. For example,

> Essentials was kind of out in front of using social determinants to address these issues in a new and different way at the time. And I think now, most programs are incorporating social determinants. And the term social determinants now has become more accepted in programs across this state.

Considering that the common agenda was broad, it also created some challenges in terms of direction. Interviewees conveyed that there were successful activities implemented as a part of the EfC Initiative, but that it was sometimes unclear how activities were aligned with the overarching common agenda. This underscored the tension between the broad agenda and the identification of concrete objectives and specific activities by the action workgroups. As this stakeholder commented,

> In terms of the mission/purpose, I felt that we did develop a common agenda. I'm just not so sure how activities were aligned. But we did internally try to align Essentials activities with our own internal activities, and strengthening families and communities. So yes, whatever the ranking is on that, I'll give it the highest ranking possible.

Backbone and Co-backbone Organizations and Organizational Structure

The EfC Initiative was and continues to be grounded in the co-backbone alliance of CDPH's SACB and CDSS's OCAP. The selection of OCAP as the co-backbone organization by SACB was perhaps the most influential decision for the EfC Initiative. Based on multiple past joint activities (e.g., child death review, the Safely Surrendered Baby Law; abusive head trauma prevention), the principal investigator (SW) understood that OCAP would be an indispensable player to enact any successful primary prevention state-level systems change within the child welfare field. The principal investigator indicated that he had hypothesized from the beginning that engaging OCAP, strengthening its understanding and commitment to a public health perspective (i.e., broadening the focus to include primary prevention, systems change and social norms change), and increasing its standing and salience within the broader CDSS organization, might be the most substantial and lasting impacts of the EfC Initiative. Although there were changes in OCAP leadership over the five-year course of the EfC Initiative, the commitment and buy-in to both the collective impact approach and the EfC goals has continued to be exceptionally strong. OCAP has provided continuous in-kind support, and incorporated many of the EfC fundamental principles into its own organizational structure and funding activities.

The relationship between the co-backbone agencies was highlighted in several interviews. Key informants commented on how traditionally there is often a tension between the public health prevention lens and social services. However, respondents shared that the collaboration between CDPH and CDSS was unique, and that the public health model helped to shape efforts internally within OCAP. For example, one respondent said, "Our enhanced partnership with [C]DSS and OCAP has really moved this agenda forward, and I think having them as engaged as they have been… was essential." Another stated:

> In particular, I think having OCAP at CDSS as our co-backbone, was very, very helpful and successful in terms of illuminating what a public health approach can be in that context… I think that… they have been able to look at broader norms and systems changes to effect CM through the work of the office.

Identification of EfC Partners

From the beginning, the primary strategy for recruitment for the EfC Initiative was a phased engagement approach of concentric circles, starting with those most closely involved in child welfare and CM prevention. In addition to the required participants as stated in the funding announcement (e.g., state Child Abuse Prevention and Treatment

organization; Prevent Child Abuse America chapter; Parents Anonymous), an initial "snow ball" process was used to identify partners through existing contacts and relationships. All the initial partners were asked to identify additional related partner organizations and the backbone staff made contact to recruit them. This process produced a robust number of players from the child welfare field who had connections to multiple relevant professional domains (e.g., early child development, education, health equity, and media). The stakeholders engaged in the EfC Initiative represented a diversity of state and local perspectives including professionals and parents from child welfare, early child development, education, health, and juvenile justice, among others. Although some non-traditional partners were also invited to the table (e.g., business), a conscious decision was made to go slow in trying to engage these partners. This decision was driven by the need to have a better understanding of their perspectives and a clear set of "asks" before engaging in successful outreach and engagement efforts.

The other primary dynamic of the EfC Initiative was driven by the basic size and scale of the complex social problem, the large state of California, and the multiple existing structures that were already in place to address it. The very magnitude and diversity of the state created major organizing challenges and opportunities. As the planning process progressed, a major challenge was whether we should convene and organize the collective impact processes ourselves, or if we should use a more macro-level structure to work with existing groups and organize pieces of their work around the mutually reinforcing and aligning principles of collective impact. For our policy and systems change domain, it became clear that we were not best positioned to implement these aspects of the goals and common agenda. As a result, we purposefully created a neutral platform to support the development of a "Network of Networks" for stakeholders and policy makers to collaborate and align activities.

Membership Organization Structure

The formal organizational structure for the EfC Initiative consisted of an executive planning body, community partners, and workgroups. The executive planning body included the co-backbone organizations, as well as a Steering Committee. CDPH and CDSS staff identified partners to serve on the Steering Committee based on their knowledge and expertise in addressing CM prevention. The Steering Committee provided input on workgroup activities that were related to the common agenda. Other responsibilities of the Steering Committee included monitoring progress and outcomes, promoting mutually reinforcing activities, advancing policy, and educating the public. In the beginning, the Steering Committee met roughly on a quarterly basis to discuss EfC Initiative progress, but over time this schedule was difficult to maintain.

The community partners formed the Leadership Action Team, or membership body for the entire EfC Initiative. The Leadership Action Team was convened on a yearly basis to receive an overview of EfC Initiative activities as coordinated by the various workgroups and to provide feedback on progress and next steps. Membership was dynamic and based on the interests and needs of the EfC Initiative's strategic priorities. Efforts were made to have the membership be reflective of California's diverse population and groups. The Leadership Action Team membership changed throughout

the duration of the Initiative, due to organizational turnover and member participation, as well as the ability of the EfC Initiative to engage and motivate involvement.

The workgroups were the primary vehicle through which the EfC Initiative activities were implemented. The four original workgroups were organized around the 10 goals of the California EfC Initiative (see Fig. 1). The Programs and Systems Integration Workgroup was comprised of service providers interested in prevention work that emphasized family strengths to provide safe, stable, nurturing relationships and environments for all children. This workgroup also focused on implementing trauma-informed policies and practices throughout public and private organizations and systems, as well as improving services for children and families.

The Community Engagement and Public Awareness Workgroup was formed around the goals of educating and engaging communities, and building public awareness and support for CM prevention. The work of this workgroup was closely aligned with communication efforts of the OCAP co-backbone agency surrounding April Child Abuse Prevention Month and their Community in Unity campaign.

The Shared Data and Outcomes Workgroup was tasked with creating a set of shared metrics. This workgroup engaged in some of the most successful activities for the EfC Initiative, as multiple partners were interested in empowering communities from a data perspective to address CM and the broader issue of adversity.

Lastly, the Public and Private Sector Policy Workgroup was created to identify policy-related priorities for the EfC Initiative. As mentioned, we quickly determined there were many existing collaboratives and initiatives with similar agendas (e.g., First Five California, Defending Childhood, and California Campaign to Counter Child Adversity - 4CA) throughout the state, and some had substantially more resources than the EfC Initiative. It was clear that we were not in the best position to lead the statewide policy effort, but rather our role could be as a promoter of a "Network of Networks". We recruited our CDPH partners in the Office of Health Equity (HiAP) to be the lead facilitator of this networking group.

Opportunistic Approach Versus Traditional Planning Process

The EfC Initiative governance structure, and in particular the workgroups, provided a vehicle to engage in activities related to the common agenda. While some of the workgroup activities were determined through traditional planning efforts, the majority of work undertaken by the EfC Initiative capitalized on emerging opportunities. An example of this opportunistic approach was the work of the EfC Initiative that focused on making California a resilient and trauma-informed state. The trauma-informed care movement was becoming a growing force among social service and prevention agencies, but tended to focus primarily on improving services for clients. The EfC Initiative and its partners seized upon the opportunity to promote an expanded vision of the "trauma informed approaches" to include primary prevention, upstream organizational and systems change, and community engagement.

Continuous Communication Efforts

Another domain of collective impact focuses on continuous communication. Considering that there was a diverse set of partners involved in the various levels

of the EfC Initiative's governance structure, it was important to update members on the various activities happening in between in-person meetings or teleconferences. Some of the work to promote communication under the collective impact structure was conducted through the Community Engagement and Public Awareness Workgroup, but the majority of efforts were undertaken by the co-backbone agencies.

The broad governance structure made it challenging for the limited EfC Initiative staff to keep all partners engaged and informed. Meeting summaries were provided for participants after Steering Committee, Leadership Action Team, or workgroup meetings. Evaluation surveys were also sent out to all participants after large in-person convenings. The backbone agencies chose not to convene partners on a regularly scheduled basis, but instead only bring stakeholders together when there was an appropriate ask (e.g., promotion of the Raising of America video; Making California a Trauma Informed State). However, this also created communication challenges and discontinuity in membership involvement. In order to improve communication efforts within the EfC Initiative, the backbone agencies began distributing a periodic newsletter than highlighted workgroup activities, as well as partner efforts. While the newsletter was a successful communication tool, it became increasingly challenging to sustain over time with limited backbone capacity and staff turn-over.

Some stakeholder interviews highlighted this communication challenge through their limited understanding of the EfC Initiative's structure and purpose, as well as a sense of disconnectedness to the group's activities. A central recommendation of several interviewees was that communication could be improved as the EfC Initiative continues into its next phase.

Shared Metrics

One of the main successes highlighted by interview participants was the work of the Shared Data and Outcomes Workgroup. As a direct result of the EfC Initiative, several partner organizations came together to launch a new set of childhood adversity and resilience data indicators on Kidsdata.org. The purpose of this data topic was to bring together a broader set of indicators than originally reflected in the Adverse Childhood Experiences (ACEs) study, such as living in poverty or violent neighborhoods, or experiencing chronic food insecurity, to provide actionable data at the local level. As this stakeholder said,

> The Data Workgroup really took off in a wonderful direction because we had partners from ACEs Connection, partners from CA First 5, and Kidsdata.org, and so we were looking at different…measures. It was great to see work move consistently, and I think that is certainly one of the lessons learned when you can have a staff member engaged consistently over time, there's more progress that can be made.

Participants shared how the Childhood Adversity and Resilience data topic included community-level data that could be used to identify different sources of adversity at the local level. The unique nature of this collaborative activity was highlighted across

multiple interviews and is an example of how the EfC Initiative responded to community needs, as identified by our partner organizations. For example, this partner said,

> To me, it was helping get important child adversity and resilience data into the hands of communities to be able to use it. Prior to our Essentials project… there were lots of different places to find ACEs-related data, but Kidsdata was able to compile it in one place. And the MIHA [Maternal and Infant Health Assessment] data was just really powerful data combined with the BRFSS [Behavioral Risk Factor Surveillance System], and the CAHMI [Child and Adolescent Health Measurement Initiative] data in an easy to find format, easy to access format. That doesn't happen in any other state.

Stakeholders also commented on how the work of the Shared Data and Outcomes Workgroup has continued to influence community-level activities. A key component of the work was to create the online state and county-level dashboards with a broader set of family and community adversity and resilience indicators, along with a small list of criteria-driven risk and protective factor indicators across the life course. The partners engaged in this work also provided hands-on trainings to local communities to disseminate the data and build capacity to use it.

Along with the distal level indicators monitored by the CDC, the indicators identified for the state and county-level dashboards served as shared metrics for the EfC Initiative. During the grant period, we did not anticipate that we would be able to show (or take credit for) any meaningful statewide changes in these high-level indicators. This is because the social determinants of health framework, as adapted in the context of CM, emphasizes multiple structural and intermediate determinants of child and family well-being. Impacting these high-level indicators are long-term goals of the EfC Initiative, but for the purpose of the grant, the emphasis for evaluation was more on process-related outcomes.

In summary, this workgroup:

- Created a new data topic on Kidsdata.org and state and local EfC dashboards using three adversity measures (i.e., BRFSS, Maternal Infant Health Assessment (MIHA) and National Survey of Children's Health (NSCH) – to broaden the scope of child adversity by including other social determinants of health. Specifically, the workgroup has been able to:

  - Expand the trauma-informed lens beyond the original ACEs focus on family dysfunction by identifying additional data sources that capture broader socio-ecological risk and protective factors for adversity (e.g., NSCH, MIHA).
  - Build upon the existing Kidsdata.org platform to add the first new data topic in 6 years on Childhood Adversity and Resilience using three data sources to provide better statewide and county level indicators of child adversity status.
  - Create online state and county–level dashboards with the new adversity and resilience indicators along with a small list of criteria-driven risk and protective factor indicators across the life course.

– Conduct outreach to provide hands-on trainings to local communities to disseminate the data and build capacity to use it (including application of framing techniques informed by the Berkeley Media Study Group and CDC-supported consultation from Dr. Lynn Davey). Training sessions have been held in Butte (nine rural northern California counties represented), Alameda (seven bay area counties represented), Fresno, San Bernardino, and Riverside counties.

Mutually Reinforcing Activities

The collaborative nature of the EfC Initiative brought together multiple diverse state and local agencies and non-profit organizations to engage in conversations and mutually aligned activities to tackle CM with a primary prevention lens. Stakeholder interviewees shared that these conversations helped to move the EfC Initiative agenda forward. The use of the collective impact framework helped to strengthen relationships across sister agencies at the state and local level, as well as internal and external relationships at other agencies.

The EfC Initiative has multiple examples of successful aligned resources and activities:

- Provided ACEs data to inform new statewide legislation restricting the use of "willful defiance" as grounds for suspension of K-3 children (that was being applied in a disproportionate and unequal manner with young black children);
- Through their educational efforts, EfC Initiative partners have informed multiple additional legislative changes, including expanded paid and unpaid family leave, increased subsidized child care slots, increased minimum wage, California Earned Income Tax Credit expansion, Trauma-informed legislative resolution, a Trauma-informed EPSDT benefit workgroup, and a new $10 million, three-year project entitled All Children Thrive to provide training and technical assistance on trauma-informed policies and practice to local jurisdictions;
- Joint agreement among First Five California, Department of Education and HHSA to support the ongoing inclusion of the ACEs module in the California BRFS;
- Promoted and disseminated the Raising of America (see Klevens & Alexander in this issue for description), Paper Tigers (documentary about a trauma-informed school; KPJR 2015), and Resilience (documentary about ACEs and therapies that mitigate their effects; KPJR 2016);
- Formal CDPH department-wide recognition and prioritization of ACEs and the EfC agenda (e.g., Let's Get Healthy California and Violence Prevention Initiatives) with dedicated and funded staff within CDPH for the Violence Prevention Initiative to provide a sustained platform to facilitate and coordinate collaboration, including among EfC partners;
- Under the "healthy beginnings" goal of Let's Get Healthy California, the EfC Initiaitve provided two baseline indicators that focused on CM and ACEs;
- Formal CDSS OCAP recognition and prioritization of ACEs and the EfC Initiative agenda into its: a) strategic planning efforts; b) expansion of family strengthening and trauma-informed supports and training opportunities (e.g.,

Strategies 2.0); c) Community in Unity campaign (e.g., April Prevention Month); and d) release of 10 local Economic Empowerment grants;
- Provided data and technical support on framing educational messages to the California Campaign to Counter Child Adversity's (4CA) two Policy Maker Education Days at the State Capitol, July 11, 2017 and May 22, 2018.
- Promoted outreach and support for the federal and state Earned Income Tax Credits and Cal-Works as evidence based primary prevention programs;
- Assisted partners in receiving foundation grants for EfC-related work (e.g., Blue Shield Foundation grant to HiAP to promote trauma-informed organizational change; Lucile Packard Foundation support for EfC Initiative Data Workgroup ACEs outreach efforts);
- Multiple partner efforts to promote "Building a Resilient, Trauma-Informed State";
- Multiple joint educational presentations on EfC and ACEs science, including recent 2018 events: First 5 California, Child Health, Education and Care Summit, April 10–12, 2018; Child Abuse Prevention Center, Toward a Trauma-Informed Northern California, April 18, 2018; Health Officers Association of California and MCAH Action, The Road to Resilience: A Public Health Approach to Adverse Childhood Experiences, May 11, 2018.

Accomplishments

In addition to the accomplishments noted above (e.g., adversity data metrics and strategic alignments), several other accomplishments should be noted.

Integration of EfC into Organizations' Agendas

Perhaps the most powerful and lasting impact of the EfC Initiative has been the degree to which the two backbone organizations have been able to embrace and incorporate the goals, principles, and public health perspective into their broader organizational structure and priorities. Within CDPH, for example, core components of the EfC agenda have been integrated into several ongoing structural and functional aspects of the department, including as share metric indicators and in the Let's Get Health California and the Violence Prevention Initiatives. There is also high-level buy-in at the Directorate level of management within CDPH. For our co-backbone CDSS partner, OCAP has embraced both the upstream social determinants focus (e.g., economic empowerment grants) and the broad trauma-informed policy and organizational agenda (e.g., Building a Resilient, Trauma Informed State) into its training, community building and intervention grants.

Although several partners conveyed support for the EfC Initiative framework and understood its value in addressing CM, interviewees also reflected on how the EfC Initiative fit into their own organizational agendas. For example,

> I think that we've been very mindful of the Essentials work. We understood the Essentials work. We supported the Essentials work. We believed in the vision…

> I'm looking at the common agenda of Essentials… thriving in safe, stable, nurturing relationships and environments, that totally aligns with our agenda and it's very positive. For us, it took us away from just preventing child abuse and neglect and broadening that.

However, some participants shared that while they personally supported the EfC Initiative and bought into the common agenda, it did not necessarily integrate with other efforts in their organization. Organizations have their own agendas and often engage with multiple initiatives. Even if there is alignment between initiatives and activities, it may not translate at the agency level. As this stakeholder commented, "They've [agency staff] got five other initiatives that they're all thinking about, and so this [Essentials] didn't really fit into their world very easily. Not that they didn't embrace it, but they just didn't really understand it."

Challenges

Limited Staff Capacity

The main challenge highlighted for the EfC Initiative concerned limited staff capacity. Through engaging in this work, it became clear that managing a collective impact initiative is very time-intensive and requires enough staff to facilitate the governance processes and coordinate multiple workgroups. The backbone team experienced two major challenges: 1) limited CDPH staff time (less than one full-time equivalent staff funded through the CDC grant); and 2) changes to OCAP leadership and staff turnover. In addition, the EfC Initiative project activities created competing time demands for both backbone agency staff that made it challenging to convene the Steering Committee, Leadership Action Team, and workgroups as often as desired. As this participant stated,

> I think the biggest challenge, and I think that this needs to be said is that…it lacked resources. And by resources, I mean human resources. And yes, it had a convener who did just an excellent job, and I don't know if that convener was fully devoted to the time or not because in terms of my interaction with that individual, they did an outstanding job… I just think that there was a gap in making this happen at a more localized level.

Interview participants also considered the idea of what could have been accomplished with better staff capacity. Additional staff may have helped to move the common agenda further forward by regularly convening the workgroups. For example,

> If we had more resources and more staff dedicated to this… To have more continuous opportunities to have the workgroups meet more frequently and have more people engaged, we might have even made more progress."
> The backbone could only do what they could do. They only had limited staff, and limited resources, and limited support. So…with more backbone support, my guess would be we could have done more at Essentials. But we only had what we had.

Mixed Involvement EfC Initiative Activities

Another challenge concerned stakeholder involvement in EfC Initiative activities. Engaging in a collective impact process requires sustained backbone support and in-kind support from partners. As a result, it can be challenging to keep participants involved throughout the duration of the EfC Initiative. Clearly there was a great set of individual champions across the duration of the Initiative, but there were also many partners who were not fully involved. For example,

> The huge ones [champions] that come to mind, obviously like the partnership with public health and OCAP was you know, really great, the Lucile Packard Foundation, ACEs Connection, and the Health in All Policies Workgroup… 4CA. There are so many partners, and that was the wonderful part of the project, but also probably made it a little bit challenging to kind of manage all the moving pieces and stuff, the various agencies and state agencies, and other agencies.

Lack of Clarity About the Collective Impact Process

Another major challenge that emerged from the stakeholder interviews and was also echoed in meeting evaluation notes, concerned a lack of clarity surrounding the collective impact process. Stakeholders shared that the initial meetings for the Efc Initiative were exciting, but over time, some meetings were confusing or lacked clear direction. For example,

> I remember that first meeting that I attended, and it was kind of like okay we're going to take on the world…and that was exciting to me…. There's plenty for us to do in public health, coming from a public health perspective myself. But it was also a little difficult to explain what we are doing.

The slow nature of the initial stages of a collective impact project and the request for in-kind support from participants also limited involvement for some individuals. Stakeholders were more likely to be engaged when activities were directly related to the work of their organizations. The EfC Initiative consisted of several different workgroups, which created a "disconnect" between participants, and contributed to the lack of clarity about how we were moving forward on activities related to the goals and common agenda. As this participant stated,

> This was for the most part kind of added on to what busy people are already doing… I found that when we all got together, I thought the general convenings were productive. It was just the follow through after that that I'm not so sure what happened.

State Versus Local Focus

There was also a clear recognition of the difficulty of addressing both the state and local level for a large state with limited resources. As these participants summarized,

> Sometimes we didn't always hear the local perspective as often as we might. But again, it's hard. That's one of the challenges. So, we did hear it sometimes. For example, some of the people that work at county-level agencies or county non-profits that spoke at some of the meetings. But I think one of the challenges is how to link the state level agencies with county-level agencies, whether they're government agencies or non-profits because I think that's where a lot of the work is to make things happen.
>
> California is such a diverse type of state … we have so diverse communities. We have the rural north that could be Idaho. And then we have urban Bay Area, Los Angeles, San Diego, [and] the whole urban swatch, which has completely different issues than the rural north. And then we have the Central Valley, and the Inland Empire, and the border counties that are very different... I don't know how much I heard those discrete different perspectives.

Conclusions

This case study has attempted to document fundamental elements of the collective impact approach used by the California EfC Initiative and highlight some of its successes and challenges in addressing CM. This review relied upon meeting agendas and summaries, data and progress reports, semi-structured interviews of key stakeholders and the authors' personal reflections. It is not intended to be a comprehensive evaluation of the EfC Initiative, but rather its purpose is to shed light on the implementation process and identify lessons learned to inform our next steps.

Interview participants expressed a general understanding of the common agenda which suggests stakeholder buy-in to the purpose and goals of the EfC Initiative. Participants also lauded the value-added of the public health perspective when engaging in CM prevention. The primary prevention lens and social determinants framework were seen as unique assets for bringing together cross-sector partners and focusing on systems-level changes. The co-backbone partnership between CDPH SACB and CDSS OCAP also proved to be very fruitful. OCAP provided continuous in-kind support, and has also incorporated EfC principles into its own organizational structure and funding activities. The EfC workgroups engaged in various productive activities to move the common agenda forward, led by the backbone staff and a small group of very dedicated and committed champions. This included the efforts of the Shared Data and Outcomes Workgroup to develop a new Childhood Adversity and Resilience set of metrics on Kidsdata.org (and local dashboards) designed to provide actionable data for local partners. Their work was one of the major successes for the EfC Initiative.

The EfC Initiative contributed to several additional systems and policy changes across the state, but many of these successes tended to be the result of opportunistic efforts, rather than systematic steps of an explicit action plan. In addition, instead of trying to do everything within the EfC Initiative, the backbone staff purposefully supported the development of a neutral "Network of Networks" forum among multiple existing coalitions and initiatives to collaborate and align activities.

The EfC Initiative also experienced some major challenges. One of the main takeaways from an organizing perspective was that it is incredibly challenging to operate under a collective impact structure at a state-level. With limited funds and resources, the EfC Initiative was hampered in its ability to implement the common agenda to its fullest capacity. Collective impact requires a lot of time and energy from backbone staff. Although the EfC Initiative had success in recruiting diverse partner organizations, it struggled to maintain their engagement and active participation. Limited staff capacity impeded the backbone agencies' ability to convene the Leadership Action Team and workgroups on a regular basis, and to engage in continuous communication. As a result, some stakeholders reported experiencing a "disconnect" between the shared agenda and the specific activities of the workgroups. This contributed to a lack of clarity surrounding the collective impact process and influenced stakeholder engagement and participation. While some partners were individually invested in the common agenda and goals, the EfC Initiative was not always integrated into efforts within their own organizations. Furthermore, it was challenging to engage in collective impact in a state as geographically and demographically diverse as California. Interviewees voiced concerns that local partners could have been better engaged in the Initiative's efforts.

Considering the complex nature of the problem, the size and diversity of the state, and the length of this initial grant, the EfC Initiative was able to guide a substantial amount of valuable work that we believe has helped to promote safe, stable, nurturing relationships and environments for children and families within the state. The EfC Initiative was unique in that it provided an avenue for collaboration across state and local agencies and partners to engage in primary prevention CM work with a system change and social determinants perspective. The common agenda of the EfC Initiative also overlapped with several other initiatives, which allowed us to bring the primary prevention and upstream public health perspective to them as well. Stakeholder interviewees also expressed a continued interest in the California EfC Initiative. Participants were eager to provide feedback and think about next steps for the EfC Initiative collective impact process.

Lessons Learned

In moving forward, we hope the EfC Initiative can learn from this case study and the reflections of the participants interviewed. Some of the lessons we have learned that we hope to apply to our future efforts are summarized below.

- Co-backbone organizations: The CDPH and CDSS partnership was a critical factor in the EfC Initiative's successes, both internally and externally. We will strive to continue to strengthen this partnership.

- Staff capacity: This was a major limiting factor. The EfC Initiative will focus on adding more dedicated staff to the backbone agencies of CDPH and CDSS. We expect this will allow us to better support workgroups and improve communication. Ideally, it would be helpful to have one staff person dedicated per workgroup. For example, when the Shared Data and Outcomes Workgroup was supported by the same staff person over time (MA), it was able to accomplish the planned activities within a feasible timeframe.
- Public health perspective: There was strong support for the goal of strengthening the public health voice in the child welfare and early childhood education domains to promote upstream primary prevention strategies, policies and practices. The focus on broader policy and systems-level approaches to address the primary economic and other social determinants of CM is a unique and necessary value-add of the EfC Initiative.
- Clarity of purpose: The goals of the common agenda were very broad, and for many there was a significant disconnect between the goals and activities designed to achieve them. One of the initial steps identified for future efforts is to revisit the common agenda and identify more specific and feasible objectives.
- Reasonable expectations: Expectations for the EfC Initiative need to be moderated because of the size of the state, the magnitude and complexity of the social problem, and the large number of organizational players involved.
- Collective impact organizing model: We see the collective impact approach as primarily a disciplined and structured approach to collaborative work to achieve significant and lasting social change.
- Opportunistic approach: The majority of the work undertaken by the EfC Initiative capitalized on emerging opportunities. However, an opportunistic only approach will be insufficient to sustain the EfC Initiative.
- Action oriented: The early success of the EfC Initiative to quickly generate a common agenda helped avoid a protracted "paralysis by analysis" needs assessment process.
- Alignment with other initiatives: The creation of a neutral "Network of Networks" platform to support multiple coalitions and initiatives in mutually reinforcing and aligned activities was an innovative approach to address the multiple existing efforts. Given the scope of the problem and challenges of a large state, we need to continue to align our efforts with other collective impact initiatives that focus on similar issues.
- Non-traditional partners: Although we made a conscious decision to go slow in trying to engage non-traditional partners, we will need to expand our scope to include more diverse partners from a wider range of domains (e.g., local partners; business sector). However, we will need the skills, sensitivity and capacity to support the engagement and retention of these new partners.
- Framing effective communication messages: Simply asserting the facts is usually not sufficient to change minds or behavior. Lasting and widespread change requires changing the dominant public narratives that shape how people understand and interpret their world and see what is possible. We need educational messages that can help create a "new" public awareness and engagement around CM that is grounded in values and beliefs that support safe, stable, nurturing relationships and environments for all parents and children. This narrative should propose a set of shared values that focus on our shared responsibility and the possibility for pro-active solutions.

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References

Anda, R. F., Brown, D. W., Dube, S. R., Bremner, J. D., Felitti, V. J., & Giles, W. H. (2008). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine, 34*(5), 396–403.

Bohn, S., Danielson, C., Fisher, J., Kimberlin, S., Mattingly, M., & Wimer, C. (2017). The California poverty measure: 2014. Retrieved from https://inequality.stanford.edu/sites/default/files/CPM-2014_technical-appendix.pdf. Accessed 7 Dec 2018.

Brown, D. W., Young, K. E., Anda, R. F., Felitti, V. J., & Giles, W. H. (2006). Re: asthma and the risk of lung cancer. Findings from the adverse childhood experiences (ACE). *Cancer Causes & Control, 17*(3), 349–350.

California Department of Finance (2015). Enacted budget detail. Retrieved from http://www.ebudget.ca.gov/2015-16/Enacted/BudgetSummary/BSS/BSS.html. Accessed 7 Dec 2018.

California Department of Public Health (2016). Adverse Childhood Experiences (ACEs): California update, 2011–2013 data. Retrieve by contacting CDPH at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/ChildMaltreatmentandChildAbusePrevention.aspx#.

California Department of Public Health (2018). EpiCenter - California Injury Data Online. Retrieved from http://epicenter.cdph.ca.gov/, August 2018. Based on California Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010–2060.

Center for the Study of Social Policies (2018). Strengthening families: a protective factors framework. Retrieved from https://cssp.org/our-work/projects/protective-factors-framework/. Accessed 7 Dec 2018.

Center on the Developing Child at Harvard University (2018). Retrieved from https://developingchild.harvard.edu/science/. Accessed 7 Dec 2018.

Coleman-Jensen, A., Gregory, C., & Singh, A. (2014). Household food security in the United States in 2013 (Economic Research Report No. 173). Retrieved from https://www.ers.usda.gov/webdocs/publications/45265/48787_err173.pdf?v=0. Accessed 7 Dec 2018.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

KPJR (2015). Paper tigers. Retrieved from https://kpjrfilms.co/paper-tigers/. Accessed 7 Dec 2018.

KPJR (2016). Resilience. Retrieved from https://kpjrfilms.co/resilience/. Accessed 7 Dec 2018.

Let's Get Healthy California Task Force (2012). Let's get healthy California task force final report. Retrieved from Let's Get Healthy California website https://letsgethealthy.ca.gov/. Accessed 7 Dec 2018.

Putnam-Hornstein, E., Needell, B., King, B., & Johnson-Motoyama, M. (2013). Racial and ethnic disparities: a population-based examination of risk factors for involvement with child protective services. *Child Abuse & Neglect, 37*(1), 33–46.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (2015). Child Maltreatment 2013. Retrieved from https://www.acf.hhs.gov/cb/research-datatechnology/statistics-research/child-maltreatment. Accessed 7 Dec 2018.