

# Build

Strong Foundations For  
Our Youngest Children



The BUILD Initiative helps states create comprehensive early childhood systems – coordinated, effective policies that address children’s health, mental health and nutrition, early care and education, family support, and early intervention. BUILD’s vision is at the center of an emerging and vibrant state-based policy movement in the early childhood development field. We work with those who set policies, provide services and advocate for our youngest children to make sure that they are safe, healthy, eager to learn and ready to succeed in school. Visit [www.buildinitiative.org](http://www.buildinitiative.org).

## A Framework for State Leadership and Action in Building the Components of an Early Childhood System

*Charles Bruner, Child and Family Policy Center and The BUILD Initiative*

### **Introduction: Building a Systemic Approach to School Readiness** ● ● ●

In 1989, President George Bush and the nation’s Governors, led by Arkansas Governor Bill Clinton, established seven national education goals. The ambitious first goal and its objectives were that:

#### **First National Education Goal For Children**

By the year 2000, all children will start school ready to learn.

#### **Objectives**

- All children will have access to high-quality and developmentally appropriate preschool programs that help prepare children for school.
- Every parent in the United States will be a child’s first teacher and devote time each day to helping such parent’s preschool child learn, and parents will have access to the training and support parents need.
- Children will receive the nutrition, physical activity experiences, and health care needed to arrive at school with healthy minds and bodies, and to maintain the mental alertness necessary to prepare to learn, and the number of low-birth weight babies will be significantly reduced through enhanced prenatal health systems.

While this aspirational goal has not been achieved over the last two decades, progress has been made in developing public responses to achieve each of the objectives, and a much richer understanding of the pathway to achieving the goal has been developed. The bipartisan goal has continued to propel work at the state and national level and has been the subject of continued attention by state policy makers.

Importantly, the First National Education Goal recognized that young children and their families require health, early care and education, family support, and community services in order to start school healthy and prepared for success. Achieving the goal extends beyond any one program or departmental responsibility – and therefore requires a systemic approach.

The National Education Goal was able to achieve broad bipartisan support because it recognized the essential role of the family and community in supporting children’s healthy development. In *Building the Foundations for Bright Futures* (2005), the National Governors Association Task Force on School Readiness offered a set of “school readiness core principles” that offered an implicit framework for developing state early childhood systems.

## NGA Task Force on School Readiness Core Principles

**The family plays the most important role in a young child's life.** Public policies should seek to support families in this role and to expand parents' options for the care, health, and education of their children.

**Responsibility for school readiness lies not with children, but with the adults to who care for them and the systems that support them.** Public policies should seek to provide comprehensive information, resources, and support to all who are responsible for children's development.

**The first five years of life are a critical developmental period.** Important opportunities exist to influence the healthy development of children in the early years. Public policies should seek to address the risk factors affecting children's development from before birth to age five.

**Child development occurs across equally important and interrelated domains – physical well-being and motor development, social and emotional development, approaches to learning, language development, and cognition and general knowledge.** Public policies should seek to address all of young children's developmental needs.

**Governors and states can pursue various options to promote school readiness.** There is no one-size-fits-all policy approach to promoting school readiness, and states will pursue different options based on their needs, resources, and priorities.

In 2006, the Early Childhood Systems Working Group<sup>1</sup> came together to develop an explicit, common framework to describe such an early childhood system, building upon the individual work of the members. Working Group members were providing information and technical assistance to states on strengthening early childhood services, often around very specific topics, but wanted a common, undergirding framework they could use to put their specific work in context.

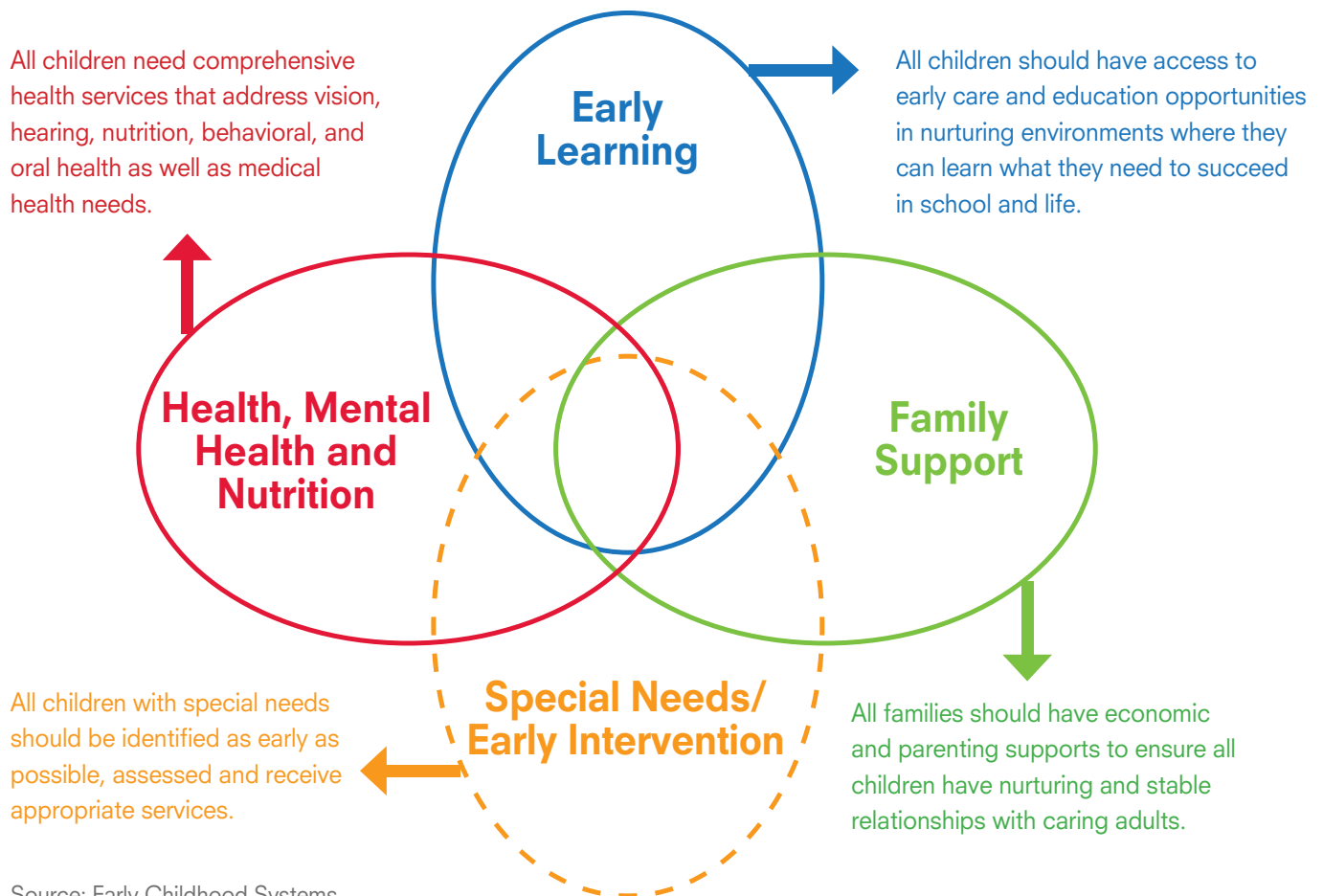
The framework consists of four substantive components of a public early childhood system, visually depicted by four overlapping ovals. These four components – health, mental health, and nutrition; early learning; family support; and special needs/early intervention – themselves include a number of different services and supports that young children and their families need to access and draw upon. Their interconnections display the need for the components to communicate, coordinate, and collaborate with one another.

As states work to establish their early childhood systems, the framework emphasizes the need to fully develop each component/oval in its own right and then to ensure that it successfully links with the services and supports in the other ovals.

“Public policies should seek to address all of young children's developmental needs.”

<sup>1</sup> Initial members of the Early Childhood Systems Working Group were: Alliance for Early Childhood Finance, Build Initiative, Children's Project, Center for Law and Social Policy, Council of Chief State School Officers, National Center for Children in Poverty, National Child Care Information Center, National Conference of State Legislatures, National Governors Association Center for Best Practices, Smart Start National Technical Assistance Center, State Early Childhood Policy Technical Assistance Network, and ZERO TO THREE. Since that time, membership has grown to incorporate the following additional organizations: American Academy of Pediatrics, Birth to Five Policy Alliance, the Center for the Study of Social Policy, Child Trends, the Finance Project, National Association for the Education of Young Children, National Association of State Health Policy, National Early Childhood Technical Assistance Center, the Ounce of Prevention Fund, Strengthening Families through Early Care and Education, and United Way Worldwide.





Source: Early Childhood Systems Working Group. 2006.

As states develop needs assessments or “opportunity analyses” regarding their next steps in building their state systems, they can benefit from more detailed information about each of the components/ovals in the following areas:

- The evidence base regarding effective practices within each component/oval that enable it to fulfill its role and link with others;
- The current status of development of the component/oval and gaps that need to be filled to meet the needs of young children and families in the state;
- Exemplary state actions in building the component/oval; and
- Exemplary state actions in linking each component/oval with other components/ovals.

There are substantial opportunities for states to conduct such needs assessments and “opportunity analyses” within the federal funding and guidance provided through Early Childhood Advisory Councils. This resource brief offers an overview of each of the components/ovals according to their evidence base, status of development, exemplary state actions in building the component/oval, and finally, a set of exemplary state actions in linking each component with other components/ovals.

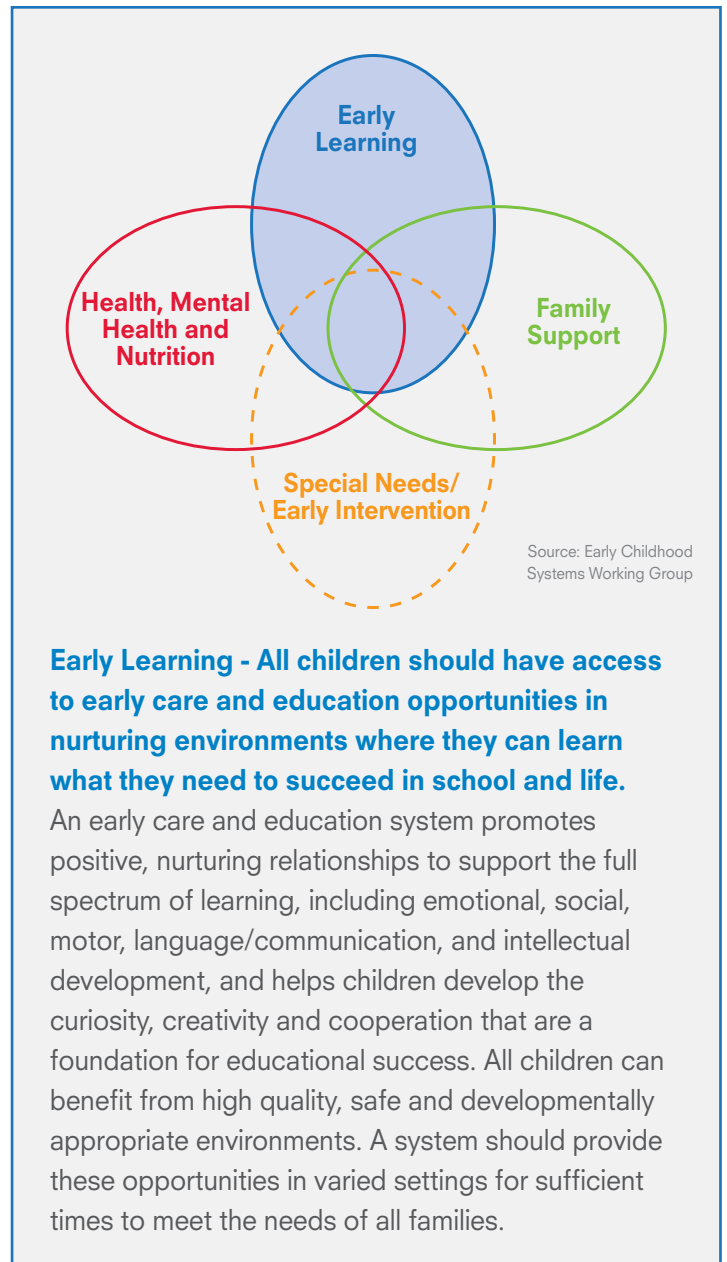
## Building the Early Learning Component ● ● ●

### Evidence Base – Effective Practices.

Young children need constant and consistent supervision throughout the day, and they need stimulation during the times they are awake that enable them to explore and learn. Parents provide most of this supervision, and some families are able to provide such supervision without outside help. Most families, however, need help in terms of formal child care settings (child care centers, family child development homes, or preschool programs) or informal child care arrangements (family, friend, and neighbor care).

Research is clear that quality matters in providing this care – that children require safe and developmentally appropriate environments for their healthy development and for their learning. This can be provided by parents, relative care providers, or formal child care arrangements – but those caring for children need to recognize and respond to children in developmentally appropriate ways and offer activities that stimulate children’s growth and development.

Research also shows that high quality preschool programs for three- and four-year olds, with intentional<sup>iii</sup> learning environments and well-trained staff, can benefit all children, whether or not they have other child care experiences. Research on exemplary programs has shown they can significantly narrow (but not eliminate)<sup>iii,iv</sup> current kindergarten readiness gaps evident for low-income and minority children, in particular, and produce high “returns on investment” to government and society, as well as to the children and their families.

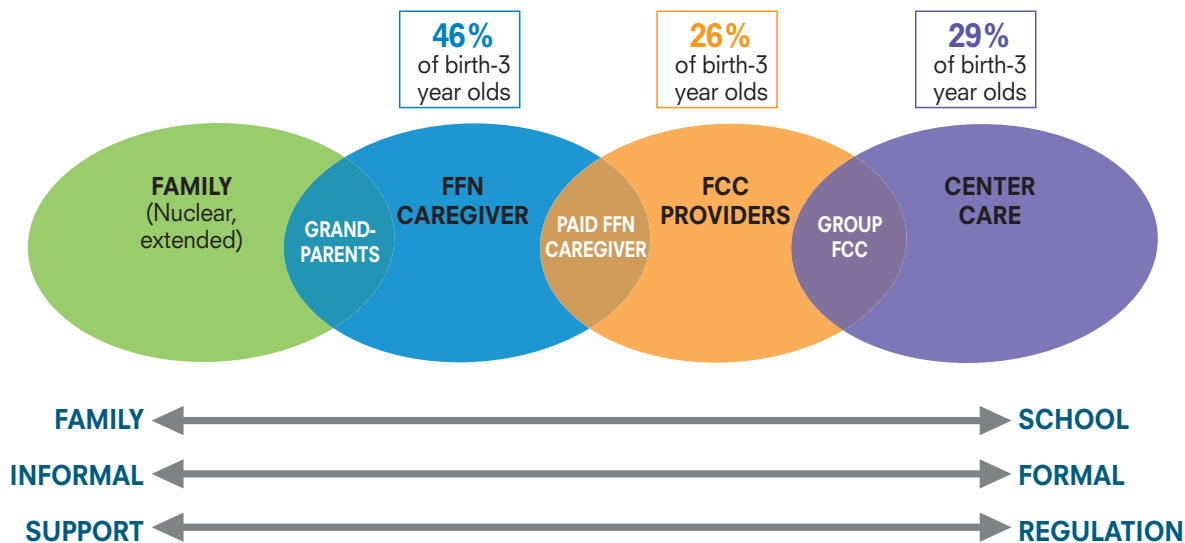


Parents make choices related to the care settings for their young children based upon a variety of issues, including accessibility, quality, affordability, and intimacy. The Working Group description recognizes the need to view the issue not as an “either-or” approach to ensuring quality care but a “both-and” approach to supporting quality care in all settings. National surveys indicate that up to half of all care provided to young children is by relatives in largely unpaid relationships; that parents of all races and incomes generally prefer more intimate settings for infants and toddlers; and that the vast majority of parents want their children to have

some form of preschool as four-year olds that stresses pre-literacy and other skill development, along with socialization that promotes social and emotional development.

State policies that establish quality care arrangements across these settings involve different approaches – some in terms of financing and regulation and others in terms of providing information and opportunity. The continuum of early care arrangements is shown in the chart below, and each involves different state supports and policies to help ensure that children receive the safe and developmentally appropriate supervision, guidance, and instruction they need.

*Figure 1: Family, friend, and neighbor caregivers in the care continuum*



FFN: Family, friend and neighbor

FCC: Family child care

Source: Cochran, M. (2005), adapted from T. Porter & R. Rice (2000), *Lessons learned: Strategies for working with kith & kin caregivers*. New York, NY: Bank Street College of Education

Source: Toward a National Strategy to Improve Family, Friend and Neighbor Child Care: Report of a Symposium. National Center for Children in Poverty. 2006.

### Current State of Development.

One of the greatest changes in the United States over the last half century has been the expansion of the workforce and the rise in the proportion of families where both parents (or the only parent) are working.

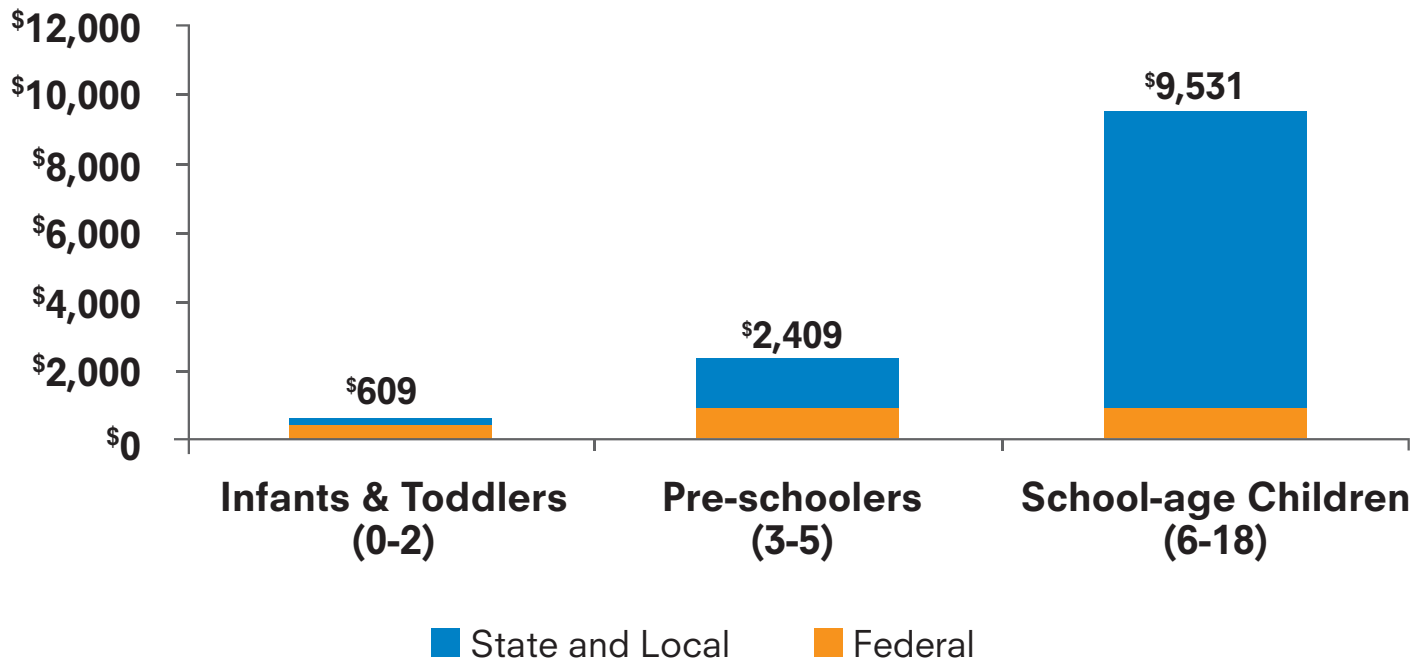
Nationally, more than six in ten families with young children have all parents in the workforce, more than doubling the percentage of working families since 1960<sup>v</sup>. While responsible for much of America’s economic growth, this also has placed increased demands upon providing child care, particularly in the years before children enter school.

Child care has grown substantially during this period to meet that demand, but many parents find obtaining consistent and affordable child care very problematic. While child care represents one of America’s lowest wage occupations, moderate income working families still struggle to pay for what child care is available. As the most recent *Early Learning Left Out*<sup>vi</sup> report shows, public investments in early learning (including special education) are very small in proportion to public investments in school-aged children.



## 50 States & District of Columbia Composite Assessment

### Per Child Composite Investments in Education and Development by Child Age



Source: U.S. Census 2000 & American Community Survey 2006

As a consequence, the overall quality of much child care in the country is mediocre or poor. Again, research indicates that high quality early care and education promotes child development, but mediocre or poor quality care does not, and can even do harm.

States largely have provided funding for early learning through either their state child care subsidy program (supported by federal CCDBG and TANF funds) or through a publicly-funded preschool program. State child care subsidy programs largely have been designed to provide child care to enable low-income families to work, rather than to create intentional early learning environments. Most states now have developed some quality improvement activities, including Quality Rating and Improvement Systems (QRIS), which seek to improve the quality of care in child care settings. States vary widely in the degree to which they invest in child care and help subsidize the costs of care for working parents. Often in separate actions, states are developing or expanding state-funded preschool programs that usually complement federal Head Start programs. These preschool



programs are designed to provide those intentional learning environments to help children acquire the skills to succeed in school, whether or not they are in any other form of child care. Clearly, high quality early care and education environments should be able to serve the same purposes as preschool programs, and it is not the name of the program but the quality of the service that impacts child development. Finally, a few states are looking at how public policies can support informal care providers through voluntary opportunities for information or activity participation. These informal care providers also play a very important role in young children's lives.

## Exemplary State Actions – Early Learning Component.

With support from the federal government through both CCDBG and TANF, states have dramatically increased their investments in subsidized child care and have given increasing attention to the quality of that care, but wide variations across states exist in both income eligibility criteria and in payment rates to providers. Similarly, there are wide variations among states in the degree to which child care is monitored and regulated, and what services are available to providers to help them improve their practices. While no state is perfect, **Pennsylvania, Rhode Island, and North Carolina** often are cited for the attention they have given to creating an affordable, high quality early childhood education system.

Many states have established strategies involving information to parents and incentives for providers to improve the quality of child care for infants, toddlers and preschoolers. Twenty-four states have followed the lead of **North Carolina** and **Oklahoma** in developing Quality Rating and Improvement Systems (QRIS), which employ market-based levers to promote and support quality through consumer education and identification (i.e. star quality ratings)<sup>vii</sup>. QRIS typically also offer incentives for providers to adopt quality improvement measures through professional development scholarships, grants, and tiered subsidy reimbursement rates or bonuses. **Illinois** has placed a special focus upon the needs of at-risk infants and toddlers, incorporating a set-aside for birth-to-three services within its Preschool for All funding stream.

States also have developed career lattices that provide pathways for early care and education professionals to advance from one educational level to the next. Paraprofessionals can enter and advance on a career lattice, based on their training, educational background and their career goals. **Maine** and **Pennsylvania** have developed professional development systems that support advancement with scholarship opportunities, links to training, coursework, degree and credential opportunities and career advising. **New Jersey** has created articulation standards that provide for transfer of credits from community college courses providing early childhood teaching associate instruction to institutions of higher learning as part of gaining bachelor's degrees in child development.

Direct appropriations are not the only means for supporting early learning. A number of states have worked to make child care more affordable by establishing their own child care credits within their individual income tax programs, usually building upon the federal child and dependent care tax credit. **Louisiana** has established a series of child care-related tax credits that apply to families and to child care providers and provide incentives to improve child care quality as well as to make child care more affordable.

In 2008-9, thirty-eight states invested a total of \$5 billion annually in preschool programs for 3-and 4-year old children, which vary from part-day instructional programs designed for all children to more comprehensive and intensive programs targeted to at-risk populations. States including **Florida, Illinois, Iowa, New York, Oklahoma, and West Virginia** have established goals for providing preschool for all children, and for the most part, phasing-in enrollment over a period of years. **Oklahoma** leads the nation in the proportion of four-year olds in publicly-funded preschool, with 87% served in the state preschool program, special education, or Head Start. Many other states, such as **New Jersey** and **Arkansas**, have prioritized funding for at-risk preschoolers in an effort to address the achievement gap in its earliest stages.

Finally, several states have taken special action to support informal, family, friend, and neighbor care. **Minnesota** has provided funding specifically to support informal family, friend, and neighbor care, through its child care resource and referral system, and **Washington** has developed provisions for family, friend, and neighbor care as well. **Iowa** has incorporated family, friend, and neighbor care into its Early Childhood Iowa state and community partnership to strengthen all aspects of young children's healthy development and learning. **Illinois** has included family, friend and neighbor care as participants in its statewide QRIS.

## Building the Health, Mental Health, and Nutrition Component ● ● ●

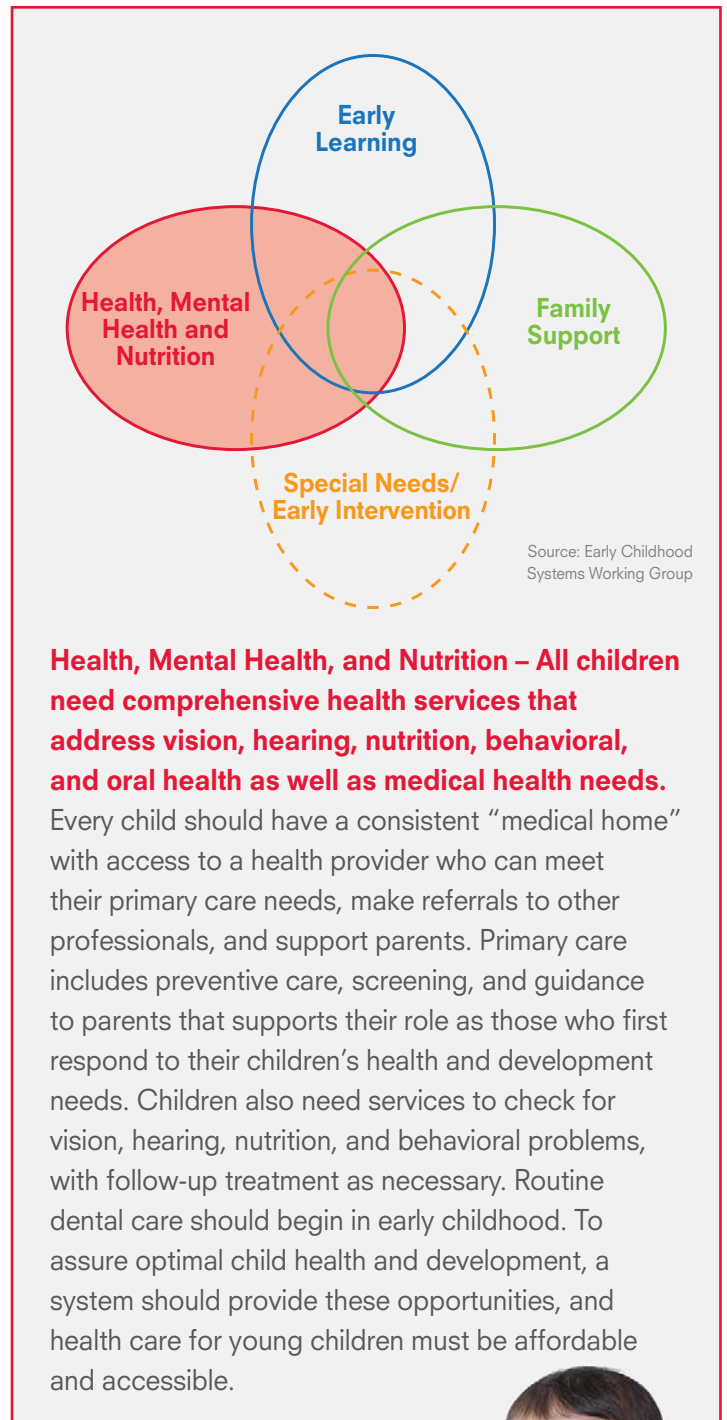
### Evidence Base – Effective Practices.

While it is common to talk about preventive health services as providing for health maintenance for adults, young children are growing and developing. Primary and preventive health services have the opportunity, beyond maintenance, to promote healthy child development. This includes influencing nutrition and exercise habits, parental nurturing and discipline practices, and safety issues such as exposure to second-hand smoke, lead paint, and other environmental toxins.

Health insurance coverage is necessary to ensure children’s use of primary services and to improve child health, but comprehensive and developmental health services are necessary to produce optimal healthy development. The American Academy of Pediatrics has established guidelines for pediatric practice, *Bright Futures*, which take a whole child approach to young children’s well-child care. A number of exemplary pediatric practices exist that provide children with medical homes that embrace such practice and have produced positive child outcomes – including Healthy Steps, Bright Futures, Help Me Grow, Centering Parenting, Child FIRST, and Reach Out and Read. Campaigns such as I-Smile have helped to increase preventive dental care services to young children that also are critical to their success.

Nutrition and exercise are critically important to children’s healthy development. Research is clear that breast-feeding for most mothers offers the best source of nutrition and health and reduces the likelihood of obesity. The federal Women, Infant, and Children (WIC) program provides nutrition counseling as well as food vouchers that encourage breast-feeding and other recognized practices.

Comprehensive, preventive, and developmental well-child health care affect the trajectory of children’s health that has lifelong health implications. As shown in the chart at right, ensuring optimal healthy child development involves health insurance coverage, a comprehensive approach to providing primary and preventive health services, and identification and referral to other systems when children’s developmental needs are identified.



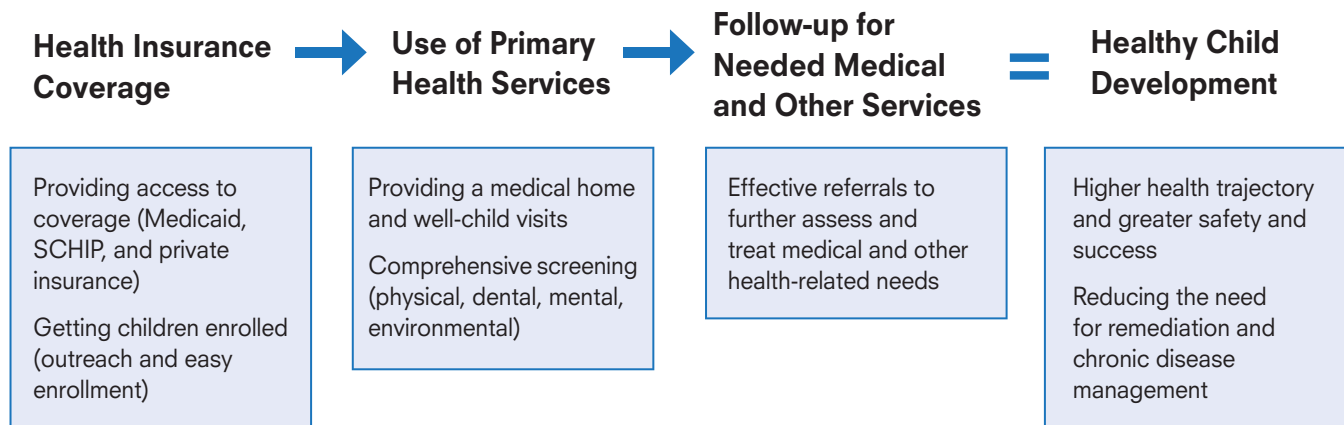
“...health care for young children must be affordable and accessible.”





## Current State of Development.

In 2005, it was estimated that nearly 9 million American children, or 10% of all children, did not have health insurance coverage. Millions more were not covered for part of the year or were underinsured, often not receiving primary and developmental health services. As child health insurance costs have risen (average annual worker and employer contributions for family coverage rose from \$5,791 in 1999 to \$13,770 in 2010<sup>viii</sup>) the challenge to securing affordable child health insurance coverage increasingly became a middle-class concern.



Source: Healthy Child Storybook. Child and Family Policy Center. 2007

Even prior to enactment of the federal Child Health Insurance Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordability Care Act of 2010 (ACA), many states had taken significant actions to expand child health coverage and some had developed policies to expand the provision of preventive and developmental child health services.

While states have made gains over the last decade in covering children, there remain challenges both in public and private sector coverage. The number of uninsured children has been dramatically reduced through public health coverage, but there remain at least 4 million children in America who are not now covered. Many private sector insurers have policies whose coverage is either inadequate in providing all services or not affordable for families, or both. State rates vary dramatically in what they provide in reimbursement to health practitioners for coverage under Medicaid and CHIP, and in many states it is difficult to find dentists, in particular, willing to accept children on Medicaid. The Early Periodic Screening Diagnosis and Treatment (EPSDT) provision under Medicaid provides a strong general standard to states for providing all “medically necessary” services to children, but in practice states and practitioners often fall short of providing these services.

The ACA now requires health plans to provide preventive services to children, without co-payments, and based upon the *Bright Futures* guidelines, but it largely will be up to states to ensure that this becomes a true standard of care.

Moving toward broader use of exemplary child health practices requires improvements in insurance coverage, greater focus upon and use of child health quality and impact measures, and supports and incentives for health practitioners serving young children to take on a more comprehensive approach.

In addition, while exemplary practices have developed strong relationships with related child development programs and services – including Part C of IDEA (discussed in the section on special needs), maternal and child health programs, and Head Start and other child care and preschool

programs – many health practitioners serving young children are unfamiliar with services outside the medical world that can address children’s developmental needs. Almost ninety percent of all young children see a health practitioner for a well-child visit at least annually, while only thirty percent are in a formal child arrangement or any other setting where their developmental needs might be identified and addressed. Therefore, child health practitioners are critical to the early identification of developmental delays and other conditions that can compromise healthy development. Creating stronger linkages across the components/ovals and, in particular, between health practitioners and other community services in the other ovals, is critical to getting children what they need for their healthy development and readiness for success in school.

Finally, disparities in child health outcomes by income, race, and ethnicity and the rise in obesity among both children and adults mean that, for the first time in this country’s history, children are projected to live shorter and less healthy lives than their parents. Increases in childhood obesity, asthma, and other health conditions require additional state as well as federal responses. Obesity and malnutrition both afflict a growing share of the American child population and require community-wide public health as well as individual approaches.

### Exemplary State Actions – Health Component.

States often are called the laboratories of democracy and have led the way on child health care reform. In particular, states have taken on the role of laboratories of democracy by successfully covering more than 7.1 million previously uninsured children through expansions to state CHIP programs that include increased outreach, streamlined eligibility processes, and expanded coverage<sup>xi</sup>. Prior to both CHIPRA and ACA, **Illinois** and **Pennsylvania** established state financing and policy standards that sought to ensure that all children have health insurance coverage. **Massachusetts** established its insurance exchange approach to covering all its state residents, including children. **Washington, Texas**, and **New York** extended their health coverage under CHIP and Medicaid to ensure that immigrant and refugee children have access to insurance, the population of children nationally most likely to lack health insurance

coverage and access to preventive health services. **Louisiana** developed re-enrollment policies for its CHIP program that help insure continuity and avoid disruptions in coverage that can be associated with the administrative re-enrollment processes.

Despite tough state budget times, many states took advantage of the opportunities to expand coverage presented in CHIPRA by expanding coverage to higher income levels. **Iowa** took advantage of nearly all the provisions in CHIPRA, increasing its eligibility for CHIP from 200% to 300% of poverty, adopting streamlined eligibility provisions including continuous and presumptive eligibility, simplifying re-enrollment provisions, and providing coverage for legal immigrant children. **Oregon, Wisconsin**, and **Colorado** expanded their coverage of children and some adults through hospital assessments/taxes that also enabled them to increase reimbursement rates to those hospitals.

**Maine** and **Vermont** have been leaders in expanding their mental health services to young children, recognizing that diagnosis of mental health issues for young children requires different approaches than diagnosing such conditions among adolescents and adults. **Maine** initially developed a crosswalk classification system for mental health diagnoses for young children that enable Medicaid billing for addressing behavioral and mental health concerns among infants and toddlers, now in much broader use across states.

Even before the ACA, **Virginia** officially adopted Bright Futures guidelines as the state child health standard.

**Colorado** and **Iowa** enacted “medical home” statutes that apply to all children and seek to ensure all children have a consistent source of primary care that also ensures needed care coordination and referral to both medical and transmedical services needed to respond to the child’s health needs.

Obesity is a growing problem in the country, and often begins in early childhood, as infants and toddlers develop eating habits that are likely to continue throughout life. Combating obesity among young children needs to be addressed both within health practices through anticipatory guidance to parents and through public health programs and campaigns.



**Delaware** has worked with Nemours Health Services on a comprehensive public education campaign “five-two-one-almost none.” This campaign, targeted at young children emphasizes *five* fruits and vegetables, no more than *two* hours of TV or computer time, *one* hour of physical activity and almost *no* sugary drinks. **Arkansas** is the only state in the nation with a state Surgeon General, and the Arkansas Surgeon General has made the issue of childhood obesity a top state public health focus and encouraged multiple approaches to addressing it, with very promising results.

In short, states, usually working closely with pediatric health practitioners, have taken leadership roles in further promoting a comprehensive and developmental approach to child health. As states respond to new federal guidelines under the ACA and CHIPRA, they can build upon such work, recognizing that this broad and effective approach to children’s health care is still in its own early developmental stage.

## Building the Family Support Component ● ● ●

### Evidence Base – Effective Practices.

Parents remain their children’s first and most important teachers. While actions can be taken within the other substantive components of an early childhood development system to close current kindergarten readiness gaps, only part of those gaps are likely to be addressed by health, early learning, and special needs programs alone. Strengthening parenting confidence and consistency is needed if current gaps in school readiness are to be fully addressed. Poverty and the lack of consistent parental nurturing remain the biggest contributors to school unreadiness. Ensuring that parents have sufficient sources of economic/income support to provide stable homes that meet basic needs also is essential to all children’s development.

In some instances, simple lack of knowledge or information on parenting is an issue. While the research on home visiting and family support programs is mixed, there is evidence that home visiting and family support programs can be very effective, particularly with first-time parents. Effective programs have qualified and motivated staffs who build relationships with parents, provide instruction and mentoring on child development, and connect parents with other quality programs and sources of support. These programs are most effective when they are also linked to quality programs for children, including child care and preschool programs providing specific developmental instruction. Through the ACA, all states will receive federal funding through their maternal and child health bureaus to support evidenced-based home visiting programs, but many states already provide substantial support for home visiting and parenting education.

Family support programs also can include children’s reading hours, family literacy programs, or young children’s recreational programs that include parenting activities. Community centers, child care facilities and Head Start programs, schools, and libraries often can be loci for such programs. As voluntary programs, they require relationship building. Families participate because they feel an affinity with others who are involved and they often help one another and strengthen support for young children through reciprocity. Nationally, there is a growing number of Family Place Libraries that place particular emphasis upon providing opportunities for parents and their young children to participate in programs and activities that support child development and develop pre-literacy skills.

### Current State of Development.

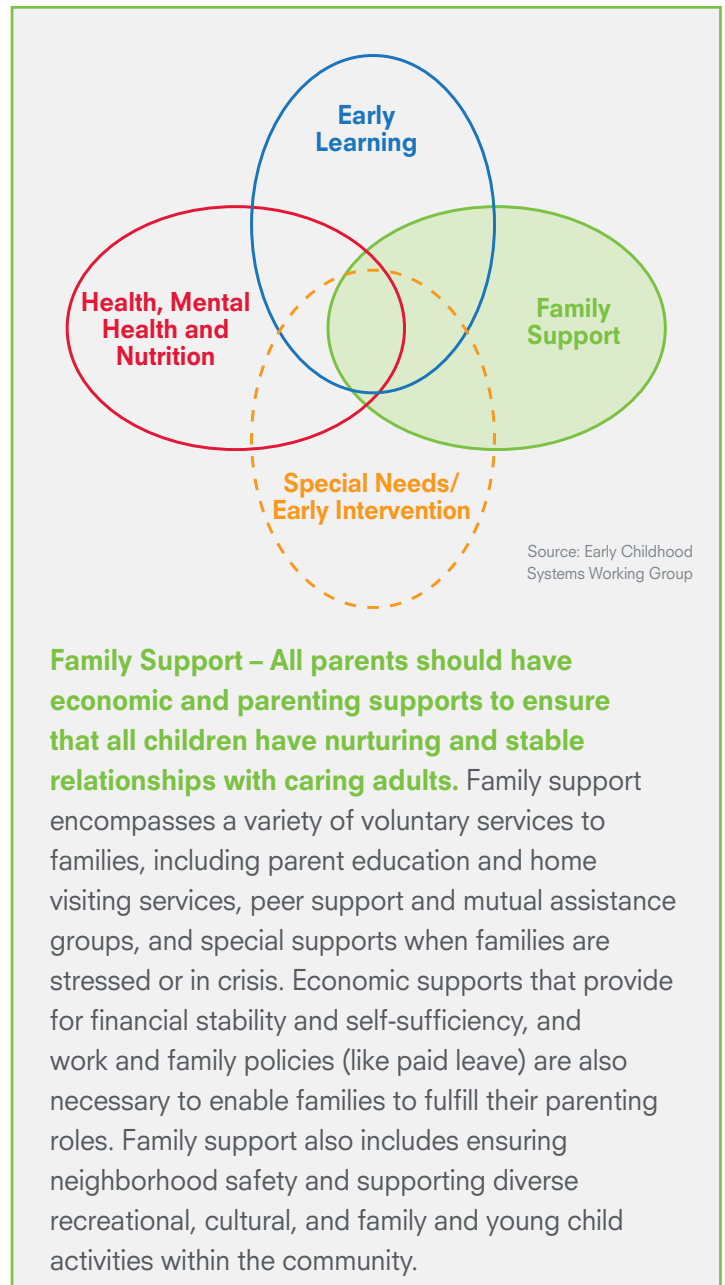
Unlike many other countries, the United States has not established universal programs that support parents of young children, such as extended paid family leave, universal home visiting, or broadly

available family support centers. Most home visiting and family support services which states have developed have been targeted to families identified as at risk. An increasing number of young children are now being raised by grandparents, who often have additional needs as they care for their grandchildren, but there are few programs designed specifically to support them in their role.

Many family support programs have developed locally, through community resources and funding as well as state grants or demonstration programs. These programs often do not have access to training and technical assistance that can support their development and continuous improvement. Often described as prevention programs, home visiting, parenting education programs, family resource centers, and other family support programs require skilled staffing that can engage families with young children to be effective. Generally, while at least one-quarter of parents with newborns have some characteristics (single parenting, adolescent parenting, poverty, lack of positive parenting experiences as children, or significant life stressors) that make them good candidates for such prevention programs, programs that exist serve only a small share of this population and often do not have outreach strategies to reach those who are most likely to be isolated.

### Exemplary State Actions – Family Support Component.

Through different programs, states have taken significant first steps to expand outreach to and engagement of families with young children, particularly through developing voluntary home visiting programs and family resource centers. Among the longest standing home visiting programs are **Missouri's** Parents as Teachers and **Minnesota's** Early Child Home Education programs, both with statewide availability and strong popularity with parents. **California's** First Five Initiative has established a variety of county-based family support programs and an emerging family support network to support effective practice. Similarly, **Iowa's** Early Childhood Iowa program offers direct state funding to counties to develop programs that support parents of young children. Several states, including **Pennsylvania** and **Colorado**, have invested in the research-based



Nurse Family Partnership program, while **Arkansas** has led the country in investing in the Home Instruction Parents of Preschool Youngsters (HIPPO) program. **Connecticut** has made significant investments in family resource centers, and its Nurturing Parents Network is a statewide program that visits first time mothers in the hospital and offers services and support as they transition into their role as parents. While many of these programs have some research base and shown the potential to improve parenting resiliency and, coupled with high quality early learning programs, healthy child development, with a few exceptions, they largely remain individual demonstration programs that are not available



in more than a few jurisdictions in a state and without a great deal of overall rigor in model replication from one setting to another.

Most home visiting and family support programs focus upon parents in the home, and usually work primarily with mothers. States also have taken actions to support fathers in their parental roles, recognizing that children generally need two sources of economic and emotional support. The Fatherhood Initiative of **Connecticut** has developed a certification program, through which community-based fatherhood programs can strengthen their services to fathers and families, and be recognized statewide for their exemplary practice. **Minnesota**'s Fathers and Families Network promotes initiatives that inform public policy and help develop the field of fatherhood practitioners in that state. These efforts look at both the role of fathers in the home raising their children, and fathers who are not living with their children but still have ties with and roles to play with their children.

As the percentage of children being raised by grandparents has increased (to 6.3% of all children, according to the 2000 census) and as grandparents are the primary source of child care for many other children, several states have taken steps to support grandparents, as well.<sup>x</sup> **Hawaii** has developed extensive Play & Learn programs that enable grandparents, as well as parents and other caregivers of children, to bring children to structured activities that provide learning activities for the children and information about child development for the adults.

Parents are their children's first and most important teachers. States that have worked to strengthen and support parents in this role recognize that their strategies need to be voluntary. For voluntary programs to be successful requires that parents themselves be engaged and invested in them. As states work to build effective early childhood systems, they must ensure that they can reach families and young children with the most to gain, while respecting parental rights and responsibilities. Fortunately, there is growing evidence within exemplary family support programs that this balance can be achieved through voluntary programs that connect with families.

Finally, states such as **California**, **New Jersey** and **Washington** have passed legislation to support paid family leave. California and New Jersey enacted legislation providing for six week of paid leave in the case of a new child, to care for a family member or to care for own disability in 2002 and 2008 respectively. Legislation in Washington signed in 2007 is still waiting to be enacted due to lack of funding mechanism.

## Building the Special Needs/Early Intervention Component ● ● ●

### Evidence Base – Effective Practices.

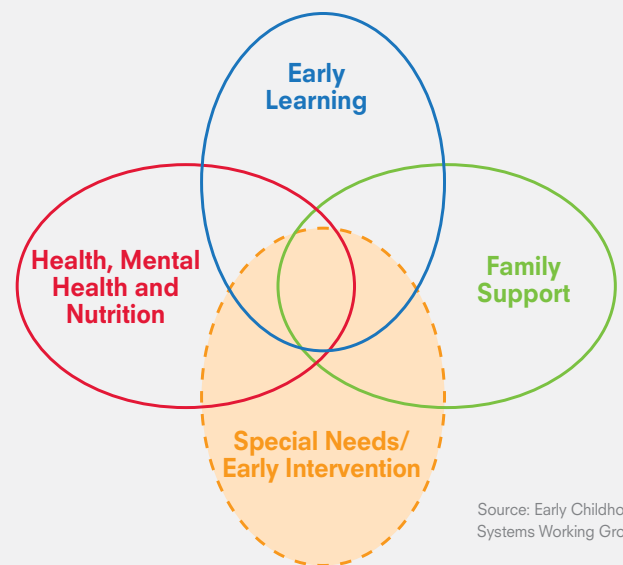
All children are special and unique. They grow and develop differently, according to their own constitution and environment. Most can grow and develop through receiving general, normative public services. Some children, however, have special needs that require more concerted, intensive, and individualized responses. These special needs can be physical, developmental, behavioral, or environmental. Physical special needs can cover a range of conditions that limit physical activity, including asthma, spinal bifida, cerebral palsy, and conditions that make children ventilator dependent or requiring assistive devices for mobility or communication. Developmental needs can include developmental disabilities and delays and mental retardation, both limited and profound. Behavioral needs can include organic mental illnesses or nonorganic aggressive or withdrawn behaviors. Environmental needs can relate to responses to exposure to trauma or violence, an absence of nurturing, lack of protection, or the presence of physical or emotional abuse.



Professionals in children’s medicine, child development, child psychology, and child welfare have developed responses to address the specific special needs of children, including:

- Physical. Child health specialty clinics and services and medical coverage (particularly under Medicaid) to respond to physical needs, including home and community based waivers and the Family Opportunity Act.
- Developmental. Individuals with Disabilities Education Act (IDEA) Early Intervention Part C services for infants and toddlers and special preschool program under Part B to respond to developmental needs.
- Behavioral. Title V community mental health services and Medicaid and other insurance program services to respond to behavioral and mental health issues.
- Environmental. Child welfare services, including family preservation and other family centered services and foster care services, to respond to child abuse and neglect.

In all instances, early identification and response is important to addressing the special need and promoting overall healthy development. For instance, early identification and response to autism improves overall child development and minimizes the effects of that autism. Early identification and response to child neglect through maternal depression improves parent-child relationships and child development, as well as improving parental health. Efforts across all these areas of special need are most effective if they work to integrate children with special needs into settings where typically developing children live, learn and play, or integrating special services and supports into everyday routines and learning opportunities, through using the “least restrictive environment,” “inclusion,” or “normalization.” Care coordination and training and support for parents often play a critical role in developing effective strategies. Research shows that interventions that reduce separation from normal childhood activities, while addressing special needs, are most effective, particularly in averting child reactions that, regardless of what kind of special need, can result in withdrawal, depression, or aggression as a result of being marginalized.



**Special Needs/ Early Intervention. Children with special health care needs, disabilities, or developmental delays need to be identified as early as possible, assessed, and receive appropriate services.** Early intervention includes direct services to children, in inclusive settings, and supports to their families. Early intervention also means responses from the child welfare system that work to preserve and strengthen families while addressing the development and safety needs of the child. This oval has a dotted line for two reasons. First, funding streams, program requirements and state structures can sometimes prevent integration of special needs/early intervention services into other early childhood development supports and services. The dotted line indicates a goal for more integration than currently exists.

The second reason for the dotted line is that special needs/early intervention services only apply to a subset of all children. Unlike the other three ovals, this piece of the system offers particular services at particular times in response to particular needs. It might, however, apply to any child when disease, social risks, or other factors lead to a change in health or developmental status.



## Current State of Development.

National estimates are that 12-16% of young children have some special developmental or behavioral need that could be subject to direct diagnosis that will compromise their healthy development. In most states, however, far fewer children are seen and served by systems that can provide specialized help. The IDEA Part C Early Intervention program, for instance, serves only a little more than two percent of infants and toddlers nationally. Child mental health systems in most states are small; finding child psychiatrists and psychologists who serve very young children is difficult.

More than one in twenty young children will come to the attention of the child welfare system before they reach school age, and these children represent many of children most vulnerable to starting school behind their peers. While child welfare systems identify instances of child abuse and neglect, most focus primarily upon child safety and, particularly when children are of preschool age, do not examine and address developmental concerns. Recent federal legislation now requires states to offer families in the child welfare system Part C developmental assessments for young children who are subject to abuse or neglect, but many state child welfare systems do not have a structure for addressing such child development issues in a concerted fashion.

One in ten children has a physical condition that requires special, ongoing treatment and can limit involvement in many childhood physical activities. While most children with severe physical disabilities receive treatment, parents often struggle as they work to maintain those children in their homes and additional supports to them are limited. Physical disabilities compound family stress and jeopardize child development in other areas. Medical treatments often do not address these other issues nor provide parents with respite services.

Particularly for children with special needs, it is essential that services be linked to the other parts of an early learning system. The Doris Duke Foundation's Strengthening Families Initiative has this emphasis in promoting child care centers as a locus for linking family support and health and special services to meet family and community needs that promote healthy child development. There is increased need for family support, for early care and education settings that can integrate children with special needs with other children while responding to those special needs, and for health services that can be flexible and provide training and guidance to family members and other professionals involved in the child's life.

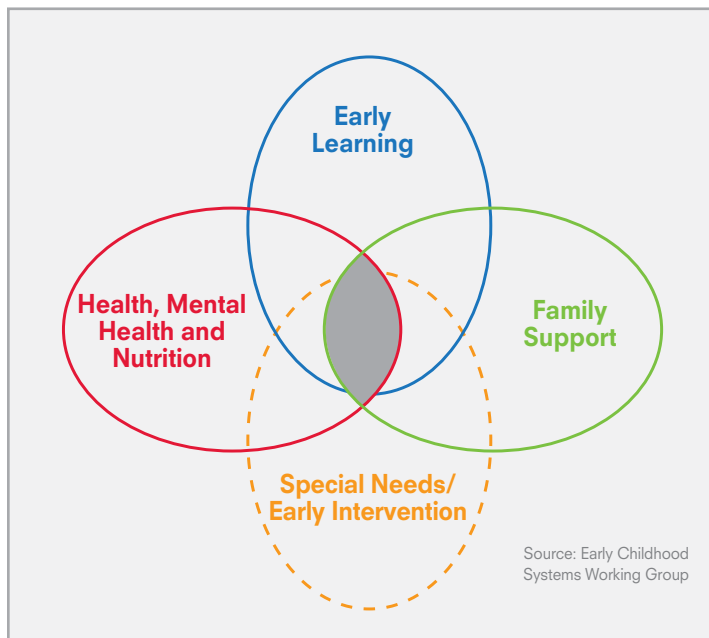
## Exemplary State Actions – Special Needs Component.

States vary substantially in their response to children's special needs, but there are exemplary state programs that can be drawn upon for effective responses. **Michigan, Hawaii, and Massachusetts** are leading states in the percentage of young children in their states who participate in their early intervention (Part C) programs to respond to children's developmental needs serving more than five percent of all children in their states. **Hawaii and New Jersey** have created models for providing comprehensive care for children with special medical needs that enable parents to keep those children at home. **Vermont** has developed a comprehensive approach for young children's mental health that includes family support and prevention and community consultation among its core services and that is being integrated into its Building Brighter Futures comprehensive early childhood planning efforts.

In better serving young children with special needs, the challenge and opportunity for states is both to develop effective strategies at the community-level, where they involve collaboration within the community that draw upon multiple resources, and to create state structures that can ensure that these community-based efforts exist across the state.

Expansion statewide requires attention to maintaining fidelity to the elements of programs that make them successful within the communities where they were initiated. States need data systems that look at their populations of children with special needs across health, developmental, behavioral, and environmental factors and that examine current responses to those special needs. In particular, young children with special needs and their families require coordination across systems to meet the often complex needs of the children, with family support to respond to the stresses that the special needs produce.

## Exemplary State Actions: Creating Linkages to Other Components ● ● ●



### Early Learning.

In addition to strengthening early care and education programs and services, states also have worked to create stronger linkages with other components/ovals of the early childhood system.

States that truly represent exemplary practice in early learning have created an intentional and aligned early care and education system. States such as **Pennsylvania, North Carolina, Illinois** and **Rhode Island** have been intentional in their efforts to not just improve funding for specific areas identified under early learning, but have put plans to align strategies, planning and services within practice.

**Colorado, Iowa** and **Rhode Island** support statewide networks of nurse consultants to child care programs both to monitor the health and safety of those programs and to provide advice on nutrition, exercise, and other healthy behaviors within the programs. Nurse consultants can be particularly helpful in enabling providers to respond to children with special health, developmental, or behavioral needs. **Rhode Island's** child care licensing regulations require that a nurse be on-site for 15 hours a week in programs serving infants and toddlers younger than 18 months.

States also have worked for strong linkages between early care and education and the school system. These have included work to develop early learning standards for young children and make sure they are aligned with primary and secondary learning standards. **Washington's** and **Alaska's** Early Learning Standards have been recognized for their attention to addressing issues of language and culture in child learning and development.

QRIS also can recognize elements of quality effective linkages not only within in the early learning oval and system but across all areas of a comprehensive early childhood system. High quality early learning systems ensure that children's health, mental health, and other special needs are identified and provide effective referrals to those services, when necessary. High quality early childhood programs also nurture family involvement and strengthen the capacity of family members to take on leadership roles in their own children's and other children's development. **Idaho, Arkansas** and **Pennsylvania** are state examples of QRIS that include these types of elements in their definitions of quality.

### Health.

Primary health care providers see almost all young children and are in the position to identify developmental as well as medical concerns that deserve attention. On developing comprehensive primary and preventive health services and effective linkages to other services, **Iowa** funds a First Five

Healthy Mental Development Initiative to encourage pediatric practices (including pediatricians, family physicians, and nurse practitioners) to provide developmental screening and monitoring as a part of well-child visits and then follow-up with other service providers when needs have been identified. With support from the Commonwealth Fund and its Assuring Better Child Health and Development (ABCD) Initiative, **North Carolina, Utah, Vermont, and Washington** have expanded Medicaid coverage to cover developmental assessments and to follow-up with recommended further screenings and treatment services. **Minnesota's** Great Start project is creating a primary care model of service delivery and Medicaid financing that includes coverage for mental health screening in a variety of venues, establishes a benefit for at-risk children as well as those meeting diagnostic criteria, and trains primary pediatric practices to assist in infant mental health integration.

In this respect, **Connecticut** has financed the nationally-recognized Help Me Grow program that strengthens both health practice and its linkages to other systems through a comprehensive, community-based approach. Help Me Grow trains pediatric practitioners in conducting “developmental surveillance” on young children and includes child care coordination and community health resource component that provides schedules, referrals and follow-up services needed to address developmental concerns and promote healthy child development. These follow-up services include special education services under the early intervention (Part C) program as well as family support and parenting education services that help parents address behavioral and developmental issues their children may face. Through support from the Commonwealth Fund, technical assistance is being provided by Help Me Grow to state teams in **Kentucky, New York, Oregon, South Carolina and Colorado** to develop similar approaches to strengthen developmental health services. **Vermont** has created Child Health Improvement Partnerships that enable community teams to tackle specific child health concerns, including responses to children with allergies or asthma, that involve both medical and non-medical approaches. **North Carolina** has established community partnerships that incorporate care coordination and community services into a medical home approach to addressing children’s overall health needs.

In addition, **Michigan** has emphasized the need for all practitioners serving children to be able to identify and act as first responders to children’s emotional and behavioral needs, through establishing a child mental health credential.

Health professionals can also play important roles in linking with other early childhood system components. **New York and Illinois** have established mental health consultants who assist child care providers and preschool programs in addressing behavioral concerns that those providers may encounter. **Louisiana** has integrated measures of the social-emotional climate of programs into its QRIS while also building a cadre of infant mental health consultants to work with child care programs in that state. Expulsion from child care and preschool due to aggressive and challenging behaviors is an increasing concern, but also highlights the need for developing effective responses (and the attendant expertise) within those programs to address those behaviors, as these children will be entering schools and will continue those challenging behaviors, unless they are addressed.

### **Family Support.**

In addition to developing programs and services specifically designed to provide parenting education and support services to families with young children, states also are working to incorporate parenting education and support within other programs that serve young children. The federal Head Start program has a long history of engaging families and has included family service workers to fill this role. Its Early Head Start program for parents of infants and toddlers has a primary focus on supporting

and strengthening families. Some QRIS include some measure of family engagement, including regular conferences with parents, a newsletter or a more formal parent support system that might include home visits or health or mental health consultation. In **Delaware, Kentucky, Louisiana, Maine, New Mexico, Pennsylvania,** and **Rhode Island** standards are set for infants and toddlers that set benchmarks for family engagement activities within their QRIS. The United Way's Born Learning campaign is active in numerous states, including **Virginia,** and **Pennsylvania,** and encourages parents to take advantage of "teachable moments" for young children that occur throughout the day, and other public education campaigns have developed to re-enforce positive parenting.<sup>xi</sup>

Programs designed to reduce child abuse require a holistic approach that identifies ways to engage parents and build upon their strengths. Seven states – **Alaska, Arkansas, Illinois, Missouri, New Hampshire, Rhode Island,** and **Wisconsin** – were initially selected to participate in the Doris Duke Foundation's Strengthening Families through Early Care and Education Project. The project promotes child care providers as a locus for engaging parents and fostering their resilience through expanding their social connections, providing information and resources on child development, and addressing specific concrete support in times of need. Based upon extensive research related to child abuse prevention, the Project strengthens children's social and emotional as well as cognitive development through leadership from within the early care and education community in supporting families. Due to its popularity, there are now nine state partners and 16 affiliates (including Washington, D.C.).

Similarly, a number of states implementing public preschool programs have established requirements for parental involvement as part of the preschool program. States such as **Arkansas** and **California** have made concerted efforts to ensure that parents are an integral part of the preschool community, requiring each program to develop a strategy to include parents in program design and operation, as well maintaining an "open-door" policy for parents to visit and participate in classroom activities at any time. **Arkansas** provides comprehensive child health screenings as part of its

public preschool program, as well as twice a year parent conferences offering family assistance and support.

Finally, states are bolstering existing community programs for families with resources designed specifically for parents of young children. Libraries and community centers can be a great resource for families and their young children, not only for educational materials but also as places for parent-child activities and programs. A Family Place Library network now exists in twenty-four states, which provides resources and activities directed toward parents and other care providers for young children, with state support for public libraries enabling such efforts to grow and expand.<sup>xii</sup>

A big issue that remains is creating a statewide and regional structure to coordinate home visiting and other family support and parenting education efforts. When there are multiple care coordination, home visiting, and parenting education activities in a community, some families may be approached by several programs while others are not reached at all. Meanwhile, programs may have difficulty independently providing training, staff development, and monitoring services and managing outreach efforts. The federal home visiting funding not only provides states resources to develop or expand services, but also the opportunity to begin to better define and coordinate existing services and ensure that they are effectively accessed and used. Lessons for this might be learned from efforts such as the Office of Home Visiting in **Utah**. This Utah Department of Health Office is there to promote a coordinated service continuum across their early childhood system focusing on home visitation.

### **Special Needs.**

Addressing children's special needs requires coordination across systems, as well as expertise in developing regimens for care and treatment of the young child with a special need. As with other substantive components of an early learning system, states are leading the way in developing new approaches, generally starting with demonstration efforts at the community level and then seeking to effectively diffuse and expand upon them throughout the state.





**New York**, through its judiciary, and **Missouri**, through its differential response and community partnerships approach to child abuse, have increased developmental assessments of children and helped ensure follow-up services and community supports that can meet them. Through First Five state funding, a number of **California** counties have developed integrated approaches to meeting multiple child and family needs from a community-based, strength-based family support perspective. **Wyoming** dramatically expanded developmental screenings of young children through incorporating those screenings within community-based settings and fostering referrals to address identified special needs.

The **Oklahoma** Respite Resource Network is a public-private partnership with the goal of increasing the availability and accessibility of respite services for families and caregivers. Families receive vouchers through one state entity, and are considered the “employer” of the respite provider – allowing them the flexibility and autonomy to find a respite provider that best fits their needs. Family Ties of **Massachusetts** is a statewide parent-to-parent support program and information resource for families of children with special needs and chronic illnesses.

The **Alaska** Youth Initiative established a wrap-around services approach to meeting the complex needs of its most vulnerable children and avoiding the need for placements in care, which often had required moving children outside the state, disrupting all family ties. Since that time, other states have established wrap-around service funds and programs that provide unconditional care to young children.

Through funding support from the federal government, twenty-one states are developing Project LAUNCH Projects designed to provide more comprehensive approaches to vulnerable children and their families from birth into the school system and age eight. Project LAUNCH is designed to demonstrate effective strategies to improve systems addressing the physical, emotional, social, cognitive and behavioral growth of young children. Lessons learned from the Project Launch sites in areas of service coordination, public awareness, and culturally relevant evidence based practices in promoting child wellness will act as national models.

As with other substantive components of an early learning system, states are leading the way in developing new approaches, generally starting with demonstration efforts at the community level and then seeking to effectively diffuse and expand upon them throughout the state. The challenge and opportunity is not only to develop effective strategies at the community-level, where they involve collaboration within the community that draw upon multiple resources, but also to create state structures that can ensure that these community-based efforts exist across the state with fidelity to the elements that make them successful within the communities where they were initiated.

## Conclusion ● ● ●

There are a variety of estimates of what it will require in investments to fully develop an early childhood system. States and the federal government have made major advances in providing more comprehensive health services for children and financing preschool, but neither has been completed. There continues to be a mismatch between what parents can afford to pay for child care and what is needed to ensure that care is developmentally appropriate and of high quality. State investments in family support programs remain largely small-scale demonstration efforts rather than broadly available services. As *Early Learning Left Out* shows, while billions of dollars are invested in young children’s development and education, much more is needed to achieve the First National Education goal and close the gaps too many children face at kindergarten



entry. Since that goal was established, progress has been made, but the task is unfinished.

This early childhood systems building work needs to be put into context. Prior to the Civil War, America did not have a public education system for children and youth. It took decades to develop America's K-12 education system to the point that there was a universal education system in place for all children. By the turn of the 20th century, higher education was reserved for a select few. Building America's higher education system of public and private colleges and universities also took decades to reach the point where college became an avenue available for advancement for children across all classes and races. Both the K-12 education system and the higher education system were not designed and constructed overnight, but took state leadership and innovation to develop.

The same holds for developing an early childhood system. States can and should be the laboratories for democracy in this charge. While federal financing and leadership also will be needed to fully develop and sustain an early learning system that meets the objectives set out by the First National Education Goal, states need to continue to be leaders in advancing the field.

**Editor's Note:** The field's understanding and articulation of systems building work continue to evolve, seeking greater simplicity, clarity, and strategic approaches. The "four ovals" framework, as noted earlier, was developed by the ECSWG in 2006 along with the system elements construct, and proved to be a groundbreaking resource for the field and for leaders in states. The concepts of these graphic representations of a "system of systems" have successfully fueled states' thinking and varied adaptation for their own use, planning, and objectives.

The ECSWG has recently focused on revision of the ovals graphic to address new experiences with systems building in states and to clarify some areas that remained unclear to users across the country. As systems thinking and graphic frameworks emerge, these tools are offered as additional resources to prompt and push thinking and adaptation by states. For information on how states have used and adapted the four ovals framework, along with the newly revised versions of the framework and core functions of a system, visit the ECSWG page at <http://www.buildinitiative.org/content/ecswg>.

## Endnotes ● ● ●

<sup>i</sup> Early Childhood Systems Working Group, National Governors Association, *State Early Childhood Development System*, (Washington, D.C.: National Governors Association, Early Childhood Systems Working Group, 2006), at: <http://www.nga.org/Files/pdf/07EARLYCHILDFRAMEWORK.PDF>.

<sup>ii</sup> "An intentional curriculum is: content driven, research-based, emphasizes active engagement with children, includes attention to social and regulatory skills, and is responsive to cultural diversity and children just learning English... it promotes positive peer and teacher interactions...and is developmentally appropriate." Taken from the National Center for Children in Poverty [http://www.nccp.org/publications/pdf/text\\_695.pdf](http://www.nccp.org/publications/pdf/text_695.pdf) page 3.

<sup>iii</sup> Magnuson, Katherine A., and Jane Waldfogel, "Early Childhood Care and Education: Effects on Ethnic and Racial Gaps in School Readiness," *The Future of Children* 15, no. 1 (2005): 169–96, at: [http://muse.jhu.edu/journals/future\\_of\\_children/v015/15.1magnuson.pdf](http://muse.jhu.edu/journals/future_of_children/v015/15.1magnuson.pdf).

<sup>iv</sup> W. Steven Barnett, "Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes," *The Future of Children* 5, no. 3 (1995): 25–50, at: [http://www.futureofchildren.org/usr\\_doc/vol5no3ART2.pdf](http://www.futureofchildren.org/usr_doc/vol5no3ART2.pdf).

<sup>v</sup> Amy R. Susman-Stillman, and Patti Banghart, *Demographics of Family, Friend, and Neighbor Child Care in the United States*, (New York: Child Care & Early Education Research Connections, 2008), at: <http://www.childcareresearch.org/SendPdf?resourceId=14337>

<sup>vi</sup> *Early Learning Left Out: Building on Early Learning Childhood System to Secure America's Future*, 3rd Edition. (2010). Voices for America's Children: Washington, DC.

<sup>vii</sup> National Association for the Education of Young Children, *NAEYC Quality Rating and Improvement Systems (QRIS) Toolkit*, (Washington, D.C.: National Association for the Education of Young Children, 2008), at: <http://www.naeyc.org/files/naeyc/file/policy/state/QRSToolkit2010.pdf>

<sup>viii</sup> Kaiser Family Foundation and the Health Research and Educational Trust. (2010) *Survey of Employer Sponsored Health Benefits, 1999-2010*.

<sup>ix</sup> Centers for Medicare and Medicaid Services, *FY 2007 Annual Enrollment Report*, March 2008. Available at: <http://www.cms.hhs.gov/NationalSCHIPPpolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemId=CMS1208791&intNumPerPage=10>.

<sup>x</sup> AARP Grandparent Information Center, *Lean on Me: Support and Minority Outreach for Grandparents Raising Grandchildren*, (Washington, D.C.: AARP, 2003), at: <http://www.aarp.org/research/family/grandparenting/aresearch-import-483.html>

<sup>xi</sup> For more information, see: <http://www.bornlearning.org/default.aspx?id=26>.

<sup>xii</sup> For more information, see: <http://www.familyplacelibraries.org/>.

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