THE PRIMARY SCHOOL

A DECADE OF INTEGRATED SUPPORT FOR CHILDREN AND FAMILIES



EXECUTIVE SUMMARY







OVERVIEW

Children's development depends on supports that extend across multiple systems — health, home life, and early learning. Yet the schools, health providers, and family services designed to provide those supports rarely work together. Families are left to navigate them on their own, piecing together help without a clear guide or consistent partner.

Since opening its first site in East Palo Alto, California in 2016, The Primary School (TPS) set out to change that, designing a model that brought together early childhood and K-8 education, dedicated parent support, and coordinated access to health care, enrolling families with children as young as 12 months old. Over its operation, TPS served 1,099 children: predominantly low-income, Hispanic/Latino (63%), with 75% from homes where a language other than English was spoken and an average of 20% holding an IEP. These families navigated real and compounding challenges, and the outcomes the school achieved in that context are what give this account its significance.

As TPS prepares to close its two sites in 2026, the organization partnered with the Stanford Center on Early Childhood's (SCEC) Continuous Improvement Rapid Cycle Learning and Evaluation (CIRCLE) team to capture what the school built, what it tried, and what it learned. This is not a conventional program evaluation. It is a practice account of what the model set out to do, what the evidence shows, and what it required. It is intended for practitioners, school leaders, funders, and policymakers working on similar challenges. The full report, which includes detailed methodology, program data, and appendices, is available here.

Stanford | Center on Early Childhood

CIRCLE

THE MODEL: THREE INTEGRATED STRATEGIC PILLARS

TPS organized its work around three strategic pillars, each designed to reinforce the others. The model did not treat health and family support as supplements to education. TPS treated them as inseparable from it and designed the school accordingly, creating a place where all three could operate in genuine coordination rather than in parallel.

STRATEGIC PILLAR 1: Start Early
The Early Family Foundations program enrolled families with children as young as 12 months, supporting them through the transition to preschool at age three. Early Family Foundations combined developmental screenings with active follow-up to connect children to early intervention services, and structured group sessions (Connections and Bridge to Preschool) to build early language skills and social-emotional readiness in both children and their caregivers. A two-year preschool program followed, designed to build on what families had experienced in Early Family Foundations.

STRATEGIC PILLAR 2: Partner with Parents
TPS assigned every enrolled family a dedicated Parent Wellness Coach who provided individualized and group-based support centered on parents' own goals, well-being, and capacity to navigate community systems. Coaches worked alongside teachers in bi-annual Children's Circles and facilitated monthly Parent Circles that gave families a consistent peer community and a space for shared learning.

STRATEGIC PILLAR 3: Integrate Health
Rather than constructing a standalone school-based health center, TPS partnered with community pediatric medical homes (Ravenswood Family Health Network in East Palo Alto and Kaiser Permanente in the East Bay) to embed health coordination into the school's daily operations. A shared nurse worked in close partnership with dedicated health staff at each site to coordinate preventive care, screenings, and active follow-up to ensure needs would be addressed rather than merely referred.

KEY OUTCOMES AND LEARNINGS

Start Early

GOAL 1: Identify and Address Possible Developmental Delays
TPS embedded developmental screening as a routine part of how the program engaged with every family from the start, producing screening rates far above state and national benchmarks. Equally important, TPS recognized that identification is only the first step. Referral, evaluation, eligibility determination, and enrollment in services is a multi-step process. TPS supported families through each stage of that process, achieving referral-to-service rates on par with national benchmarks. This is a notable finding given the compounding barriers these families faced in navigating systems and reflects TPS's active coordination throughout the process.

GOAL 2: Increase Language at Home to Support Child Language Development
Families who participated in Connections talked more with their children and engaged in more back-and-forth exchanges at home. Gains were spread broadly across participating families, with the largest improvements among families who started with the lowest language levels. Because these measures capture how caregivers behaved rather than how children naturally develop, the gains reflect real changes in how parents engaged with their children. Children's language skills grew in turn, with the strongest gains among those who entered with the lowest levels.

GOAL 3: Increase Child Social-Emotional Skills and Parent Strategies to Support These Skills
TPS supported growth in children's social-emotional skills, particularly for those who started with lower levels of those skills. By design, children practiced the same skills in two settings simultaneously. The strategies parents learned mirrored what children experienced in the program environment, creating an intentional alignment between home and school. Parents reported strong gains in their understanding of the core strategies the program emphasized. While the children who entered with the lowest levels of social-emotional skills experienced the most growth, many had not yet reached age-expected benchmarks by preschool entry, pointing to the need for more differentiated and intensive support for children with the highest needs.

Start Early Key Takeaways

Impact
▪ **By building strong relationships and trust with parents, TPS achieved high rates of screening and service initiation for children with needs.** Ongoing coordination when children entered preschool ensured they continued to receive needed services. ▪ **TPS helped parents learn how to foster development of critical early language and social-emotional skills in their young children.** Families experienced increases in home language and child language skills, particularly those who started at lower levels. Children's social-emotional skills and parents' strategies to support their child's social-emotional development also increased. At the heart of this work is TPS's focus on building strong connections between parents and children.

Challenges	Opportunities for Growth
Children with the greatest needs made significant gains but often still lagged behind age-appropriate benchmarks by preschool entry.	Schools implementing a similar model should consider differentiating programming and providing more intensive services for children and families with the most room to grow, rather than relying solely on universal programming for all families.
Social-emotional skills are difficult to measure, take time to develop, and are context-dependent.	Shorter-term programs (e.g., 6-8 weeks) have the opportunity to support children with readiness skills like separation and routines, but deeper social-emotional skills development can take longer and require more time for practice, ideally in settings with peers that mirror the classroom environment.
Most early childhood programming was designed for parents, but programming that also involves children may more directly impact child outcomes. Parents also expressed a clear preference for programming that involved their child.	Incorporating child-facing and joint parent-child programming alongside caregiver-focused content has the potential to produce even greater gains.

Partner with Parents

GOAL 1: Invest in Parent Well-Being

Families who engaged with TPS longer consistently reported stronger resilience and social support and connections. The longer families stayed, the more likely they were to report feeling equipped to handle challenges and connected to others who could help. Perceived stress told a more nuanced story: the model proved better at building parents' capacity to cope than at reducing the underlying stressors themselves. Families built resilience while navigating real hardship, and that may be the more relevant measure of what a school-based model can realistically achieve.

GOAL 2: Support Families to Better Navigate Their Social Needs

While the overall prevalence of social needs remained relatively stable over time, families with longer enrollment were less likely to report having social needs and showed stronger readiness to access supports. Even as the structural conditions driving needs such as food security and housing stability remained beyond the school's reach to resolve, TPS consistently helped families navigate lived realities with more knowledge, support, and confidence.

GOAL 3: Parents Support Child Development, Health, and Learning

TPS designed its parent programming with an explicitly two-generational goal: that stronger, more confident parents would show up differently for their children. Both quantitative and qualitative data point in the same direction. Parents

reported strong intentions to apply what they learned from Parent Circles to how they supported their children at home. Parents named two things that set TPS apart from other schools: the sense of community and the absence of judgment. Coaches guided families toward solutions rather than prescribing them, leaving parents feeling capable rather than dependent.

Partner with Parents Key Takeaways

Impact
▪ **Parents reported stronger protective factors when they engaged longer with TPS.** Over time, families built resilience, social support, confidence navigating systems, and knowledge of strategies to support their child's development with a cumulative effect tied to length of engagement. ▪ **Personalized, parent-led coaching and peer support produced meaningful individual growth.** Supported by parent coaches and other parents, families made progress on personal goals that affected their own well-being, family stability, and relationship with their child. ▪ **Families built a foundation of protective factors that positioned them to address deeper needs over time.** While underlying social needs persisted at the population level, families with longer tenure developed stronger capacity and readiness to access resources – a foundation that created conditions for more ambitious goal-setting as engagement deepened.

Challenges	Opportunities for Growth
Parent program outcomes were more closely tied to non-academic outcomes like social-emotional skills, which research shows are linked to longer-term child outcomes.	To strengthen the connection to academic outcomes, parent programming could layer more direct academic success strategies on top of wellness and protective factors. For example, programs could support families to learn about home reading and learning activities, build in school leadership opportunities for parents, or teach families how to navigate complex school systems.
Addressing a family's underlying social needs presents structural conditions too complicated for a school to solve on its own.	For schools interested in focusing on social determinants of education and health for families, consider starting with protective factors around capacity and readiness to access community resources, and then building on this in specific areas relevant for community needs, like financial wellness, likely in partnership with external organizations with expertise in those areas.
Group programming was universal, limiting how deeply parents could engage with topics most relevant to them.	Offering differentiated and choice-based programming would allow parents to go deeper in areas like economic mobility or adolescent development. This would better serve families at different stages and with different priorities, and keep families engaged over the long run.

Health Integration

GOAL 1: Detect and Address Vision and Hearing Concerns

TPS achieved vision and hearing screening and follow-up rates far above state benchmarks, demonstrating what becomes possible when identification is paired with active coordination through treatment. Embedding screening broadly across grade levels and assigning a nurse and dedicated health staff to actively manage follow-up, rather than routing families through a passive referral process, produced outcomes that exceeded those seen in comparable populations across California. Getting glasses into children's hands and keeping them on throughout the school day remained a persistent practical challenge that required ongoing attention.

GOAL 2: Resolve Identified Health Needs through Coordinated Care
Health case management connected students to needed services at high rates, spanning a wide range of health and developmental needs. A substantial share of students received health case management support in a given year, and the majority of those cases resolved with students successfully connecting to indicated services. What the resolution rate reflects is active follow-through: someone at the school owned the referral loop that traditional systems routinely leave open. Families managing chronic conditions described the difference this made in concrete terms, including reduced emergency visits, fewer missed days of work, and the experience of having a school that genuinely knew and tracked their child's health needs.

GOAL 3: Ensure Students Are Current on Preventive Health Services
TPS achieved well-child visit and preventive dental care rates substantially above comparable populations. The shared nurse, dedicated health staff, and community medical home partnerships sustained these outcomes consistently over time, reflecting ongoing coordination rather than a single point of intervention. When families trust a school and its relationship with health providers, they show up for well-child visits, dental cleanings, and follow-up appointments they might otherwise have deferred.

Health Integration Key Takeaways

Impact	
■ **Strong collaboration with medical partners supported children in accessing needed health services at rates above comparable benchmarks.** Close partnership made on-site services more accessible and approachable, enabled active case management, and produced significant benefits for students with serious health needs, improving both their health and their ability to engage at school. ■ **Trusting family relationships enabled TPS to move beyond screening to actual connection with care.** Families more willingly chose to engage with health services, follow through on referrals, and act on clinical guidance when they felt trust. The school served as a bridge, reinforcing provider messages, helping families navigate insurance and appointments, and reducing the friction that causes families to fall out of the care pipeline.	
Challenges	**Opportunities for Growth**
Sustaining health partnerships required shared goals tied to viable funding, which proved difficult to maintain over time.	Schools pursuing health integration should invest early in identifying shared goals - in particular, goals tied to the health system's quality metrics. Those goals should be aligned to sustainable funding mechanisms, ideally through billable revenue (e.g., Medicaid, public health), and schools should prioritize partners with sufficient patient-student overlap to create genuine shared incentive.
Providing the entire range of services and support for all students became difficult as the student population grew.	Schools should consider tailoring health services by age rather than applying universal annual programming, prioritizing well-child visits and dental care for younger children, and shifting toward chronic condition management such as asthma as students get older.
FERPA and HIPAA regulations created barriers to school-health communication that a school may not be able to solve alone.	Establishing privacy consents and data-sharing agreements early, before they become operational bottlenecks, can reduce friction that can slow communication. However, streamlining communication between school and health systems ultimately requires systemic solutions. Policymakers could consider reimagined privacy rules specifically designed to support integrated school-health models.

STUDENT OUTCOMES

Student outcome data focus on the years following TPS's return to full in-person instruction after COVID-19, a deliberate choice that reflects the value of examining the model under conditions of relative stability. Where instructive, pre-pandemic context is noted.

Kindergarten Readiness

Kindergarten readiness rates improved over the measured period. To put these results in context, TPS compared its rates to two groups from the Big Lift, a local early literacy initiative in San Mateo County. The overall Big Lift population outperformed TPS, but that group is generally higher income and faces fewer challenges linked to lower school readiness. When looking at the Big Lift families most similar to TPS's population, those from lower-income households where a language other than English was spoken, TPS outperformed that group consistently across all four years.



Literacy and Mathematics

TPS showed steady improvement in both literacy and mathematics over the post-COVID measured period. On average, TPS outperformed local East Palo Alto schools in both subjects across all three years of available data, though results varied across individual schools. Results remained below the California statewide average, at least partially reflecting the persistent structural inequities facing the communities TPS served. Improving steadily while outperforming comparable local schools represents real progress in this context.

Chronic Absenteeism

Chronic absenteeism declined steadily over four years, dropping at a steeper rate than at comparable local schools. TPS's rate, which had started above that of local schools in the immediate post-COVID period, came down more quickly and fell below local schools by the final year. The rate remains above the California statewide average, and the downward trajectory over four years held consistent.

Social-Emotional Development

By the final year, the vast majority of students met or exceeded social-emotional benchmarks across all five CASEL competency domains, with consistent improvement across all domains over four years. Because teachers both delivered the instruction and completed the assessments, and no external comparison data exist, these results are presented as an internal trend rather than a benchmark comparison. The consistency of improvement across all five domains over four years offers an encouraging signal about the social-emotional environment TPS cultivated.

ORGANIZATIONAL LESSONS LEARNED

Build the Right Foundation First

The integrated elements of this model are most effective when layered onto a functioning instructional core. TPS leaders recommend a deliberate sequence: establish instructional stability first, then add one integrated element at a time with genuine checkpoints before expanding. A clear and stable vision, specific enough that every team across programs can articulate how their work contributes to it, must accompany that foundation and be protected as leadership transitions. When the vision points toward outcomes that take years to achieve, it must equally be protected from the pressure to shorten the timeline before the work has had time to show results.



Distribute Leadership Structurally
TPS experienced consistent principal turnover, and leaders identified this as a structural problem, not a personnel one. The demands of an integrated model exceed what a single person can sustainably hold. Viable alternatives include co-principals, a director of integration sitting alongside the principal, or shared central office roles distributed across sites. This structure must be designed from the outset, not treated as a later adjustment.

Build Integration Into the Structure, Not Just the Vision
Integration does not emerge from proximity alone. It requires explicit structural investment: clear role definitions, protected coordination time built into the schedule, data-sharing and consent protocols with health partners established before implementation begins, and intentional design of how parent engagement intersects with teacher and coaching roles. Friction at TPS consistently reflected the cost of addressing these questions reactively rather than by design.

Invest in People and Community Relationships
The model requires staff at all levels to work across traditional professional boundaries. That disposition must be screened for in hiring, reinforced through onboarding, modeled by leadership, and supported through workload design. Parent and community engagement requires the same intentional investment, including dedicated capacity for parent co-design and community input. Understanding what families actually need, rather than what staff assume they need, requires someone on the team with explicit responsibility for that work.

Build for Sustainability and Scale from the Start
TPS's per-pupil costs were comparable to local elementary district schools, a finding that challenges the assumption that integrated models are inherently cost-prohibitive. Sustainable implementation requires mapping available public funding streams early, including IDEA Part C, Medicaid billing, and others, and making explicit resource allocation decisions before implementation is underway. Families enrolled earliest and longest showed the strongest outcomes across every pillar, making early enrollment and long-term retention strategically significant priorities. The model's reputation as a supportive environment attracted a concentration of high-need families that eventually exceeded what the school could sustain, pointing to the importance of matching the population to the school's actual capacity.

CONCLUSION

As TPS closes, most of the children in both communities are transitioning to local public schools. The organization has partnered with regional and national organizations to share its model and approach more broadly, with the hope that its learnings will seed and grow integrated approaches in different places alongside children and families for years to come.

Nearly a decade of implementation has led to something the field has too little of: a detailed, honest account of what it looks like to build a two-generation, health-integrated school model in communities facing concentrated and compounding disadvantages. The report details what worked, what proved harder than anticipated, and what others can build on going forward. The organizational lessons point in a consistent direction. Integration requires intentionality. It demands a stable instructional foundation, distributed leadership, protected time for coordination, staff who genuinely want to work across disciplines, and a funding strategy built with clarity from day one. These conditions do not emerge on their own. They must be designed, resourced, and protected.

The problems TPS set out to address have not gone away. Families will continue to navigate fragmented systems, and children's outcomes will continue to be shaped by supports that extend beyond the classroom. The path forward is clearer for the work TPS has done and the legacy it leaves behind.