THE PRIMARY SCHOOL

A DECADE OF INTEGRATED SUPPORT FOR CHILDREN AND FAMILIES



INTRODUCTION

Children's development depends on institutional supports that extend beyond any single system. Health, home life, and early learning experiences all shape how children learn and grow. Yet the systems designed to support them, including schools, health providers, and family services, often operate separately. Families are left to navigate these systems on their own, piecing together support without a clear guide or consistent partnership.

The Primary School (TPS) set out to address this challenge. Since opening its first site in East Palo Alto, California in 2016, TPS designed and implemented a school model that brought together early childhood, K-8 education, dedicated parent support, and coordinated access to health care. TPS began working with families when children were as young as 12 months old, building relationships early and aligning supports over time.

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 document what was built and what was learned along the way. This report differs from many impact evaluation reports, in that it is a practice account that documents what TPS tried to do, what happened, and what conditions were needed to support the model. It draws on nearly a decade of quantitative data alongside interviews and focus groups with TPS families, staff, and leaders.

This report serves three purposes:

1. **To examine outcomes** across TPS's three core strategies, Starting Early, Partnering with Parents, and Integrating Health, documenting where and how the model contributed to improvements in identification of developmental needs, access to services, parent wellness, and student well-being, and ultimately how the strategies came together to support student outcomes;
2. **To identify cross-cutting lessons** from nearly a decade of implementation, including what it took to build and sustain an integrated model over time, with particular attention to leadership vision and structures, integrated program design, and cross-sector collaboration;
3. **To generate insights** that practitioners, school leaders, and policymakers can apply in similar contexts.

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Throughout, the report centers the experiences of children, families, practitioners, and educators. The challenges TPS set out to address remain. TPS also created a companion video to uplift those experiences. Families will continue to navigate fragmented systems, and children's outcomes will always be influenced by supports that extend beyond school walls. The lessons in this report are offered to anyone working to build more connected systems for children and families.

BACKGROUND

The background information below draws on conversations with Primary School leaders and reflects their account of the school's origins, vision, and design. We have endeavored to capture their perspectives as accurately as possible.

Co-founders Priscilla Chan and Meredith Liu launched The Primary School (TPS) in East Palo Alto, a community shaped by long-standing inequities in access to education, health care, and economic opportunity. Families, educators, and health providers described a common challenge: they could see what children needed, but they did not have a reliable way to connect across systems to meet those needs. A pediatrician might refer a child to a specialist without knowing whether the family could follow through for any variety of reasons. A teacher might recognize that a child struggled, but lacked understanding of, or access to, pathways to address underlying health or family challenges. Families carried the responsibility of navigating these disconnected systems on their own, and children faced barriers to being able to learn in school.

In response, Chan and Liu brought perspectives from health and education and worked with families, community leaders, and local partners to design a different approach. Rather than adding services onto a school, they reimagined the school itself as a place where education, health, and family supports could operate in coordination. From the beginning, TPS focused on starting earlier in children's lives, building sustained relationships with families, and aligning supports across the systems that shape development.

The first TPS site opened in 2016 after more than two years of community engagement and co-design. Over time, the site served the following age ranges: (1) Early Family Foundations: Ages 1-2; (2) Preschool: Ages 3-4; (3) Elementary School: Grades K-5; (4) Middle School: Grades 6-8. TPS opened its second site in Alameda County ("East Bay") in 2020, offering (1) Early Family Foundations: Ages 1-2 and (2) Preschool: Ages 3-4, in addition to a similar set of integrated health and parent supports adapted in partnership with local community organizations.

Research from multiple fields grounded the model's design. Studies on Adverse Childhood Experiences (ACEs) (Felitti et al., 1998; Webster, 2022; Sawyer et al., 2024) and Positive Childhood Experiences (PCEs) (Bethell et al., 2019) shaped how the school understood the long-term influence of early experiences and the importance of buffering adversity with strong supportive relationships.[1] Recognizing the barriers that youth, particularly children of color, face due to systemic inequities such as racism and cultural marginalization (Dettlaff & Boyd, 2021; Friedman-Krauss & Barnett, 2020; Rosado et al., 2021), TPS focused on serving families who would benefit most from comprehensive services and offered a tuition-free education to all enrolled.[2]

[1] See Appendix A: Model Influence

[2] The preschool program operated on a California State Preschool Program (CSPP) contract, which tied admissions criteria to CSPP eligibility requirements, including both income eligibility and demonstrated need for services.

TPS identified as a whole child model, defining success in a holistic way that included measures of academics, social-emotional learning, and physical and mental health. It treated these outcomes as independently important and also interconnected, recognizing that children's academic development is dependent on children being healthy, feeling safe, and developing social-emotional skills. The model also recognized parent well-being as foundational for child outcomes.

Rather than layering services on top of a traditional school, the TPS model integrated supports into the daily work of the school itself.[3] Schooling served as an anchor and a hub for coordinated support rather than a place focused solely on instruction. Daily contact with children and families created opportunities to build relationships, understand needs, and respond with timely and appropriate support. Early Family Foundations, health, and parent programs collaborated with school staff to build family capacity and reduce barriers to teaching and learning.

To support this work, organizational values emphasized strengths-based and trauma-informed[4] approaches to working with children and families. Staff used shared frameworks such as Early Relational Health, highlighting the role of consistent, responsive relationships in supporting children's development and family well-being (Garner & Yogman, 2021).[5] These foundations helped with alignment in both cross-program design and day-to-day interactions with families.

The East Palo Alto site operated for 10 years, from fall 2016 to its closure in June 2026, and the East Bay site operated for 6 years. During this time, both sites navigated significant disruptions from the COVID-19 pandemic, including shifts to remote and hybrid learning, staffing turnover, and related challenges with attendance and engagement.

The table on the next page shows the demographics of children who attended TPS, including both the East Palo Alto and East Bay sites.[10]

SYSTEMS CHANGE STRATEGY

From the outset, TPS aimed to do more than operate a single school. The organization worked to develop and refine a model that could inform broader systems. The East Palo Alto site served as a flagship location where TPS could build and test the model with philanthropic support. At the same time, TPS worked to understand how elements of the model could operate within public funding systems, including through a partnership with the California State Preschool Program (CSPP).[6]

The organization planned to expand this work over time as part of a broader effort to test how the model could operate across different contexts and funding conditions. The East Palo Alto site operated as a private, nonprofit school that allowed TPS to build and refine the model with flexibility and speed, supported by a central administrative office.[7] Philanthropic funding made this work possible and covered the full range of academic and wraparound services, allowing TPS to offer programming at no cost to families.[8] TPS had the long-term goal to build on the model's design and learning in East Palo Alto by opening a small number of additional sites in communities with diverse needs and varying public systems constraints, and to contribute to a growing body of evidence that can shape how systems support children and families more broadly.[9]

[3] TPS drew inspiration from the Community Schools model (Swain et al., 2025).

[4] A trauma-informed approach in a school setting recognizes that children's behavior, learning, and relationships may be shaped by experiences of trauma and seeks to create safe, predictable, and supportive environments that promote trust, emotional regulation, and positive relationships while avoiding practices that may retraumatize students (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

[5] For children and adults alike, supportive relationships can reduce cortisol, mitigate the effects of trauma and toxic stress, increase likelihood to seek and access care, increase protective factors, support nervous system regulation, increase resilience, and improve learning outcomes.

[6] The organization accessed public funding where possible, developing a set of budget parameters for the site tied to the potential resources of a fully public system. While per-pupil spending at TPS was higher than the overall Bay Area average, it was similar to local elementary districts, which are more demographically comparable. See Appendix B: Growth, Structure, and Funding.

[7] The central office led model design, learning, improvement, and codification; identified strategic partnership and growth opportunities; managed fundraising; and provided back office support to each site. This structure resembled many Charter Management Organization (CMO) models. See Appendix B: Growth, Structure, and Funding

[8] Core operating funding came primarily from Chan Zuckerberg Initiative philanthropic funding. Other contributions came from individual donors and other foundations.

[9] TPS opened the East Bay site in order to advance this goal. TPS originally planned to expand the East Bay site to include a publicly funded elementary school.

[10] All demographics except IEP status are based on all students who ever attended TPS.

Table 1. Demographics of Children who Attended TPS (including Early Family Foundations, ECE, and K-8)

	EPA	EB	Total
Total Children Served	771	328	1,099
Race/Ethnicity			
Hispanic/Latino	73%	41%	63%
Asian	2%	28%	10%
Native Hawaiian or Other Pacific Islander	9%	5%	8%
Multi-racial	7%	6%	7%
Black/African American	6%	8%	7%
Other/Unknown	3%	12%	5%
Home Language Other Than English	73%	78%	75%
Eligible for Free/Reduced Lunch	83%	N/A	N/A
Students with IEP (annual average)	20%	23%	N/A

Note. Eligible for Free/Reduced Lunch data are not available for the East Bay site, which operated exclusively as an early childhood program.
IEP figures reflect annual averages and cannot be combined into a single total across sites

METHODOLOGICAL APPROACH AND CONSIDERATIONS

In this section, we detail the data sources, both quantitative and qualitative, presented in this report about learnings and outcomes from The Primary School (TPS) and the approaches used to analyze them. We also describe the roles of TPS and the CIRCLE team in analyses, as well as key considerations for interpreting the data included in this report.

Data Sources

This report draws on TPS's administrative and program data, survey data collected from students and parents, and qualitative data collected by the CIRCLE team in Winter and Spring 2026. Administrative and program data capture key indicators across the model, including developmental screenings, referrals and service uptake, health screenings and follow-up care, attendance, and participation in family and parent programming. Survey data track changes over time in areas aligned with TPS's core strategies, including early developmental identification, home language environment, child language and social-emotional development, parent well-being, and family social needs and readiness to access resources.[11]

The CIRCLE team led the design, data collection, and analysis of qualitative data, which included interviews with parents and focus groups with staff and leadership. These data provide insight into how families experienced the model, how staff implemented integrated supports, and how different components worked together in practice. Qualitative findings also help explain patterns in the quantitative data, particularly where survey measures do not fully capture changes in knowledge, behavior, or experience.

[11] Standardized tools TPS used to measure child outcomes include the EOWVT/ROWVT for language development, the Social Skills Improvement System (SSIS) and Devereux Early Childhood Assessment (DECA) for social-emotional development, the Dynamic Indicators of Basic Early Literacy Skills (DIBELS) for early literacy in kindergarten through second grade, and the NWEA MAP Growth assessment for literacy and math in grades three and above.







Analytic Approach

TPS and CIRCLE teams each contributed to the analysis for this report. Key members of the TPS team applied a consistent set of analytical strategies across quantitative data sets collected throughout the school's tenure, with the exception of the protective factors data, which TPS and CIRCLE teams analyzed together.

TPS aggregated data across years, cohorts, and sites. Because the organization's programming and measurement approaches evolved over time, sample sizes vary across analyses. When different instruments measured the same outcome, TPS standardized results to a common metric, typically percentile rank, to support comparison over time. Where possible, the analysis examined changes over time and differences across subgroups, with particular attention to families enrolled for different lengths of time, as duration of engagement proved a key variable across multiple areas of the model. Similarly, TPS administered school assessments, including social-emotional measures and academic assessments, two or three times per year.[12,13]

The CIRCLE team conducted thematic analysis of qualitative data, including interviews with parents and staff and focus groups with program leaders. The two teams jointly analyzed open-ended survey responses from parents to identify recurring patterns and contextual factors that deepen interpretation of the quantitative findings. Qualitative and quantitative evidence is integrated throughout this report to shed light on how and why these patterns emerged.

Considerations for Interpreting Findings

Readers should keep several things in mind when interpreting the findings in this report. TPS operated as a small, single-organization school serving specific communities, and results may not generalize to other settings without accounting for differences in population, resources, and system conditions. Findings show what outcomes looked like at TPS and, where possible, how those outcomes compared to similar local populations or national benchmarks, but they do not establish a causal link between the model and the results observed. The absence of a comparison group means factors outside the model may have influenced outcomes. Sample sizes for several analyses are modest, reflecting the scale of TPS's enrollment.[14] Exact sample sizes are noted in footnotes throughout the report. Several measures rely on parent self-report, which may reflect changes in understanding as well as changes in behavior.[15]

[12] The timing of pre and post data collection varied by program and measure. For Early Family Foundations outcomes related to home language and social-emotional skills, pre refers to the start of the relevant program component (Connections or Bridge to Preschool) and post refers to its end. For early child language development, TPS measured pre before Connections and post before preschool entry. TPS generally administered parent surveys annually with the exception of the social needs survey, which TPS administered twice per year in the years following COVID. TPS administered school-based assessments, including social-emotional measures and academic assessments, two to three times per year.

[13] Survey response rates ranged from 75% to 85% across waves. Among survey participants, 65% to 80% contributed matched pre and post data.

[14] Sample sizes vary considerably across analyses. For early childhood program outcomes, including home language, child language, and social-emotional skills, analyses typically include between 29 and 142 participants, with some subgroup analyses based on smaller samples. For parent well-being and social needs data, tenure-group samples range from 37 to 110 families. For student outcomes, grade-level cohorts in the academic sections typically included between 55 and 170 students at TPS, and year-to-year variation in these results can reflect shifts in just a handful of children. Exact sample sizes for each analysis are noted in footnotes throughout the report.

[15] Data systems and assessment tools evolved across TPS's implementation years. Key changes include the transition from the Preschool Language Scales-5 to the Receptive and Expressive One Word Vocabulary Tests (EOWVT/ROWVT) for early language assessment and the introduction of NWEA MAP Growth as the school added upper grades.

KEY OUTCOMES AND LEARNINGS

This section of the report describes The Primary School's (TPS) learnings across its three strategic pillars: Starting Early, Partnering with Parents, and Integrating Health. It also details TPS's student outcomes. For each strategy, we describe what TPS set out to do, what the data show about outcomes, and what families and staff experienced along the way. We share both the things that worked and the places where gaps remained. To ground the data, each section closes with spotlight stories, which are real accounts from TPS families, and key takeaways. Together these findings offer a picture of what this model can accomplish, what it takes to make it work, and areas for consideration for others doing similar work.

Strategic Pillar 1: Start Early

For TPS, starting early meant working with families during the critical window of child development around 12 months of age. Over the course of its operation, the TPS Early Family Foundations program served approximately 300 families across both sites. The Early Family Foundations program supported families and enrolled children as early as 12 months through the transition to preschool at age three. Early Family Foundations had two main components: 1) developmental screenings, including referrals with follow-ups to connect children to early intervention services, and 2) group sessions to build early language and social-emotional skills. The Connections parent group aimed to help caregivers strengthen language-rich interactions with their children, while Bridge to Preschool worked to prepare children and families for the transition to the classroom and build social-emotional skills. A two-year preschool program followed, designed to build on what families had experienced in Early Family Foundations.

GOAL 1: IDENTIFY AND ADDRESS POSSIBLE DEVELOPMENTAL DELAYS

87%

of children in Early Family Foundations received at least one developmental screening before age 3

TPS achieved far higher rates of developmental screening compared to state and national benchmarks. **Eighty-seven percent of children in Early Family Foundations received at least one developmental screening before age three** (many received more than one), compared to 41% in CA Medicaid & CHIP populations and 36% in California according to results from the 2023-2024 National Survey Children's Health.[17] These data reflect a structural reality: screening rates in the general population remain low because identification systems are fragmented and hard to navigate, and TPS's high rate reflected their practice of embedding screening as a routine part of how the program engaged with every family from the start.



TPS recognized that identifying a developmental concern is only the first step. What follows, including referral, evaluation, eligibility determination, and enrollment in services, is a multi-step process that many families never complete. Each transition is a potential exit point, and families navigating it without support often disengage from services along the way. At TPS, 72% of children referred to a regional center or school district completed an evaluation, 79% of those evaluated qualified for services, and 88% of eligible children began services (see Figure 1).[18] These rates are on par with national benchmarks.[18] According to the 2023 U.S. Government Accountability Office Report on IDEA Part C Early Intervention, 73% of referred children nationally completed an evaluation, 78% of those evaluated were found eligible, and 92% of eligible children enrolled in services.

[17] Screening rates reflect the percentage of Early Family Foundations children who received at least one developmental screening before age three, tracked through TPS's internal screening tracker across approximately 300 children enrolled in EFF across both sites over the program's full tenure. State and national comparison figures are drawn from the 2023-2024 National Survey of Children's Health and CA Medicaid & CHIP Core Set data, which measure well-child visit completion rather than developmental screening specifically; TPS figure reflects a higher bar, direct developmental screening, making the comparison a conservative one.

[18] The referral pipeline figures are drawn from the same administrative tracking data. The comparison to U.S. Government Accountability Office benchmarks provide useful context but are not a causal comparison.

Figure 1. Developmental Screening Pipeline: Percentage of Children by Stage, Identification Through Service Enrollment

87% of children **received at least one developmental screening** before entering preschool at age 3 → **72%** of children **completed an evaluation** (of those referred to the regional center or school district) → **79%** of children were **eligible for services** (of those who completed an evaluation) → **88%** of children **began services** (of those eligible for services)

What makes TPS's performance notable is the population it served: families who face disproportionate barriers to accessing services, including language barriers, limited familiarity with special education systems, and the logistical challenges of navigating multiple agencies. Matching national averages under those conditions required active, sustained coordination.

In interviews, parents shared that developmental screenings contributed to their children's needs being identified and supported early on, impacting the child and the parent in myriad ways. Parents highlighted the speed and momentum with which TPS facilitated developmental screenings and subsequent referrals, which led to diagnosis and education plans. This is described by one parent below:

> "They do [Early Family Foundations] before they even start school, just to get them prepped for when school actually starts… [The health staff at TPS] noticed that my son was showing signs of autism and he wrote a referral to our physician, which got us a quick evaluation for him, and he was diagnosed with autism that September… So thanks to that, we were able to get the ball rolling on all his therapies and everything, and all the supports he needed." - TPS Parent

Parents also valued learning what to watch for and that TPS made screenings available to every family, regardless of circumstance:

> **"[TPS] started putting in topics… like, what are some signs that could be an indicator of your child having… a developmental delay or mental disability? And so… they'd give out forms you can fill out, and then they would… connect you to resources to go and get your child diagnosed, or checked, or really…push for families to get an early start…"** - TPS Parent

TPS went beyond screening by reducing the drop-off that typically occurs between identification, evaluation, and enrollment in services, which are the points at which children most often lose access.

[19] Adult word count and conversational turns were measured using the LENA (Language Environment Analysis) device, which records the home language environment over a full day. Caregivers wore the device during a typical day at home. Pre refers to the start of the Connections program and post refers to the end of participation. These analyses include 142 families with complete pre and post data; the subgroup analysis of families who started with low levels of adult word count includes 92 families.



GOAL 2: INCREASE LANGUAGE AT HOME TO SUPPORT CHILD LANGUAGE DEVELOPMENT

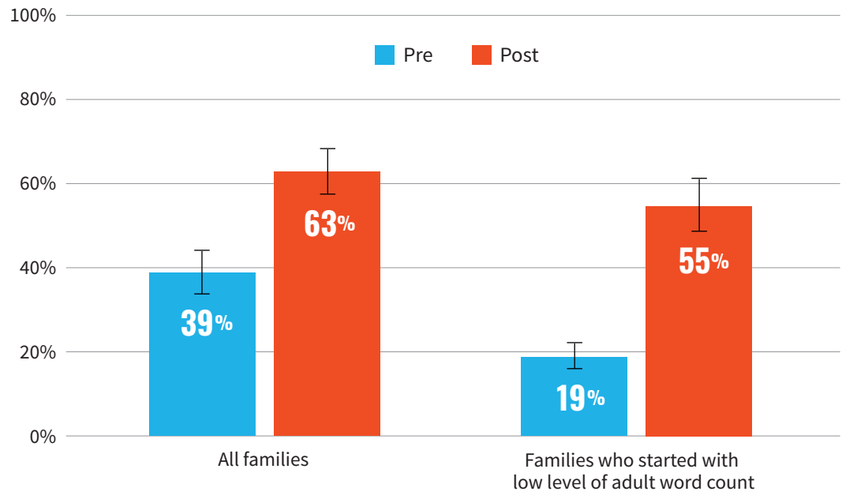
TPS supported early language by helping caregivers make the most of everyday interactions with their children, including conversations, back-and-forth exchanges, and the words spoken during ordinary moments at home. Families in the Connections program made gains in two measures of rich home language use: adult word count and conversational turns. Adult word count is the total number of words a child hears from adults in a day. Conversational turns are the back-and-forth exchanges between caregiver and child that reflect the quality of that interaction and are especially important for early language development. A wearable digital recorder that tracks how much language a child is exposed to at home captured both measures.



Growth in Home Language

Families participating in Connections showed statistically significant improvements in adult word count, with mean scores rising from the 39th percentile at baseline to the 63rd percentile after participating in the program ($p < .001$), representing an increase in how much language children hear at home.[19] Families who started out below the 50th percentile experienced the largest gains, with mean scores rising from the 19th to the 55th percentile (see Figure 2). To give a sense of how broadly these gains were distributed, nearly 7 in 10 families (69%) improved by at least 5 percentile points, suggesting that the average improvement was not driven by a small number of families with unusually large gains, but reflected movement across the distribution.[20]

Figure 2. Average Percentile of Adult Word Count, All Families vs. Those Who Started Below the 50th Percentile[21]



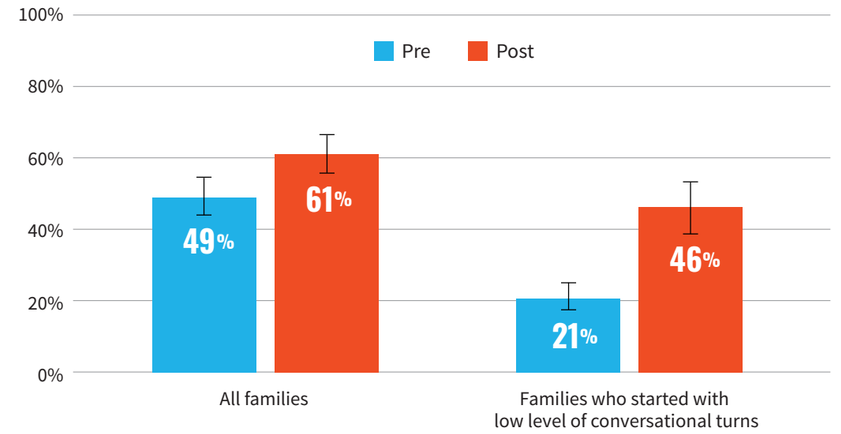
Families participating in Connections also showed statistically significant improvements in conversational turns ($p < .001$). Mean scores rose from the 49th to the 61st percentile, and more than half of families (56%) improved by at least 5 percentile points, indicating that gains were broadly distributed rather than concentrated among a small subset. As with adult word count, families who started with fewer exchanges showed the strongest average gains (see Figure 3).[22]

[20] Because adult word count and conversational turns measure caregiver behavior rather than child development, these statistically significant gains are more plausibly explained by changes in how caregivers engaged with their children than by normal maturation. Without a comparison group, other influences on family experiences over the same period cannot be fully ruled out.

[21] Throughout this report, all error bars represent 95% confidence intervals.

[22] Conversational turns analyses include 142 families with complete pre and post data; the subgroup analysis of families who started with low levels of conversational turns includes 72 families.

Figure 3. Average Percentile of Conversational Turns, All Families vs. Those Who Started Below the 50th Percentile



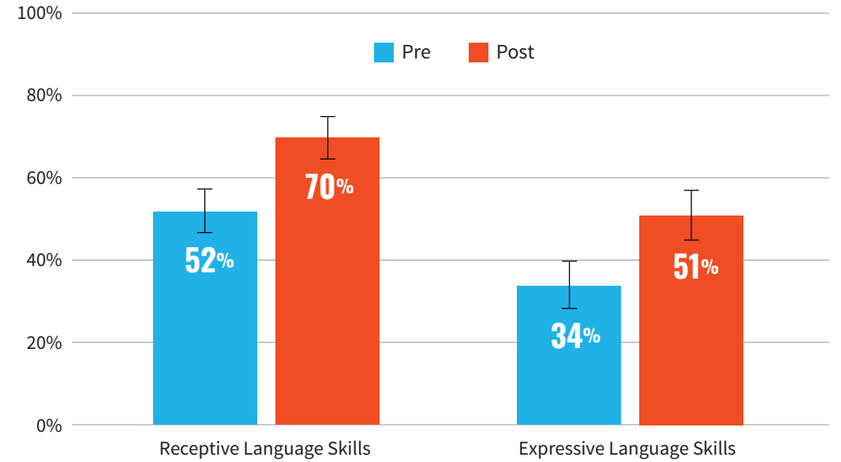
In interviews, parents also shared their experience of participating in the Connections program and how it shaped them as parents:

> **"I think it's great that they have this model… and starting from… when the mother is pregnant, talking about your goals… have the baby, and…then you do the whole LENA [Connections] program, and you figure out how much electronics the child is exposed to, and how many words. I'm very thankful to TPS for that because… they do a great job at modeling what that looks like… and…I know that they played a huge part in who I am today."** - TPS Parent

Growth in Child Language Skills

Children made statistically significant gains across both receptive and expressive language during their time in Early Family Foundations ($p < .001$).[23] The percentage of children meeting age-expected benchmarks, at or above the 50th percentile, increased from 52% to 70% in receptive language and from 34% to 51% in expressive language (see Figure 4).

Figure 4. Percentage of Children Meeting Age-Expected Language Benchmarks, at or above the 50th Percentile



[23] TPS measured child language development using EOWVT/ROWVT, administered before Connections and before preschool entry. TPS converted all results to percentile scores to support comparison across cohorts. These analyses include 117 children with complete pre and post data for both receptive and expressive language.

Average scores improved as well, with receptive language rising from the 46th to the 59th percentile and expressive language from the 35th to 49th percentile. Children who entered with the greatest needs showed the most dramatic progress. Among those who started below the 50th percentile, nearly half (48%) reached age-expected levels in receptive language by the end of the program, up from zero, and 29% did so in expressive language, also up from zero.

Children who entered already meeting benchmarks largely maintained those levels. Across the data, children experienced receptive language gains consistently stronger than expressive gains, which reflects a well-established pattern in child development that comprehension typically grows before production.[24]

GOAL 3: INCREASE CHILD SOCIAL-EMOTIONAL SKILLS AND PARENT STRATEGIES TO SUPPORT THESE SKILLS

TPS recognized that children's ability to manage emotions, build relationships, and navigate social settings is strongly influenced by what happens at home. Rather than focusing only on children, TPS worked with parents directly, equipping caregivers with strategies they could use in everyday interactions to support their children's social-emotional growth.

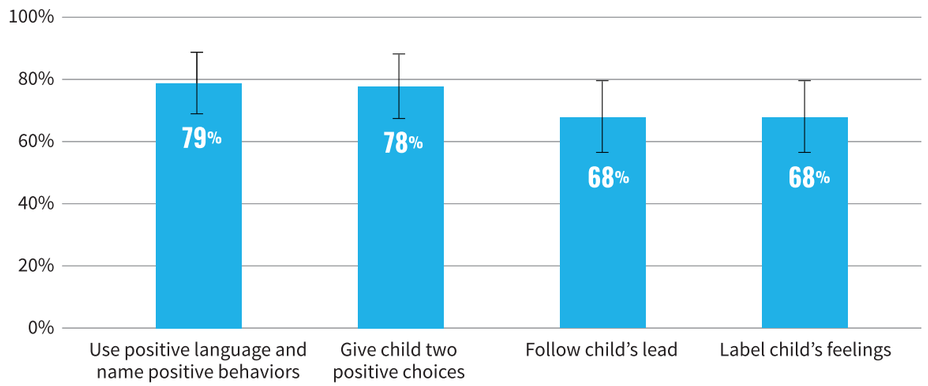
Parent Outcomes

Early Family Foundations emphasized a set of core strategies to help parents strengthen their relationship with their child and support social-emotional development. These strategies included providing positive choices, using positive language, following the child's lead, and naming emotions. TPS measured change in two ways.[25]

The first measure asked parents before and after Bridge to Preschool how often they used these strategies.[26] Parents reported mixed results, with between 22% and 34% of parents reporting increased use. These numbers are somewhat difficult to interpret because most parents reported using the strategies frequently even before participating. However, participation in the program often raised parents' standards for what consistent use of strategies actually looks like.

TPS asked a smaller subset of parents[27] retrospectively to reflect on how much their understanding of each strategy grew over the course of the program. As shown in Figure 5, between 68% and 79% of parents reported growing "a lot" in their understanding across all four strategies, with using positive language (79%) and giving positive choices (78%) showing the highest growth.

Figure 5. Percentage of Parent-Reported Growth in Understanding of Core Strategies After Bridge to Preschool



[24] These analyses used a paired pre-post design in which each child served as their own comparison. While typical developmental progression may have contributed to some of the observed gains, the pattern — larger for children who started lower and consistent with what a language-rich intervention would be expected to produce — is consistent with what TPS designed the program to achieve.

[25] TPS measured parent strategy use via survey administered at an orientation session at the start of Bridge to Preschool and again at the final session.

[26] The measure of how often parents used each strategy includes 118 parents with complete pre and post data.

[27] The measure of how much parents' understanding grew, shown in Figure 5, includes 63 parents, as this retrospective question was introduced only with the most two recent cohorts. Because this second measure is based on a small, single-cohort sample and relies on self-reported retrospective recall, results should be interpreted with that in mind. They reflect parents' own sense of how much they learned, which is meaningful context but may not fully capture behavioral change.



In parent interviews, one father commented on an improved connection with his children as a result of using the right tools:

> **"You know, sometimes as parents, especially me and my wife… we thought that we understood our kids clearly. But at the end of the day, when they came back home, we were wrong. But with the TPS, they help[ed] us… to open our eyes. To make sure that we have the right tools to work together with them… [get on] the same page, that we are connected."** - TPS Parent

Through a focus on strengthening parents' understanding of social-emotional development and equipping them with practical strategies, TPS built the capacity of caregivers to reinforce these skills in everyday interactions.

Child Social-Emotional Skills

The child social-emotional outcomes reported here are drawn from initial rounds of Bridge to Preschool, which were designed to build children's social-emotional skills directly alongside parent strategies.[28]

Children showed improvements in their ability to regulate emotions, build relationships, and navigate social situations. Children's social-emotional skills improved over time, with the strongest gains among those who started with the greatest needs.[29] On average, children moved from the 29th to the 38th percentile, and more than half (53%) improved by at least 5 percentile points. For children who began below the 50th percentile, the median score jumped from the 4th to the 15th percentile, which demonstrated a shift even though many remained below age-expected levels at preschool entry. Children already meeting benchmarks at baseline maintained those levels.

These gains reflect something TPS built intentionally: children practiced the same skills in two places at once. The strategies parents learned through Bridge to Preschool, including naming emotions, following the child's lead, using calm and positive language, reinforced what children experienced in the classroom. Parents noticed the difference:

> **"They had all kinds of different breathing techniques that would help them, and they learned them since they were 3 years old… I think as they get older they hold onto some of that stuff and they know how to use it when they need it."** - TPS Parent

> **"They taught her how to control her emotions - well, not necessarily control, but more like understand them. Being able to communicate when she was sad and express that emotion."** - TPS Parent

[28] The child social-emotional outcomes reported here reflect earlier, longer rounds of Bridge to Preschool, which consisted of 16 to 20 weeks of joint parent-child sessions that TPS designed to build children's social-emotional skills directly alongside parent strategies. In more recent cohorts, the program was shorter and focused on outcomes better suited to a briefer timeframe, such as separation from parents and familiarity with preschool routines.

[29] Social Skills Improvement System (SSIS) and the Devereux Early Childhood Assessment (DECA) examined changes in percentile scores from the start to the end of Bridge to Preschool. These analyses include 86 children with complete data.

Start Early Spotlight

Martha,* a mother of 5, joined TPS when the school launched. Martha shared a unique perspective on the school's approach to starting early as one of her children received early intervention support but another did not. Martha saw the difference clearly. Martha's second child showed signs of delayed speech and required additional support. Through her insurance, TPS connected Martha to a specialist who suggested the activities and interventions needed. TPS offered additional support including a speech therapist; however, Martha experienced a challenging pregnancy with her third child and therefore declined the additional support. Martha's second child repeated Pre-K to ensure he met developmental milestones. Martha's parent coach reflected on his development:

"He just needed more time to bake, to get those things that he needed… because he didn't get the early intervention. I always wonder about him. What if [he] would have gotten early intervention, birth to 3? [He] might have still had a learning disability or needed support, but maybe it wouldn't have been so intensive." - TPS Parent Coach

When Martha's third child presented with a similar delay in her speech, TPS worked with her to start early and implement interventions. Martha's coach played a pivotal role in supporting her readiness to engage in early intervention work with her third child. The parent coach shared reflections on her role:

"I do think early intervention and that model that she was in, and my role in helping her understand the systems that she was in, in a way that was digestible, and for her to be able to engage with it… Sometimes, with those systems, they're moving so quickly... We could take the time to move her through the process a little bit easier…Our role here at TPS was this parallel process…" - TPS Parent Coach

In supporting Martha to navigate insurance resources and connect with specialists, and supporting her engagement early on, the third child received the support she needed:

"[She] received early intervention services… to mitigate any special education needs in the future… She ended up being very typical. She just needed support early on. But [without early intervention] she might have needed more support as she went through the school system, right? That piece really helped mom, because… it broke the stigma around getting special education services."
- TPS Parent Coach

Martha recalled the change she witnessed:

"I gave it to my third child, the speech therapist. Man, I wish I gave it to my second child, because my third child spoke quicker, and by the time she went into the primary, she was already speaking, doing ABCs, numbers, everything, but it was because of that initial meeting… the therapist from 1-year-old to 3-year-old." - Martha

Martha specifically credited the Bridge to Preschool program:

"They have an amazing Bridge to Preschool program… I really love that part, because they're so kind and gentle with the little ones… TPS has made it so special to me and my kids, because they learn to love school, they learn to get ready for school, this whole process.. The way that they… introduce a child into coming to school means everything to me…"
- Martha

Martha's story also exemplifies integration of the model components. Beyond the parent coach, multiple staff supported Martha and her family including the student support team who managed the IEP process, the Early Family Foundations program staff, and those who attended meetings referred to as Children's Circles, which included the teacher, coach, and parent and expanded as needed. While Martha expressed her sadness that the school is closing, Martha will use this experience to ensure her two youngest children get the support they need, early on:

"I'm there now, my fourth and fifth [children] all because of the children before. I have a lot of experience from TPS, because they showed me what my resources were within my insurance." - Martha

The parent coach concluded:

"She benefited. .. But she didn't benefit because we provided it. She benefited because she engaged with it, and she shaped it to fit her family." - TPS Parent Coach

**Names have been changed to protect families' privacy.*







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.** This coordination continued when children entered preschool so that they could continue to seamlessly receive 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. TPS's focus on building strong connections between parents and children was at the heart of this work.

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.

Strategic Pillar 2: Partner with Parents

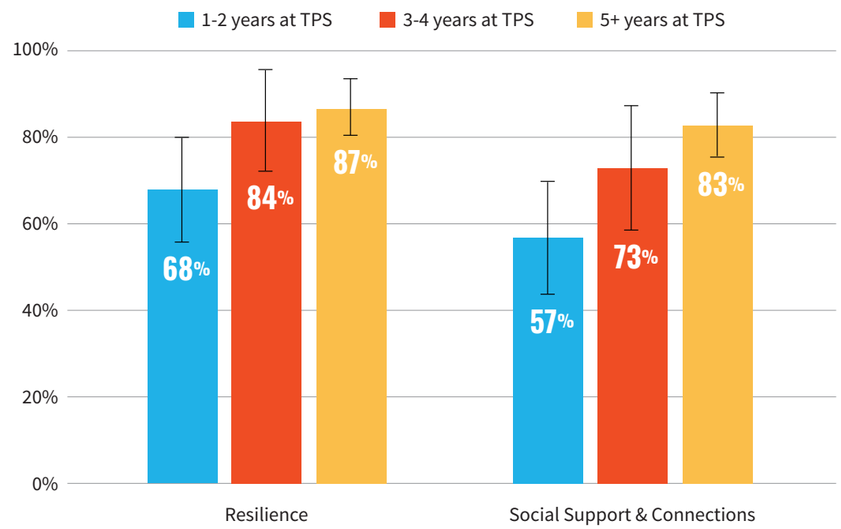


The Primary School (TPS) developed its Parent Wellness Coaching program on a simple but meaningful premise: that children do better when their parents are doing better. Rather than treating families only as partners in their child's education, TPS invested in parents as individuals, supporting their well-being, their goals, and their ability to navigate the challenges that make parenting harder. TPS assigned a dedicated Parent Wellness Coach who provided individual and group-based support to each family. Coaches worked with parents to identify strengths, set personal goals, and connect to community resources. Coaches did not tell parents what to do, but built relationships with them and asked what they wanted for themselves and their children. Group programming included a 10-week Foundations series and monthly Parent Circles, which gave parents a consistent community of peers to learn from, share with, and lean on. Coaches also worked alongside teachers and school staff on child-centered planning, including through bi-annual Children's Circle[30] meetings, helping families understand and strengthen their role in their child's learning and development.

GOAL 1: INVEST IN PARENT WELL-BEING

Families whose children attended TPS for longer periods of time reported stronger protective factors, such as resilience and social support and connections. This finding comes from the Protective Factors Survey, administered annually. Spring 2025 data showed a consistent pattern between length of enrollment and the strength of parents' protective factors.[31] Parents whose children were at TPS for one to two years reported high resilience at a rate of 68%; among those enrolled for three to four years, that figure rose to 84%, and among those there five or more years, it reached 87%. Social support and connections showed the same pattern, with rates of 57%, 73%, and 83% across those same groups (see Figure 6).

Figure 6. Percentage of Parents with High Level of Resilience and Social Support by Time at TPS



[31] Resilience and social support and connections were measured using the Parent Assessment of Protective Factors, administered annually. These are cross-sectional data from Spring 2025, reflecting responses from different families at different lengths of enrollment rather than the same families tracked over time. Analyses include 56 parents enrolled for one to two years, 37 for three to four years, and 98 for five or more years. The middle tenure group has the smallest sample, which should be kept in mind when interpreting trends across all three groups.

Although differences were not statistically significant, the consistent upward trend across all three groups for both measures suggests a cumulative benefit of longer enrollment.

When asked what mattered most about TPS, many parents immediately named their Parent Wellness Coach. For many parents, coaches acted as the connective tissue between the school and the rest of their lives:

> **"The parent coaches, the parent program, play such a huge role, especially… if you don't know what you're doing…they're totally on top of it. They're like, okay, we need to do this… there's steps… this is the first person that we need to go through, the second…"** - TPS Parent

For families new to the country, connectedness with the Parent Wellness Coach proved especially vital:

> **"There was also support for parents [new] in this country. That's very important because you arrive in a country where you don't know much, maybe there's no family around you, your support network is very very limited…"** - TPS Parent

> **"I'm a… immigrant, too. So, I didn't grow up with all this stuff… the knowledge of all the things that California… or… my county offers… Just having a friend within the school to be like, hey, you know, you could qualify for this, you should try and just apply, and that was really helpful."** - TPS Parent

The Perceived Stress Scale told a more complex story. While some parents, particularly those with higher initial stress, showed decreases over time, this pattern did not show up consistently across the full group, and longer engagement at TPS did not reliably predict lower stress in the most recent data. Notably, these data suggest that parents' resilience and capacity to cope may have grown over their time at TPS, but underlying stressors remained. Through a focus on increasing resilience and strengthening social support networks, TPS helped parents feel more equipped and connected, even in the context of ongoing stress. That distinction may reflect what a school-based model is realistically able to do.

Parents also shared reflections on stress in interviews, commenting on learning how their stress could affect their child/ren:

> **"They correlated… how it would affect your kid… I guess nobody really thinks… oh, I'm so stressed, they think it's a personal thing, but it could reflect on the child. It really makes you take a double step, and you start thinking about, okay, maybe…I should try and fix this because it's rubbing off, or it's affecting my kid in some way. So… that helped me… [to] try and change my own stuff, what was going on with me, so that it wouldn't affect the kids."** - TPS Parent

In the annual parent survey, parents consistently described Parent Circles as a valued source of respite, an opportunity to step back, reflect on their own wellness, and connect with others navigating similar challenges. Some parents noted that having dedicated time each month to discuss the stresses of parenting felt both grounding and practically helpful. Parent Circles supported parents' inner lives, but families still faced real material challenges and that is where the work of Goal 2, which focused on family and home stability, begins.



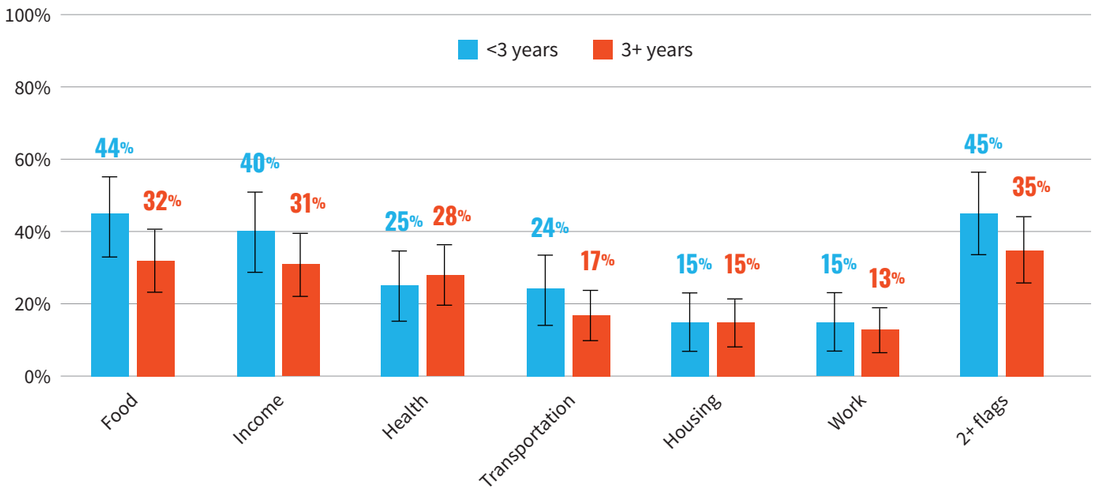
[32] To measure parents' stress, TPS used the Perceived Stress Scale (PSS-10), a widely used tool that asks about feelings of stress over the past month.

GOAL 2: SUPPORT FAMILIES TO BETTER NAVIGATE THEIR SOCIAL NEEDS

Families who engaged with TPS longer showed signs of reduced social needs[33] and were more ready to access supports, even as the structural conditions driving those needs remained beyond the school's influence. Across all survey waves,[34] the overall prevalence of social needs remained relatively stable over time with no clear decrease at the population level. This is not a surprising finding: the structural conditions that drive food insecurity, housing instability, and income gaps are not something schools may be able to resolve.

Differences did emerge when examining families by length of time at TPS. In the most recent round of data collection (Fall 2025), families who had been at the school for three or more years reported food and income-related needs less frequently than newer families, and fewer reported having two or more simultaneous social needs (35% compared to 45% among those with less than three years). While these differences were not statistically significant, they point consistently in the same direction which is toward families having fewer social needs the longer they were engaged (see Figure 7).

Figure 7. Percentage of Families with Each Identified Social Need, by time at TPS



Readiness to access supports also grew with time and differences across groups were statistically significant ($p = .012$): 57% of parents in their first two years reported high readiness, rising to 64% at three to four years and 78% at five or more years (see Figure 8).[35]

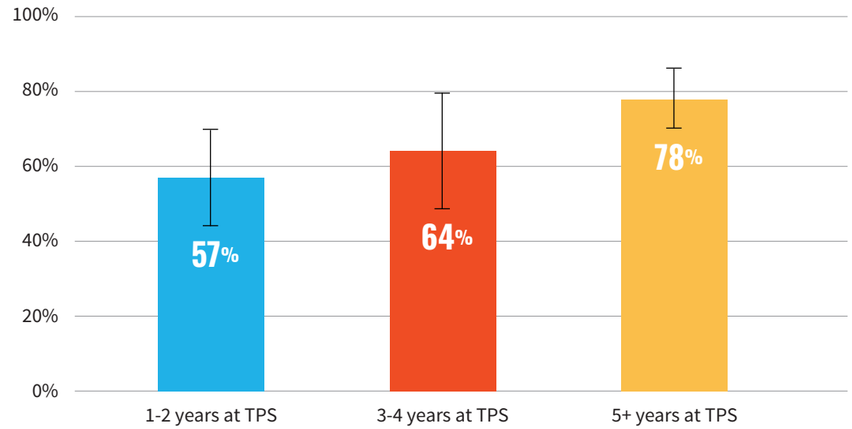


[33] A social need is an unmet material or resource need that a family is experiencing, including things like not having enough food, unstable housing, or insufficient income.

[34] Social needs were measured using a universal social needs survey administered twice per year beginning in 2021, covering food, income, health, transportation, housing, and work. These data are cross-sectional, comparing families at different lengths of enrollment at a single point in time in Fall 2025, rather than tracking the same families over time. These analyses include 75 families who had been at TPS for less than three years and 110 families who had been there for three or more years.

[35] Readiness to access supports was measured using the same social needs survey, which is a domain of the protective factors survey. These analyses include 56 parents enrolled for one to two years, 37 enrolled for three to four years, and 98 enrolled for five or more years.

Figure 8. Percentage of Parents who Report High Level of Readiness to Access Services for Concrete Needs, by Time at TPS



In interviews, parents shared how TPS helped them to connect to resources such as housing support and employment opportunities and navigate challenging circumstances such as political asylum claims and family trauma:

> **"They've done a great job… You need housing. Boom. You need food. Boom. You need help finding a job, let me help you. You don't know how to write a resume? Let me connect you to this resource…"** - TPS Parent

> **"[The Parent Wellness Coach] has been a great support… She's helped me find resources, she's given me phone numbers, she's helped me because I don't know how to read or write… I couldn't fill out my passport papers and she helped me fill out the paperwork. She's also helped me with resources for food… and also emotionally."** - TPS Parent

> **"Whenever… I'm like I need support with this…The school communicates with us. They also have resources…for whatever comes up if you need help with food, sometimes there's housing opportunities, and they'll post it on there.** - TPS Parent

While these findings suggest that TPS did not reduce the overall prevalence of social needs across families, it did support families in navigating those needs more effectively. TPS consistently helped families move through lived realities with more knowledge, more support, and more confidence.





GOAL 3: PARENTS SUPPORT CHILD DEVELOPMENT, HEALTH, AND LEARNINGS



TPS designed its parent programming with a two-generational goal: that stronger, more confident parents would be better able to support children's development. Parent Circles, individual coaching, and Children's Circle meetings all included content to help parents understand child development and translate that understanding into everyday interactions at home.

Over the years, TPS changed how it tracked whether parent programming impacted parents' interactions with and support of their children. TPS did not have well-defined outcomes for this goal so consistent quantitative data to assess progress over time do not exist. However, quantitative and qualitative data indicate that some parents were better able to support children's academic and social-emotional development. For example, when Parent Circles focused on supporting children's social-emotional development and health, a majority of parents reported in exit tickets that they were likely to do something differently with their child because of what they had learned. In other parent surveys, parents reported trying new strategies at home based on goals and approaches that had been discussed during Children's Circle meetings. In later years, several rounds of Parent Circles designed specifically for parents of older children included pre and post measures that showed increases in parents' knowledge and awareness of how to support their children through the teen years. Additionally, in qualitative comments in parent surveys over the years, parents consistently highlighted gains in their understanding of child development and their ability to connect with and communicate with their children, describing how they learned new strategies for building strong, responsive relationships with their child.

In interviews, parents echoed these themes:

> **"Our children [were] being taught by the teachers, but we were being taught by the parent coach [and] staff… about nutrition, about the way that their mind works…"** - TPS Parent

> **"So, each topic would be… to help families be better for the kids and for themselves."** - TPS Parent

Parents consistently named two things that set TPS apart from other schools they had attended: community and the absence of judgment. Parent Circles gave families a space to share struggles, hear how others navigated similar situations, and pick up ideas to try at home. Several parents noted that TPS never solved problems for them. Rather, coaches guided them toward solutions instead, leaving parents feeling capable rather than dependent. For some, particularly those from cultures where sharing personal struggles with a stranger felt uncomfortable, building trust took time. Peer community, nonjudgmental support, and a coaching approach that centered parent agency appear to have mattered as much to the learning as the content itself.







Partner with Parents Spotlight



Esther's* son started at TPS when the school launched**,** making her one of the first parents to engage in the parent focused part of the school's model. Describing herself as an introvert, Esther felt reluctant to connect with a Parent Wellness Coach at first. However, she later requested an English speaking coach who commented:

"[Esther] definitely was more comfortable in Spanish, but she wanted to be with me because she wanted to practice her English… That tells you something about Esther. She was always a woman of learning and growing…"
- TPS Parent Wellness Coach

This mindset helped Esther overcome her initial reservations, and she ended up "just waiting for the day I [was going to] have my coach talking to me, checking in on my goals." She described her as "more than my coach. [She was like] my psychologist!" Esther's parent coach reflected that parents can be used to interactions that feel like case management with steps to qualify for things. The parent coach shifted the dynamic away from telling Esther what to do to asking her what her dreams were and building a relationship with her.

Esther's coach described her as having big dreams but that she faced several significant barriers including a workplace injury that made her prioritize a career change and her health. Together, Esther and her coach worked through the barriers that persisted, which were described by the Parent Wellness Coach as "significant stuff that would have probably… stop[ped] so many other people." Esther joined a program that provided free adult education to adults in California with one goal in mind:

"I always want to get my GED. So, I decided to go back to college and focus on one goal at a time." - Esther

Not only did Esther obtain her GED, she continued her college education, and secured better job opportunities which had an effect on the whole family. The Parent Wellness Coach commented: "That GED… opened up doors for her," and Esther agreed. She had:

"better job opportunities… time for my kids… I'm not rich, but at least I can provide for my kids…. [and] less stress, to be honest." - Esther

Esther reflected that without the encouragement, structure, and support of the parent coach, she would not have known where to start and wouldn't be where she is today. Having overcome several barriers and completed her GED and college, Esther used these experiences with her son to focus on structure to ensure that he would finish the things he started too. The parent coach commented on the power it had on Esther's son:

"When she began to get consistent in that, she started to work [towards] her goals, [her son] was able to do well." - Parent Wellness Coach

He became more responsible, adopted routines, finished things, and had his own dreams, including his own college ambitions as shared by the Parent Wellness Coach:

"He was like, you know, I really want to go to college. And she was like, oh my goodness! But I think a part of it was, he saw her doing it. He saw her graduate…"
- Parent Wellness Coach

As TPS closes, the parent coach reflected:

"I think, even if we weren't closing the program, she would have been ready to not have coaching, because she was able to get through. It wasn't the motivation, it wasn't the larger goal, it was true things that got in the way, that were barriers." - Parent Wellness Coach

This spotlight illustrates the reach of two-generational support, and how working with parents can shape their children's lives in myriad ways.

**Names have been changed to protect families' privacy.*

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.



Strategic Pillar 3: Health Integration



Children's learning is compromised when they have unrecognized or untreated medical issues, when untreated asthma keeps them home, or when a dental infection makes it difficult to concentrate. The Primary School (TPS) built its health integration model with recognition that schools are often the most consistent and trusted touchpoint in a family's life, and a family's relationship with their school can be a powerful lever for improving their child's health.

TPS recognized that in traditional systems, a significant gap exists between referral and completed care. Access to referrals alone does not ensure that children actually receive needed services. That gap widens further for the families where language barriers, limited familiarity with the health care system, low trust, and systemic biases all make navigation harder. A school that has already earned a family's trust is uniquely positioned to bridge that gap in ways that a clinic or referral line cannot.

Rather than building a separate school-based health center, which requires significant funding and can duplicate existing services, TPS partnered with community pediatric medical homes to extend their reach into the school. School staff and health providers worked jointly, shared information, and followed through on identified needs. This started with establishing communication pathways and privacy agreements between the school and its partners. From there, TPS embedded screenings for the most common health barriers to learning, including vision, hearing, dental, asthma, and developmental delays. They then built in the follow-up support needed to ensure that identified needs were resolved, not just referred. At the center of the model sat a part-time nurse, shared with the Ravenswood Family Health Network in East Palo Alto and Kaiser Permanente in the East Bay. The nurse worked in close partnership with dedicated health staff at each site to coordinate preventative care, support annual well-child visits and immunizations, and ensure families could access on-site dental services. For children with more complex health needs, the integrated team met regularly for care coordination, with health partners providing clinical staff for program oversight and periodic on-site support. Finally, TPS invested in promoting healthy behaviors at school and at home in areas such as oral health, nutrition, physical activity, and hand and sleep hygiene.



GOAL 1: ALL VISION AND HEARING PROBLEMS ARE DETECTED, TREATED, AND ADDRESSED WITHIN THE SCHOOL CONTEXT

TPS achieved strong vision and hearing screening rates and built a follow-up system that moved families from identification to treatment, catching needs that would otherwise have gone undetected. California law requires schools to conduct vision screenings during grades 2, 5, and 8, but TPS went further by embedding vision and hearing screening into a broader system of identification and follow-up care.

TPS achieved strong results. Ninety-two percent of children received a vision screening, and among those identified with a concern, 72% attended a follow-up appointment with a provider. Sixty percent of children who needed glasses received them, averaging approximately nine children per year (see Figure 9).

Figure 9. Vision Care at TPS: Percentage of Children by Screening, Follow-Up, and Treatment Rates



These results are notable given how rarely follow-through occurs in California more broadly. According to a 2025 California Health Policy Strategies policy brief, only 16% of Medi-Cal school-age children received primary eye care services over a two-year period, and the authors conclude that follow-up treatment after screenings is largely not occurring statewide. A 2026 investigative report found that only around 7% of students who fail a school vision screening in California go on to see an eye doctor and return with glasses, based on accounts from school nurses and optometrists across the state (Hwang, 2026). TPS's 72% follow-up rate is far above either of these benchmarks and reflects what becomes possible when a dedicated nurse and health staff actively coordinate care from screening through treatment.

Getting glasses into children's hands and keeping them on children's faces during the school day remained persistent challenges for TPS, requiring ongoing attention and reinforcement to sustain.

One parent, who also worked as a TPS teacher, described how vision issues can be difficult to detect but have a significant impact on learning if left unaddressed:

> **"It's [vision screening] a very important thing for me, because my kid was diagnosed with myopia at a very early age, because she was at TPS, and her teachers noticed that she was struggling with reading, and I wouldn't have had that experience at any other school, personally. And this is coming from me being a teacher and not being able to see that in my own kid…. We've had lots of students… who have been diagnosed with myopia, and their parents have mentioned that's a big thing that usually goes undiagnosed for many years, if it's not caught early… Sometimes the kids are just struggling, they can't see, … the growth is not there, and they don't know what's happening, so I think that's a big thing of TPS." - TPS parent, teacher, and advisory board member."** - TPS Parent, Teacher, and Advisory Board Member

Vision problems are easily missed but consequential to ignore. TPS's screening model caught needs that would have otherwise gone undetected for years, and the follow-up infrastructure helped support students in receiving actual treatment.









GOAL 2: RESOLVE IDENTIFIED HEALTH NEEDS THROUGH COORDINATED CARE

To achieve integration of health within the model, a nurse and dedicated health staff at each site served as the connective tissue between the school and its health partners. The nurse and health staff coordinated referrals, followed up on identified needs, and helped families navigate a health system that can be difficult to access without guidance. On average, 36% of students received health case management support in a given year. Of those cases, 71% were resolved, meaning students successfully connected to the services they needed.[39]

Cases covered a wide range, including behavioral and developmental concerns, mental health needs, vision and hearing follow-up, acute illness, and chronic condition management including asthma. A key component of this work involved facilitating communication between families and health care providers, including both primary care providers and specialists. By helping families navigate appointments, referrals, and follow-up care, TPS reduced barriers that often prevent students from accessing services. Parents described the difference this made:

> **"There really was a partnership. You know, between the school and home and the healthcare provider…"** - TPS Parent

> **"In receiving advice from the nurse, it's been just a great support for me and my son, taking us into account and giving us attention… [The Doctor] from Stanford created the plan with the [TPS] nurse. She told us what the plan would be with insulin, his diet, his food… I also went with the diabetes nurses to get advice and learn how to keep my son's health well."** - TPS Parent

Families managing chronic conditions recognized the measurable difference missed work days, emergency visits, and daily stress made in their lives:

> **"[My son] was hospitalized in Stanford with asthma. Before he [started] TPS, I had to always be at school picking him up, because he was sick… all the time. So I miss[ed] a lot of days of work. How can I concentrate with anything? Since he [started] TPS, they also have a doctor in there at the beginning and they were a very important part on how to manage [my son's] asthma… …they were able to just not let the asthma go bad. Like, control."** - TPS Parent

The resolution rates reflect both strong coordination and what happens when someone at the school owns the follow through. The nurse and health staff closed the loop that traditional referral systems routinely leave open, and families felt the difference.

[39] The health team tracked case management data annually using an internal spreadsheet. The team considered a case resolved when a student attended an appointment related to their identified health need rather than full resolution of the underlying condition. The number of students receiving case management support varied considerably by year, ranging from approximately 150 students across both sites in higher-enrollment years to fewer in others, so the report presents average annual figures rather than year-by-year totals.

GOAL 3: ALL SCHOOL-AGE STUDENTS ARE UP-TO-DATE ON PREVENTATIVE MEDICAL AND ORAL HEALTH SERVICES

85%

of school-age children at TPS had an annual well-child visit

TPS students attended well-child visits at rates well above comparable populations. **Among school-age children at TPS, on average, 85% had an annual well-child visit**, compared to 55% among Medi-Cal enrollees in San Mateo County, 62% among CA Medicaid & CHIP populations statewide, and 75% in the California National Survey of Children's Health.[40] Among Early Family Foundations families with young children, 86% attended an annual well-child visit, meeting or slightly exceeding statewide rates for children ages 0 to 5.[41]

TPS increased access to preventive dental care by offering on-site services across its sites. Nearly three quarters of students (73%) enrolled in the on-site dental program. Across all TPS students, including those who saw an outside dentist, 84% received a preventive dental visit in the past year, nearly double the 45% preventive dental service rate among Medicaid and CHIP-enrolled children across 49 states, according to a 2023 KFF analysis of federal Medicaid data (Williams & Rudowitz, 2023).

One parent and advisory board member explained why the on-site setting made a difference even for children who were typically anxious about dental visits:

> **"Parents have mentioned that the kids actually refuse to go to any other dentist, because it's a very scary experience. But doing it at TPS where usually [the dentist] is smiling, she's friendly, and they have stickers and it's a comfortable setting for them. They are usually more willing to get dental work. So if they have cavities and fillings, they're more receptive to getting it done at school versus just outside of school."** - TPS Parent, Teacher, and Advisory Board Member

And for families whose children needed outside services, having coordination handled at school removed a logistical burden that had previously consumed their days:

> **"less stress, because when we did have to get outside support, it was worrying about the school schedules and then rushing. I had to go to San Jose at the time. Rushing all the way to San Jose right after school to take him for, like, an hour because of the traffic, we couldn't make the whole session… And it was just stressful doing that 2-3 times a week … On top of everything else."** – TPS Parent



These numbers reflect more than scheduling efficiency. When families trust a school and its relationship with health care providers, they show up, including for well-child visits, for dental cleanings, and for follow-up appointments they might otherwise have put off. TPS leveraged that trust deliberately, using its relationship with families to keep children connected to the preventive care that protects their ability to learn. Below we share a spotlight story from a TPS family managing a complex medical need.

[40] TPS tracked well-child visit rates through internal health records in coordination with its medical home partners. Comparison figures come from three different sources covering different populations and time periods: Medi-Cal enrollees in San Mateo County (local Medicaid data), Medicaid and CHIP populations statewide (federal Core Set data), and the California National Survey of Children's Health. Because these sources reflect different populations, geographic areas, and data collection methods, readers should treat them as contextual reference points rather than direct comparisons.

[41] The statewide comparison for well-child visits among children ages 0 to 5 is drawn from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), which tracks well-child visit rates among Medicaid-enrolled children as a standard quality measure.

Health Spotlight

Diane's* son was born with a complex physical disability that requires his medical device to be changed multiple times throughout the school day, something that can interrupt learning and requires adult support. For Diane, finding a school that could safely manage those needs during the day was essential. As she put it:

"I've never really had a school that had a health program. [Other schools] have nurses, but the nurses aren't really hands-on…" - Diane

At TPS, the nurse did not operate separately from the child's medical care. Instead, she was part of his broader care team. With parental consent, she had access to his health records and directly communicated with his providers, allowing TPS to anticipate and respond to his needs in real time. When insurance would not cover additional supplies, TPS stepped in to ensure he had what he needed during the day.

TPS also built its own capacity to provide care. Staff worked directly with his doctor and received hands-on training to manage his medical device at school. As Diane explained:

"They actually took hands-on training from his doctor to make sure they were doing things correctly… every time we have a new device, they're keeping on top of their medical training." - Diane

This meant his care could be handled during the school day, without requiring his parents to come in, reducing disruptions and allowing him to stay in class. Beyond direct medical care, TPS played an active role in coordinating her son's care, arranging medical appointments, coordinating transport, and supporting Diane through an ongoing relationship with a parent coach. As she described it:

"They're just on top of things. They know, medically, what he's going through. They're on top of his appointments, they support me emotionally if I need any assistance with setting up appointments or you know, arranging things for his health care." - Diane

This meant Diane did not have to manage these logistics alone, reducing the day-to-day burden of coordinating her son's care.

Diane shared that the support had a noticeable impact on her son's confidence. He was treated like every other child while still receiving the care he needed to participate fully in the school day. TPS prioritized his health without letting it come at the expense of his learning, providing additional materials and tutoring to help him stay on track.

Just as importantly, he spent more time in the classroom. Previously, device changes often required parents to come into school, leading to missed instructional time. With care available on site, his needs could be addressed quickly, allowing him to return to class and continue learning. This shift also changed what daily life looked like for the family. Diane and her partner no longer had to remain on standby during the school day and could return to their normal routines and work, knowing her son's needs were being met.

What made this possible was not just the presence of a nurse but a coordinated effort across TPS. Health staff, educators, leadership, and the parent coach worked together to support both the student and his family, creating a more sustainable approach to managing his health needs under one roof.

**Names have been changed to protect families' privacy.*







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

The Primary School (TPS) designed its model around a whole child approach, grounded in the research that strong academic outcomes are more likely when children are physically and mentally healthy, emotionally supported, and surrounded by resourced families. The three strategic pillars described in this report, Starting Early, Partnering with Parents, and Integrating Health, were not separate from academic goals but foundational to them. TPS focused on these other areas in light of the evidence that these often undervalued outcomes are good predictors of longer term outcomes like graduation rates, college completion, and adult well-being (Jones et al., 2015). To that end, the student outcomes data presented here reflect how children performed across literacy, math, attendance, and social-emotional development during the post-COVID years of implementation. Many factors shape how children learn, and high-quality instruction ranks among the most powerful. TPS invested in instructional quality alongside its integrated supports, but the data do not allow us to isolate the contribution of any single element of the model.

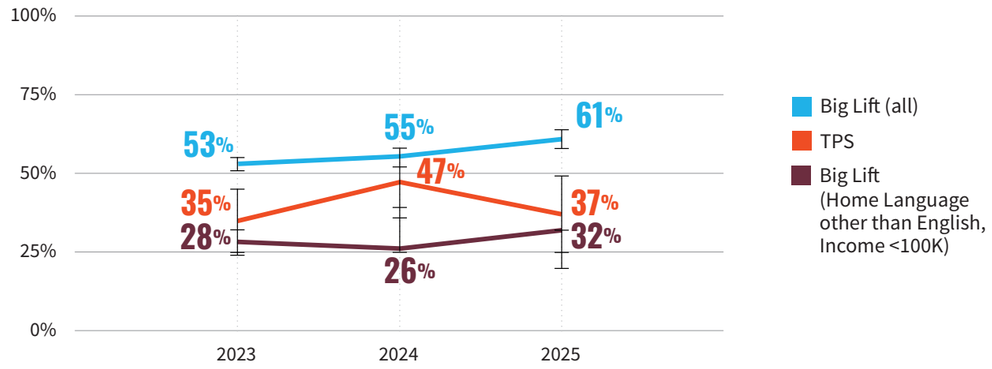
The data in this section focus on the years following TPS's return to full in-person learning after the COVID-19 pandemic. The school made this choice deliberately. In the early years, most students were in preschool or the primary grades, which limited the scope of academic data available. The pandemic disrupted learning and school operations significantly, as it did for schools everywhere. Focusing on post-COVID data captures the school's performance during a period of relative stability, when the model was more fully implemented and student populations were more consistent. Where available, the section notes pre-pandemic baselines to provide additional context.

Throughout this section, when possible, TPS compares its results to local schools with similar demographics like comparable rates of English Learners, low-income families, and students receiving special education services. These schools serve as a real-world reference point, not a scientific comparison. They give readers a way to situate TPS's results within what comparable schools were achieving at the same time.[42]

KINDERGARTEN READINESS

The results below show the percentage of students who met the overall kindergarten readiness benchmark across all three domains (see Figure 10).[43,44]

Figure 10. Percentage of Students who Met the Overall Kindergarten Readiness Benchmark, 2023-25



[42] Local comparison schools were selected because they serve demographically similar populations to TPS. Differences worth noting: TPS enrolled a slightly higher percentage of students with IEPs, while local East Palo Alto schools had a slightly higher percentage of students qualifying for free or reduced-price lunch. English learner percentages are difficult to compare directly because schools used different tools and criteria to assess English proficiency. These comparison groups are provided as real-world context, not experimental controls; the demographics are similar, but there is no matched comparison group.

[43] TPS measured kindergarten readiness using the Brigance Inventory of Early Development, a validated assessment covering three domains: academic/cognitive skills, language development, and physical development.

[44] TPS selected the Brigance because it is a validated measure also used by The Big Lift, enabling direct comparison with local benchmark data. While kindergarten readiness is typically assessed in the fall of kindergarten, TPS administered the Brigance in the spring of Pre-K because East Bay students transitioned to outside kindergartens, making spring of Pre-K the last shared assessment point across both sites. To confirm spring Pre-K results as a reliable proxy for fall kindergarten readiness, TPS administered the Brigance at both time points in two consecutive years and found similar results.

TPS compared its kindergarten readiness rates to two groups from the Big Lift, a cross-sector early literacy initiative in San Mateo County that tracks kindergarten readiness using the Brigance across participating programs. The first is the overall Big Lift population across San Mateo County. The second is a demographically similar subgroup, Big Lift families from households earning under $100,000 with a home language other than English, which more closely reflects the communities TPS served.

51%

of children at TPS met kindergarten readiness benchmark in 2026

TPS's kindergarten readiness rates increased overall from 35% in 2023 to **51% in 2026**, with a dip to 37% in 2025 before recovering. Although the overall Big Lift population outperformed TPS, with rates ranging from 53% to 61% across the same years, that group is generally higher income and faces fewer of the adversity factors linked to lower school readiness. When compared to the demographically similar subgroup, whose readiness rates ranged from 28% to 32% over the same period, TPS outperformed that group consistently across all four years.

The 2025 dip from 47% to 37% warrants acknowledgment. Staff attributed the decline primarily to significant teacher turnover at the East Palo Alto site, which disrupted instructional consistency that year. The recovery to 51% in 2026 reflects both what greater staff stability made possible and also a more intentional focus on specific literacy skills across both sites.

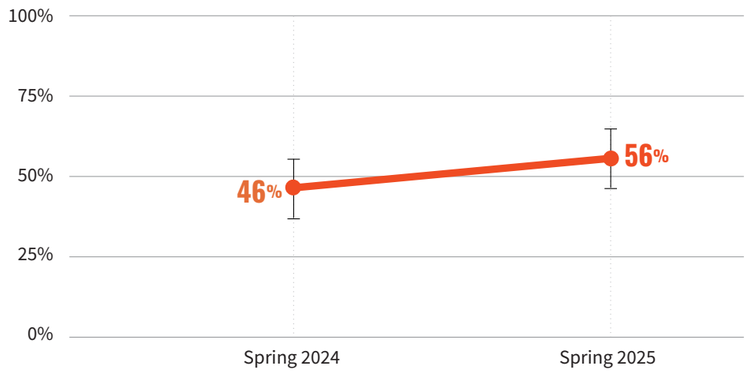
These results reflect kindergarten readiness as measured at the end of Pre-K, after two years of Early Childhood Education and, for many families, participation in Early Family Foundations. The Brigance benchmark represents a threshold rather than a continuous measure of growth, and year-to-year variation should be read with the school's small and declining cohort sizes in mind.[45]

ELEMENTARY AND MIDDLE SCHOOL ACADEMIC OUTCOMES

Early Elementary

For early elementary grades (kindergarten, first, and second grade), TPS's primary literacy assessment is Dynamic Indicators of Basic Early Literacy Skills (DIBELS), administered three times per year beginning in 2024-2025. The results below show the percentage of K–2 students who scored average or above average on the DIBELS Composite at the end of each school year (see Figure 11).

Figure 11. Percentage of Students at or above Average on Literacy Skills, Grades K - 2, Spring 2024-25



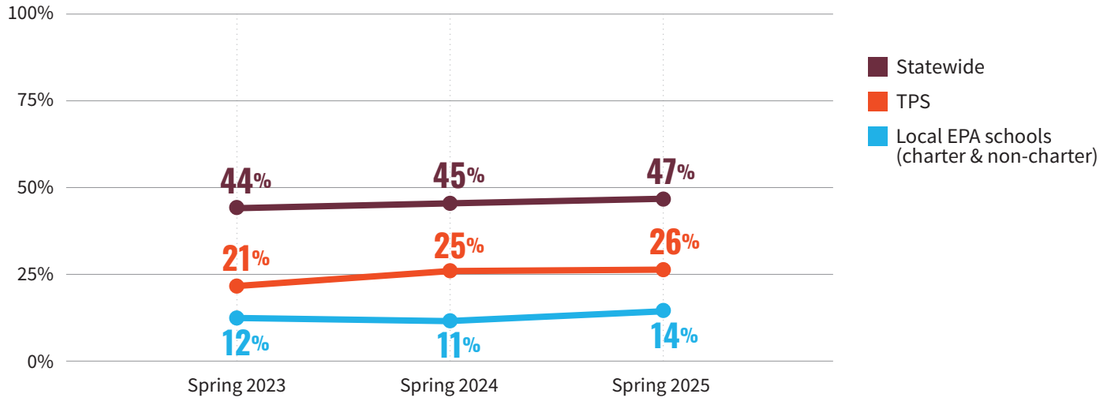
[45] Annual sample sizes for kindergarten readiness were 80 in 2023, 73 in 2024, 60 in 2025, and 55 in 2026, declining in later years for two reasons: decreased enrollment at the East Palo Alto site, and variation in the number of East Bay children in the kindergarten-eligible age range, as the East Bay site enrolls children ages 2 to 4 and only those eligible for kindergarten in the fall are included in this analysis. Given these small and varying cohort sizes, year-to-year changes can reflect shifts in just a handful of children.

TPS's K–2 students scoring at or above average rose from 46% in Spring 2024 to 56% in Spring 2025, a 10 percentage point gain in one year. No local comparison with comparable demographics is available for this assessment. For broader context, the national average across all assessed grades ranged from 60–62% at or above average during the same period. Because this national figure includes all grades and cannot be disaggregated by grade level, it is not a direct comparison to TPS's K–2 results. It does suggest, however, that scores in the 50–60% range represent solid, average performance nationally, and that TPS's trajectory is moving in the right direction.[46]

Late Elementary and Middle School

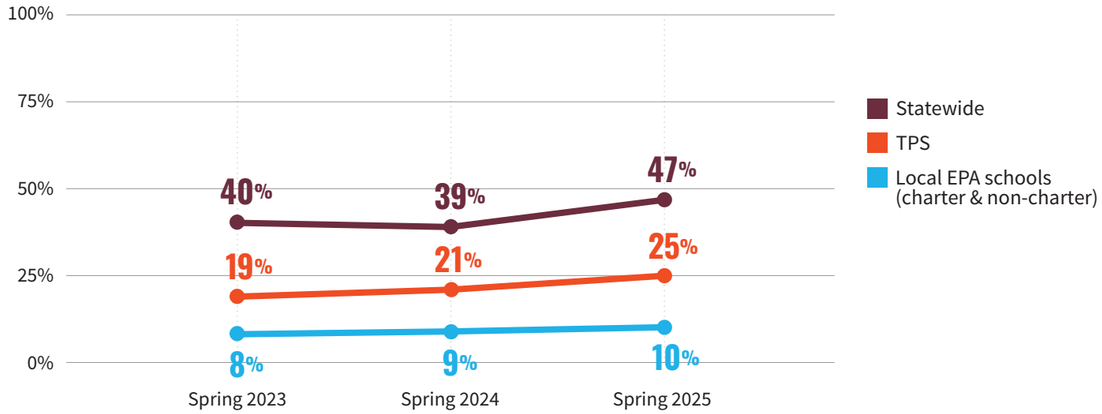
Beginning in third grade, TPS assessed student performance in literacy and math using the NWEA MAP Growth assessment, administered three times per year.[47] The results show a consistent upward trend in both literacy and math from Spring 2023 through Spring 2025, with Spring 2026 data forthcoming (see Figures 12 and 13).

Figure 12. Percentage of Students Meeting/Exceeding Literacy Standard, Grades 3 and pp, Spring 2023–25



Note. Error bars are not displayed, as confidence interval data were not available for all data points.

Figure 13. Percentage of Students Meeting/Exceeding Math Standard, Grades 3 and up, Spring 2023–25



Note. Error bars are not displayed, as confidence interval data were not available for all data points.

[46] DIBELS was administered using the Mclass data management system. The national average provided by Mclass covers all assessed grade levels and cannot be disaggregated by grade, making it an imperfect comparison for TPS's K–2 results. These analyses include 112 students in Spring 2024 and 120 students in Spring 2025.

[47] Because TPS students do not take the California state standardized assessment (CAASPP), NWEA provides algorithms based on a study of students who took both MAP Growth and CAASPP to estimate whether a student would meet or exceed grade-level standards. Results reflect these estimated equivalents and should be interpreted accordingly; they are comparable to, but not the same as, official CAASPP results. To ensure fair year-to-year comparisons as TPS added grades, local EPA school and statewide results are restricted to the same grade range as TPS in each year: 3rd through 5th in Spring 2023, 3rd through 6th in Spring 2024, and 3rd through 7th in Spring 2025. This approach was applied consistently across both comparison groups.

In literacy, the percentage of TPS students meeting or exceeding the standard rose from 21% in Spring 2023 to 26% in Spring 2025.[48] In math, it rose from 19% to 25% over the same period.[49] These gains, 5 percentage points in literacy and 6 in math over three years, represent steady improvement, particularly given the disruption of the post-COVID recovery period.

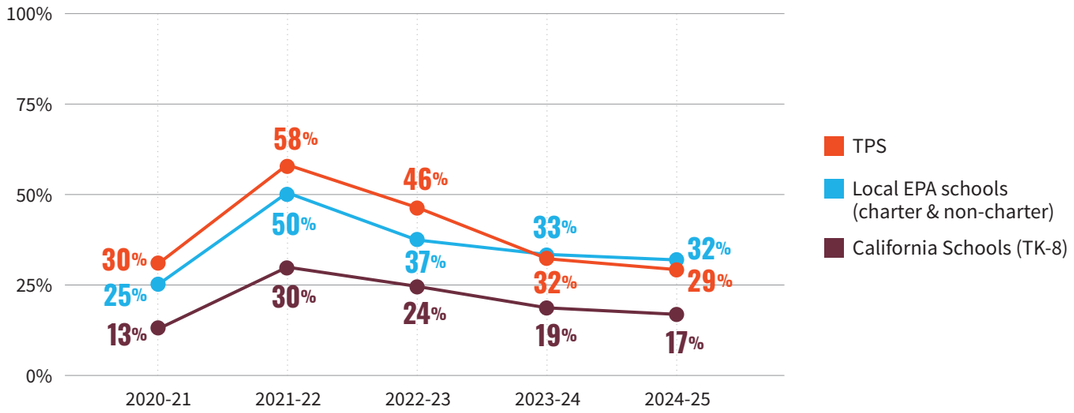
Across both subjects, TPS consistently outperformed local East Palo Alto schools, including both charter and non-charter schools. In Spring 2025, though results varied across individual schools, 14% of local East Palo Alto students met or exceeded the literacy standard and 10% met or exceeded the math standard, compared to 26% and 25% respectively at TPS. This gap held consistently across all three years of available data.

At the same time, TPS's results remained below the California statewide average, which stood at 47% in both literacy and math in Spring 2025. This gap may reflect the persistent inequities facing the communities TPS serves, where historically underfunded schools, high rates of English Learners, and concentrated poverty create significant headwinds for academic achievement. The statewide average itself represents a system where fewer than half of all students meet grade-level standards; that TPS students remained below that threshold while improving steadily and consistently outperforming similar local schools tells a story of real progress against a backdrop of structural challenge.[50]

School Attendance

Chronic absenteeism, defined as missing 10% or more school days, spiked across California and nationally in the wake of the COVID-19 pandemic, and TPS was no exception. In 2021-22, 58% of TPS students were chronically absent, above the 50% rate at local East Palo Alto schools and well above the 31% California statewide rate that year (see Figure 14).[51]

Figure 14. Percentage of Students Chronically Absent, 2020-21 through 2024-25



Note. Error bars are not displayed, as confidence interval data were not available for all data points.

[48] For literacy, TPS's sample included 121 students in Spring 2023 (grades 3-5), 132 in Spring 2024 (grades 3-6), and 170 in Spring 2025 (grades 3-7); the increase from 2024 to 2025 reflects a relatively large third grade cohort. Local EPA school samples included 800 students in Spring 2023, 1,068 in Spring 2024, and 1,354 in Spring 2025, drawn from aggregated data across one school district and two charter schools, combined to protect the anonymity of individual schools while providing a meaningful local comparison. California statewide samples included 1,276,135 students in Spring 2023, 1,655,915 in Spring 2024, and 2,071,843 in Spring 2025.

[49] For math, TPS's sample included 121 students in Spring 2023 (grades 3-5), 133 in Spring 2024 (grades 3-6), and 169 in Spring 2025 (grades 3-7). Local EPA school samples included 820 students in Spring 2023, 1,129 in Spring 2024, and 1,380 in Spring 2025, drawn from aggregated data across one school district and two charter schools, combined to protect the anonymity of individual schools while providing a meaningful local comparison. California statewide samples included 1,257,269 students in Spring 2023, 1,673,051 in Spring 2024, and 2,085,910 in Spring 2025..

[50] The gap between TPS's results and the statewide average should be interpreted alongside the demographic differences between the two populations. The statewide figures include all California students; TPS served a predominantly low-income, English learner population in communities with historically underfunded schools. This context is important when comparing TPS results with the statewide average.

[51] Chronic absenteeism data for TPS were drawn from internal attendance records. California statewide figures reflect K-8 schools only, to ensure comparability with TPS's grade range. TPS's annual samples ranged from 170 students in 2020-21 to a peak of 315 in 2024-25, ending at 274 in 2025-26. Local EPA school samples ranged from 2,688 to 3,069 students across the same years. California K-8 samples remained stable at approximately 4 million students annually throughout the period.

24%

of TPS students were chronically absent in 2025-26

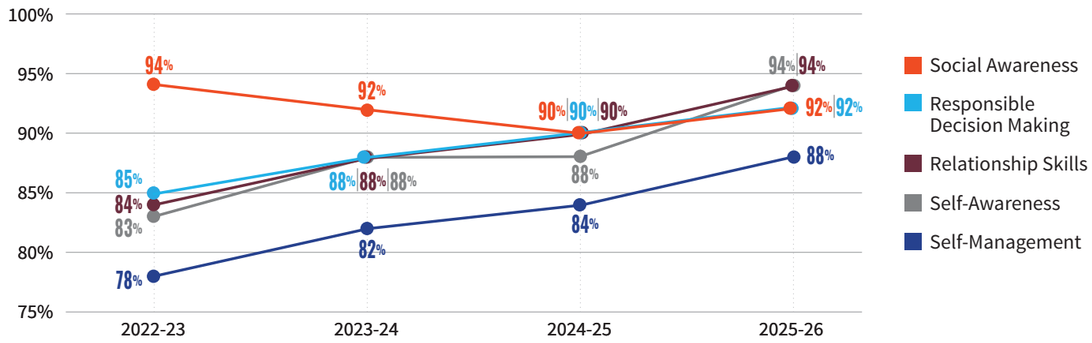
Since the 2021-22 peak, TPS made progress. Chronic absenteeism dropped from **58% in 2021-22 to 24% in 2025-26**, a reduction of 34 percentage points over four years. Local East Palo Alto schools saw a smaller reduction over the same period, from 50% to 32%. TPS's chronic absenteeism rate remained above the California statewide average for K-8 schools, which stood at 17% in 2024-25, compared to TPS's 24% in 2025-26. This gap reflects the deeper attendance challenges facing the communities TPS served, and the consistent downward trajectory over four years suggests clear progress toward closing it.

Chronic absenteeism reflects more than school culture or programming. It is deeply connected to family circumstances, health, housing stability, and community conditions. TPS's integrated model, including health case management, parent coaching, and family support, addressed many of the root causes that keep children home. The steeper decline at TPS relative to local schools may reflect the contribution of those supports, though the data do not allow us to draw that conclusion definitively.

Social-Emotional Outcomes

TPS measured social-emotional skills in 1st through 5th grade using the SSIS-SEL (Social Skills Improvement System – Social-Emotional Learning Edition), aligned to the five core CASEL competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. Results reflect the percentage of students meeting or exceeding benchmarks on the end-of-year screening across all five domains (see Figure 15).[52]

Figure 15. Percentage of Students Meeting/Exceeding SEL Benchmarks at End of Year, Grades 1-5, 2022-23 through 2025-26



Note. The y-axis begins at 75% rather than 0% to better display variation across competency areas over time.

Across all five domains, the percentage of students meeting or exceeding benchmarks increased from 2022-23 to 2025-26. By 2025-26, between 93% and 96% of students met or exceeded benchmarks across all five competencies. Self-management showed the largest gains over the four-year period, rising from 78% in 2022-23 to 93% in 2025-26, a 15 percentage point increase, while remaining the domain with the most room for growth throughout. Social awareness was consistently the strongest domain, beginning at 94% and reaching 96% by 2025-26.

Because teachers both deliver social-emotional instruction and complete the screening assessments for their own students, ratings may reflect teachers' familiarity with students as much as independently verified skill levels. No external comparison data are available for this measure, so results are presented as an internal trend rather than a benchmark comparison. Within those constraints, the consistency of improvement across all five domains over four years represents an encouraging signal about the social-emotional environment TPS cultivated.

[52] The SSIS-SEL screening was completed by teachers on all 1st to 5th grade students using a two-stage process. Teachers first rated each student on a 1 to 5 scale across all five CASEL domains using the screening scale. Students rated 1 or 2 in any domain were then assessed using a longer rating form, which yields a standardized score. A student met the benchmark in a given domain if they received a rating of 3 or above on the Screening Scale or, for those assessed with the longer form, a standard score of 85 or above. TPS used both the criterion-referenced screening scales and the norm-referenced rating forms.

CROSS-CUTTING LESSONS LEARNED FOR SCHOOLS

Across focus groups with The Primary School (TPS) leadership and program areas, several cross-cutting themes emerged about what it takes to implement and sustain a two-generation integrated school model. These lessons reflect both hard-won experience and the enabling conditions that others would need to put in place to adopt elements of this model.

Build the Right Foundation First

A consistent lesson across all program areas is that integrated elements (Starting Early, Partnering with Parents, Health Integration) are most effective when added to a functioning core. Brand new schools, or schools still developing instructional identity, curriculum plans, assessment systems, or basic structures for student support, will not have the teacher time, leadership bandwidth, or staff capacity to meaningfully engage with integrated programming. Leadership recommended the following sequenced approach: establish a strong instructional foundation first, then add one element at a time with genuine checkpoints before expanding further.

Alongside that foundation, the school needs a clear and stable vision. That vision must include a cohesive definition of both student and family success and a commitment to the values and approach that will be implemented consistently across programs. When vision and direction shifted at TPS, often in alignment with leadership changes, programs pulled in different directions, staff tension increased, and implementation became inconsistent. Directional shifts often related to the trade-offs between prioritizing academic outcomes and broader, longer-term whole child outcomes. This debate is not unique to TPS; schools across the country grapple with how to balance the urgency of short-term academic gains against the longer-term investments that a whole child approach requires. Coming out of the COVID-19 pandemic, that tension intensified at TPS, as pressure mounted to improve instructional quality and accelerate academic recovery, while leadership worked to preserve whole child strategies.

Leadership shared that a high-level vision proved ineffective on its own; it needed to be accompanied by concrete and specific annual priorities so that every team could clearly outline how they would work together to achieve a particular goal. One school leader gave attendance as an example of an effective shared priority. It has clear connections to health, family circumstances, and student motivation, giving every program a common outcome to work toward. The vision must be protected from re-evaluation as leadership transitions, and when it 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—the Principal Role Cannot Hold This Alone

High principal turnover proved a consistent reality at TPS, but every focus group named this as a structural problem, not a personnel issue. The demands of running an integrated model exceed what one person can sustainably manage. It takes intentional time and effort to align the daily work of parent coaches, teachers, and health staff. As one staff member described:

> **"It cannot be one person. It has to be held by more than one, because the load was just too heavy and too big to bear for one human being."** - TPS Leader

Viable alternatives include co-principals, a director of integration sitting alongside the principal, or shared central office roles distributed across sites. Any replication effort should build distributed leadership from the start, not treat it as a later adjustment.

Structure the Work So Integration Can Happen

Integration does not happen by proximity alone. Instead, it requires deliberate structural design. Persistent sources of friction at TPS included siloed work, overlapping responsibilities, and confusion about decision-making authority. Role clarity matters not just for day-to-day function but as a continuity mechanism: when responsibilities are clearly defined, the work is less dependent on specific individuals. This extends to data sharing and consent protocols between school







and health partners, which need to be established in advance rather than resolved on the fly. It also arises with the relationship between parents, parent coaches, and teachers, which can be challenging if there are not clear roles related to parent communication and response to parent concerns.

Equally important, coordination between teachers, parent coaches, and health staff only happens when time for it is protected in the schedule. This cannot be absorbed into an already-full day. Rather, it must be built in structurally through early release days, joint professional development, or dedicated caseload review time.

Similarly, parents have limited time to engage with their children's school, and that time must be designed intentionally, with parent input, and consider the needs of all programs. For example, parents being invited to attend a monthly parent circle meeting might interfere with their ability to be involved in more traditional school events like back-to-school nights and open houses. The more that these trade-offs in parent and teacher time are surfaced and aligned to a unified theory of change from the start, the better integrated services can be to meet student needs.

Invest in People and Community Relationships

The model requires staff at all levels to work across traditional professional boundaries. Working across systems means taking time to collaborate with professionals in areas that teachers or health professionals might typically consider outside of their scope. The disposition and desire to do this cannot be assumed; it must be screened for in hiring, reinforced through onboarding, modeled by leadership, and supported through workload design. Investing in reflective practice and protected time for cross-team staff learning allow this culture to take hold more durably.

Parent and community engagement deserves the same investment. Understanding what families actually need, rather than what staff assume they need, requires dedicated resources with explicit responsibility for parent co-design and community input. This cannot be absorbed by an already-stretched role. As one leader noted:

> **"Having parents be at the table and doing the co-design work… you need to invest capacity in that, so someone on the team needs to do that."** - TPS Leader

Build for Sustainability and Scale

Leaders highlighted that integrated elements of the TPS model cost less than people assume. TPS operated within a per-pupil budget comparable to other local schools with similar demographics. This requires deliberate allocation and creative funding from day one. While funding opportunities differ across states and districts, relying solely on per-pupil funding is unnecessarily limiting. Community partnerships, Medicaid billing, IDEA Part C, and philanthropic grants can all fund elements of this model. Budget clarity and explicit choices about priorities must come before implementation, not after.

> **"There are dollars in the community that could be co-located within schools… there's just a lot we're leaving on the table that actually could fund this work."** - TPS Leader

Planning for scale also means preparing for differentiation. The model's reputation as a supportive environment attracted a concentration of high-need families that eventually exceeded what the school could sustain. For example, the schools averaged 20% (East Palo Alto) and 23% (East Bay) students with special needs, compared to 15% statewide in California (see also California Governor's Office, 2026). The deepest gains at TPS came with higher-need families, but overloading a single site can create staff burnout and resource strain. Differentiation was a strategy that TPS adopted over time, as it learned that it was not realistic to provide the high-touch level of services it had designed for all children and families.

Outcomes also compound over time with families engaged earliest and longest showing the strongest outcomes, making early enrollment and long-term retention especially valuable. Any similar model design should be deliberate and sequenced: start in the early grades, prioritize retention, and make sure the population served is matched to organizational capacity.

Finally, leaders reflected that TPS's ultimate value is not just as a single school innovation, but as a proof of concept for what becomes possible when schools take seriously the full range of what children need to thrive – not just academic achievement, but health, family stability, and social-emotional development alongside it. Documenting outcomes, even where measuring change is difficult, builds the evidence base needed to influence policy. Data systems remain a persistent barrier, with school, medical, and early intervention data still failing to flow to each other. Developing common outcomes frameworks and integrated data infrastructure across systems can significantly advance the field's understanding of these types of integrated models.

CONCLUSION

The Primary School (TPS) set out to prove that children thrive when the systems around them work together. Nearly a decade later, the evidence is clear that this approach makes a real difference for children and families, and the evidence is also instructive about what it took. Children who moved through TPS's early childhood programs developed stronger language skills, received developmental support earlier, and entered school more ready to learn. Families grew in resilience, built social connections, and navigated systems that had previously felt inaccessible. Students received health care at rates that exceeded state and national levels. Across all three strategic pillars, families who stayed longest and engaged earliest showed the strongest outcomes.

As TPS closes, most of the children in both communities are transitioning to local public schools. TPS has also partnered with regional and national organizations to share its approach more broadly.[53] TPS hopes that sharing its learnings will seed and grow these approaches in different places alongside children and families for years to come.

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. TPS is closing, but the work it produced belongs to the field. Nearly a decade of implementation, data, and hard-won experience now offers other schools, districts, and communities a clearer picture of what is possible when education, health, and family support operate as a unified system rather than parallel tracks. The problems TPS set out to solve have not gone away. The path forward is clearer for their efforts.



[53] Local partners include: in East Palo Alto – Ravenswood City School District; Ravenswood Family Health Center; Children's Health Council; Ravenswood Early Learning; RISE. In the East Bay – Kaiser Permanente; Kidango. National partners include Transcend Education and First 10.

REFERENCES

American Academy of Pediatrics. (n.d.). *Early relational health*.

Bethell, C. D., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive childhood experiences and adult mental and relational health in a statewide sample: associations across adverse childhood experiences levels. *JAMA Pediatrics, 173*(11), e193007.

The Bowen Center for the Study of the Family. (n.d.). *Introduction to the eight concepts*.

California Governor's Office. (2026). *Governor's budget summary 2026–27*.

California Health Policy Strategies. (2025). *Are children receiving the vision services they need?* [Policy brief].

Chang, H. N., & Chavez, B. (2026, February). Unpacking California's chronic absence through 2024–25: eight key facts. *Policy Analysis for California Education.*

Dettlaff, A. J., & Boyd, R. (2021). Racial disproportionality and disparities in the child welfare system: why do they exist, and what can be done to address them? *The ANNALS of the American Academy of Political and Social Science, 692*(1), 253–274.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & 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.

Friedman-Krauss, A. H., & Barnett, W. S. (2020). *Early childhood education:* pathways to better health. National Institute for Early Education Research.

Gallegos, E. (2026, February 4). How the governor's budget proposal addresses rising numbers of students in special education. *EdSource*.

Garner, A. S., & Yogman, M. (2021). Preventing childhood toxic stress: partnering with families and communities to promote relational health. *Pediatrics, 148*(2), e2021052582.

Hwang, K. (2026, April 2). California kids are going without vision care, and the problem is getting worse. *CalMatters.*

Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early social-emotional functioning and public health: the relationship between kindergarten social competence and future wellness. *American Journal of Public Health, 105*(11), 2283–2290.

Rosado, J. I., Ramirez, A., Montgomery, J., Reyes, E., & Wang, Y. (2021). Adverse childhood experiences and its association with emotional and behavioral problems in U.S. children of Latino immigrants. *Child Abuse & Neglect*, 112(104887).

Sawyer, K., Kempe, S., Carwana, M., & Racine, N. (2024). Global and inclusive considerations for the future of ACEs research. *Child Protection and Practice*, 3(100054).

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884).

The Neurosequential Network. (n.d.). *Neurosequential model.*

U.S. Government Accountability Office. (2023). *Early intervention:* action needed to improve data and oversight of Part C services (Report No. GAO-24-106019).

Webster, E. M. (2022). The impact of adverse childhood experiences on health and development in young children. *Global Pediatric Health*, 9, Article 2333794X221078708.

Williams, E., & Rudowitz, R. (2023, May 29). *Variation in use of dental services by children and adults enrolled in Medicaid or CHIP*. KFF.

APPENDIX A: MODEL INFLUENCES

Framework or Research	Overview
Adverse Childhood Experiences (ACES)	Traumatic events in childhood that can cause toxic stress and lead to long-term physical, mental, and behavioral health issues
Bowen Family Systems Theory	Approaches families as emotionally interconnected units where individual behaviors, thoughts, and feelings cannot be understood in isolation from the family system
Community Schools	Schools that have close partnerships with and help organize community resources
Early Relational Health	Framework demonstrating that relationships, especially in the early years, are biological necessities for lifelong growth and development
Health Barriers to Learning	Undetected or suboptimally addressed health conditions that undermine a child's ability to succeed in school
Motivational Interviewing Strategies	Collaborative, person-centered counseling approach to help people explore and resolve their ambivalence about change and move toward healthier behaviors
Neurosequential Model of Education (NME)	An NMT derivative for educators to understand and navigate student learning and behavior from a neurodevelopmental perspective
Neurosequential Model of Therapeutics (NMT)	Framework used to assess a child's history and functional brain map to guide interventions for children exposed to trauma
Positive Childhood Experiences (PCES)	Experiences with family, friends, schools, and community that foster a child's capacity to thrive
School-Based Health Centers (SBHCs)	SBHCs are located in or near schools; run separately by clinics to provide health services
Social Determinants of Health	The health influence of the conditions in which people are born, grow, live, work, and age, and their access to resources
Social Genome Model	Life-cycle tool designed to map developmental milestones from birth to age 30, or from cradle to career
Strengthening Families Protective Factors Framework	Protective factors are strengths and resources that mitigate the impact of trauma
Trauma Informed Approaches to Care	Recognizes the widespread impact of trauma and prioritizes physical and emotional safety, trustworthiness, choice, collaboration, and empowerment to avoid re-traumatization and support healing across systems
Two-Generation Approach (2Gen)	Strategy that simultaneously addresses the needs of both children and their parents/caregivers together
Whole Child Education	Philosophy focused on the holistic development of children; addresses physical, emotional, social, and cognitive needs
Yalom's Therapeutic Factors	Mechanisms through which group therapy produces change





School or Organization	Overview
CAP Tulsa	Anti-poverty agency that combines early childhood education with family services
Codman Academy	Charter school that is co-located with a federally qualified health center
Educare	Network of early learning centers that offer comprehensive support including family resources and health services
EMPath	Economic mobility coaching approach to disrupt poverty
Harlem Children's Zone	Community organization that serves an entire neighborhood with comprehensive education and social service programs for children and families
Harvard Center on the Developing Child	Center that advances the science of early childhood development, emphasizing that the foundational architecture of the brain is built in the earliest years of life
Head Start / Early Head Start	Federally-funded center or home-based programs that promote school readiness for low-income children and families (birth-5)
New Haven Mental Health Outreach for Mothers (MOMS) Partnership	Community-academic partnership dedicated to parent wellness
READY (Rales Educational & Health Advancement of Youth)	School-based health center that integrates comprehensive health services with education
Real Balance Wellness Coaching	Training for supporting others to make lifestyle changes to increase health and well-being

APPENDIX B: THE PRIMARY SCHOOL THEORY OF CHANGE

OUR PURPOSE

All families want their children to access opportunities and achieve their potential. And all families rely on health and education systems to help them achieve this vision.

At the same time, many families are facing economic hardship, instability, and other stressful and traumatic experiences. Because of systemic racism, communities of color are disproportionately affected by these challenges. Yet our country's systems struggle to sufficiently address these inequities. Despite having similar goals, these systems — schools, social service agencies, early childhood settings, and health care systems — often lack the connection, capacity, or scope to address a family's interrelated challenges.

We are creating a comprehensive approach that integrates services and builds family well-being throughout a child's development, so children can lead healthy, happy, and productive lives.

START EARLY

PARTNER WITH PARENTS

INTEGRATE SERVICES

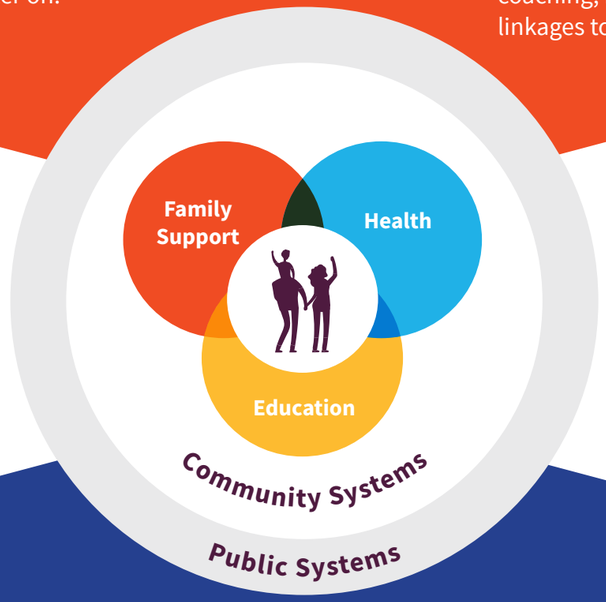
STRATEGIES

START EARLY: We reach children at a critical stage in their development by working with families with children as young as 18 months and providing full-time school starting at age three. Across all of our outcome areas, we focus on promotion and prevention by providing robust universal services, like screenings, which help to identify and address needs early. In addition, we connect families to early intervention services to reduce the need for more intensive interventions later on.

INTEGRATE SERVICES: Our unique model unites health, education, and family support, building a multi-disciplinary team and holistic system of care to address a child's full set of needs. We leverage experts, partner with community-based organizations, and use data to ensure families receive the personalized support and services they need.

PARTNER WITH PARENTS: We believe that when parents thrive, children thrive, so we support the wellness and growth of parents alongside the growth of their children. We collaborate with parents in the work of achieving positive child outcomes by sharing new knowledge and skills to engage in their child's development, health, and education. Families set goals related to both parent and child growth, and we support them in achieving their goals through coaching, information, and linkages to community resources.

INTEGRATED SYSTEMS



LENSES

TRAUMA-INFORMED: Our work with children and families is informed by an understanding of what trauma can do to the brain and a child's ability to learn. We promote resilience and mitigate the effects of trauma throughout our child and family programming. We also provide support services that directly address trauma.

CULTURALLY RESPONSIVE: We value the cultural and community identities of all of our students, families, and staff, and we promote an anti-racist approach to combat historical narratives and a deficit mindset. Our curricula and programming provide opportunities for children and families to learn about other cultures and ways of thinking, and to explore and share their own cultural identity.

WHOLE CHILD OUTCOMES

LONG-TERM OUTCOME

Children are prepared to live productive, happy, and healthy lives. As adolescents and adults, children experience secondary and post-secondary success, economic freedom and career options, emotional and mental well-being, and physical well-being.



High School, Post-Secondary, and Beyond

PARENT OUTCOMES	COGNITIVE + ACADEMIC OUTCOMES	SOUL OUTCOMES	HEALTH OUTCOMES
Parents are engaged with their child's health and education Parents and children have a healthy relationship with secure attachment Parents are able to access services and meet basic needs to provide a safe and stable home for their family Parents are resilient, self-efficacious, and have social connections and support	Children are at or above grade-level in literacy, math, writing, and science Children have age-appropriate language and executive functioning skills	Children show social skills in self-awareness, self-management, social awareness, relationships, and responsible decision-making Children have a sense of belonging and identity, and value civic engagement	Children have a medical and dental home and are up to date on preventative care Children have healthy behaviors related to oral health, sleep, physical activity, nutrition, and media use Chronic physical health needs have been identified and addressed Mental health needs have been identified and addressed
	Children have age-appropriate executive functioning and expressive and receptive language skills Children express curiosity about learning	Children have age-appropriate social skills in self-regulation, peer relationships, and peer interactions Children have the ability to form a positive relationship with their teacher	Children have a medical and dental home and are up to date on preventative care Children are receiving services for any developmental delays that have been identified



K-8



Preschool

APPENDIX C: GROWTH, STRUCTURE, AND FUNDING

The Primary School's (TPS) long-term vision was to build a model that could influence the policies and public systems that serve children and families. In order to achieve this, the organization planned to open a small number of additional sites in communities with diverse needs and varying public systems constraints— all while serving high-benefit students and families.

The first site, in East Palo Alto, was designed specifically to be a private, nonprofit flagship site, allowing for the model to be built and refined with flexibility and speed, supported by a central administrative office. Ongoing design and learning was supported philanthropically, as was the East Palo Alto site itself, offering the full range of academic and wraparound programs at no cost to families. The site opened and began serving its first cohort of preschoolers in 2016, eventually growing to provide a full slate of Early Family Foundations, preschool, elementary and middle school, parent wellness coaching, and integrated health support in partnership with Ravenswood Family Health Network (a local federally qualified health center).

Site Growth

In 2018, TPS began considering expansion to a second site — one that could serve as the first example of how the model could operate primarily through public funding. Through discussions with families, local leaders, and community partners, the organization elected to open TPS East Bay in Alameda County, California, and began serving families through Early Family Foundations, preschool, health (in partnership with Kaiser Permanente), and parent programming in 2020.

The original plan in the East Bay was to replicate the model in as close to its entirety as possible by partnering with community organizations and government entities. To that end, the organization explored obtaining a Head Start and Early Head Start contract, operating the elementary school as a district partnership school within Hayward Unified School District (HUSD), and applying to open as a charter school. In 2021, TPS East Bay began operating preschool under a full-day California State Preschool Program (CSPP) contract. Ultimately, political challenges and the scarcity of available pathways for K-8 led to a shift in strategy, as the organization chose to indefinitely postpone adding an elementary school to the site.

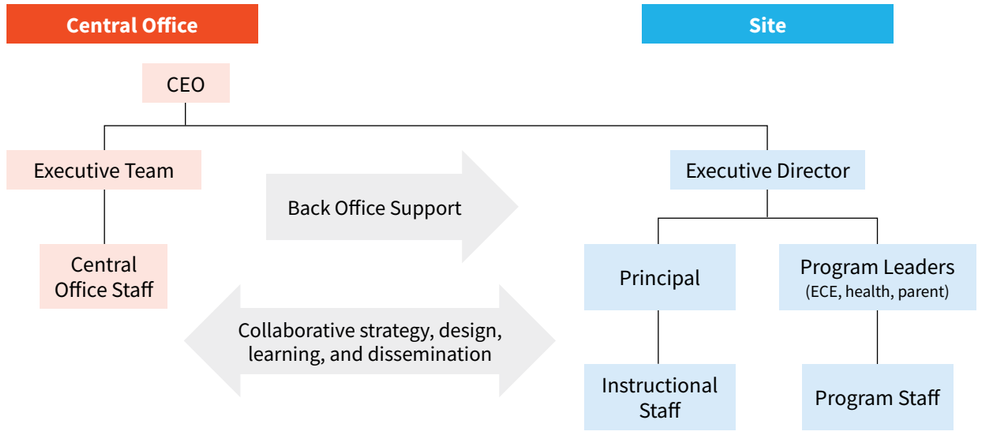
Organizational Structure

Top-level governance varied over the years as TPS worked to find the most effective operating structure for its strategic plans. In its final form, TPS comprised three distinct entities — the East Palo Alto site, the East Bay site, and the Central Office, reporting to a single Board of Directors. As noted above, the sites worked in partnership with the Central Office, with a goal of efficiently sharing resources and maintaining a unified theory of change even when day-to-day application of the model might vary across the different site contexts.

In this way, the Central Office functioned similarly to many Charter Management Organizations, and played two primary roles. First, the Central Office held responsibility for overall organizational health and sustainability, as the CEO and executive team oversaw strategy, partnership and growth opportunities, fundraising, and stewardship of the TPS model (design, learning, improvement, codification, and dissemination). Second, the Central Office provided back office support for both sites, including finance, accounting, legal, human resources, and information technology services.

Some roles were embedded more directly on school sites than others, but functionally TPS operated as a single organization, with open lines of communication between sites and Central Office staff. This structure gave rise to a critical role: given the focus on integrated services, the TPS staffing model included an Executive Director at each site, who was responsible for overseeing not only the principal, but also the on-site leaders of the health, parent wellness, and early childhood programs. The Executive Directors reported to the CEO and were part of the organizational leadership team; they worked closely with the Central Office to develop strategy and then carried out the organizational vision at the site level.

High-Level Representation of the Organizational Structure and Site / Central Office Relationship



Financial Model

Founded as a private, tuition-free school, TPS's core operating funding was primarily provided by philanthropic contributions from the Chan Zuckerberg Initiative (and some smaller donations and grants from others) with the understanding that the elementary and middle school in East Palo Alto would rely on a philanthropic base. The site was structured this way both to maximize innovation capacity and to have flexibility to provide expanded services to children and families based on evolving understanding of community needs.

Though this meant that the East Palo Alto site would sacrifice the ability to tap into many of the funding sources available to public schools in California (with the notable exception of a public preschool contract through CSPP), the organization understood that a replicable model would need to be sustained largely by public funding. Across initial and ongoing strategic planning, TPS looked closely at what was possible under public school constraints, mapped public funding streams, and ultimately developed a set of budget parameters for its sites that were tied to the potential resources of a fully public system.[54]

The integrated structure of TPS (as well as the relatively small sample size) can make it challenging to draw direct comparisons to available per pupil expenditure data at larger public school districts. The East Palo Alto site's per pupil costs, by one estimate, exceeded the Bay Area district average while remaining in line with local districts.

Estimated Per-ADA Cost of Education 2023-24 [55]

The Primary School	Local Elementary Districts	Bay Area Counties	Statewide
$33,864.65	$32,071.42	$20,663.01	$20,663.01

For comparison's sake, TPS's figure above does not account for the students in their Early Family Foundations program, even though that program shared overhead, staffing, and resources with the rest of the school and organization to some extent.[56] On the other hand, though both sites paid a management fee to the Central Office for the support services described above in order to more accurately represent the cost of education, the Central Office was likely still subsidizing those costs.

[54] Identified public funding streams included: California State Preschool Program; Transitional Kindergarten; CalWORKs; Local Control Funding Formula; California State Lottery; Mandate Block Grant; California Child Nutrition Program; Assembly Bill 602; Mental Health Services; Individuals with Disabilities Education Act; and Every Student Succeeds Act.

[55] 2023-24 estimates were used to capture the last full school year before TPS announced its impending closure. Public district estimates were obtained from the CDE. Bay Area Counties include Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma. Local Elementary Districts include Ravenswood City Elementary and Menlo Park City Elementary.

[56] TPS's East Bay site had a 2023-24 per-student cost of approximately $23,723, which included both the Early Family Foundations program and the preschool.





From TPS's perspective, expenditures were relatively aligned with those serving similar populations, and the fact that they were higher than many other Bay Area districts (or the statewide number) could be attributed in part to the relative difference in available economies of scale. However, TPS also saw it as proof of concept regarding what might need to change in the world of education funding: while the organization was trying to drive the model towards public funding sustainability, it also believed that students needed more resources allocated to them by all levels of governmental funding bodies.

Much of TPS's costs were seen as stemming from expenditures that it saw as essential to high quality education, including workforce investment, staff development, and full-day programming. But the vision of schools as the critical hub of integrated services for a child also requires increased capacity, resources, and flexibility. TPS noted that the design of key elements of the model such as the Early Family Foundations, parent wellness, and health programs have always been intended as relatively low-cost and high-impact. At the same time, the community-centered design of the programs could ironically make it more difficult for the organization itself to tap into public dollars. For instance, while partnering with neighboring medical homes may have been more impactful than providing direct services, it limited the ability for the school itself to access Medicaid funding to subsidize the health work, since any billing for services would go to partners.

TPS anticipated that expenditures would come down as it continued to learn and create new efficiencies. At the same time, it was cognizant of the real impact that the bottom line has on the ability for children and families to thrive, particularly in schools that serve historically disadvantaged groups. Finding a balance remains a key challenge for any organization, private or public, working to innovate in the education space.







THE PRIMARY SCHOOL

theprimaryschool.org

