

Healthy Children

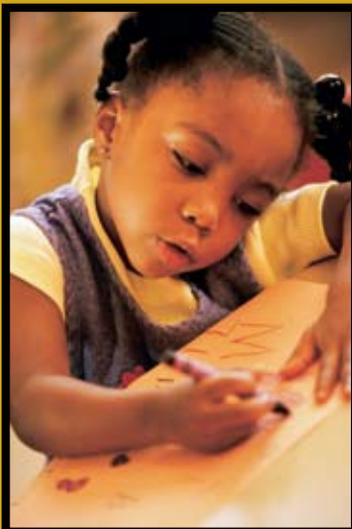


Strong Families



NYS Early Childhood Plan:
Ensuring a Great Start for Every Child

Early Learning



Supportive Communities



Coordinated Systems

NYS Early Childhood Plan:

Ensuring a Great Start for Every Child

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NYS Early Childhood Plan: Ensuring a Great Start for Every Child

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New York State Early Childhood Plan: Ensuring a Great Start for Every Child



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Council on Children and Families

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Council on Children and Families

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Dear Friends:

We are pleased to present the *New York State Early Childhood Plan*. A product of the State Early Childhood Comprehensive Systems Planning Initiative, the plan has been developed to provide a working agenda for building a high quality system of supports and services for young children and their families.

Approximately 250,000 children are born in New York State each year. As our most precious resource, every child's healthy development demands our support to secure our future as a society and our position in the global community. The Early Childhood Comprehensive Systems Plan supports this need by calling for development of a service system that includes health care, mental health, family support, and early care and education and is integrated and fully responsive to the multiplicity of family needs.

The planning process itself spurred action to implement the majority of strategies included in the plan. It is hoped that the publication of the plan will help to stimulate action to implement the remaining strategies, while serving to organize all statewide efforts to address the needs of families with young children under a common framework.

The Council on Children and Families is committed to improving the effectiveness and efficiency of our system of services for New York's children and families by providing critical information and facilitating policy development, planning, and greater accountability across health, education, and human services systems. We will continue to work with the Children's Cabinet and its Advisory Board and other partners at the state and local level to help ensure that all children in New York State have the opportunity to grow and flourish.

Sincerely,

Deborah A. Benson



David A. Paterson
Governor

Council Member Agencies

State Office for the Aging * Office of Alcoholism and Substance Abuse Services
Office of Children and Family Services * Division of Criminal Justice Services
State Education Department * Department of Health * Department of Labor * Office of Mental Health
Office of Mental Retardation and Developmental Disabilities * Division of Probation and Correctional Alternatives
Commission on Quality of Care and Advocacy for Persons with Disabilities * Office of Temporary and Disability Assistance



Deborah A. Benson
Executive Director

The Governor's Children's Cabinet



David A. Paterson
GOVERNOR

In 2007 the Children's Cabinet was established by Executive Order to oversee the implementation of the Governor's Early Childhood Agenda. The Cabinet is convened by the Chair, Kristin Proud (Deputy Director of State Operations), and by Vice Chairs Joseph Baker (Deputy Secretary of Health and Human Services) and Duffy Palmer (Deputy Secretary for Education), and is comprised of the commissioners and directors of 20 state agencies and several staff from the Governor's office.

To assist the Cabinet in its efforts, the Governor also established the Children's Cabinet Advisory Board. The Advisory Board is comprised of people with expertise in the major focus areas of the Cabinet.

The Early Childhood Comprehensive Systems (ECCS) Initiative began in 2003 when the NYS Department of Health's Division of Family Health received a grant from the US Department of Health and Human Services for this purpose. Council and Health Department staff co-chair the ECCS initiative.

A primary task for the ECCS Initiative was to develop the Early Childhood Comprehensive Systems Plan. In response to the requirement included in the Head Start Act of 2007, Governor Paterson decided to designate the Children's Cabinet and its Advisory Board as his Early Childhood Advisory Council. In making this decision, he has also asked that Cabinet and Advisory Board take responsibility for overseeing the Early Childhood Comprehensive Systems Initiative, including the implementation of the Plan. This ensures the highest level of support for both the Initiative and implementation of the Plan.

Children’s Cabinet Members

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Deputy Director for State Operations, NYS Executive Chamber

Vice-chairs

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Deputy Secretary for Health and Human Services
NYS Executive Chamber

Duffy Palmer

Deputy Secretary of Education
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Members

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NYS Consumer Protection Board

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Commissioner
NYS Division of Housing and Community Renewal

Council on Children and Families

The Council on Children and Families is authorized to coordinate the state health, education, and human services systems as a means to provide more effective systems of care for children and families. Established as Chapter 757 of the Laws of 1977 and administratively merged with the New York State Office of Children and Family Services since 2003, the Council's work remains true to its original intent—to be a neutral body within state government capable of negotiating solutions to interagency issues.

The formal Council includes the Commissioners and Directors of the State's 12 health, education, and human services agencies. For 30 years, the Council has spearheaded cross-systems approaches that improve the effectiveness and efficiency of service delivery systems, consider new or emerging service needs, and promote coordinated, rational, and consistent policies as a means to improve outcomes for children and families. The Council's Executive Director is Deborah Benson.

The Council on Children and Families provides staff support to the Children's Cabinet and its Advisory Board. As such, Council staff will play a key role in implementing the ECCS Plan.

Council Member Agencies

State Office for the Aging

Office of Alcoholism and Substance Abuse Services

Office of Children and Family Services

Division of Criminal Justice Services

State Education Department

Department of Health

Department of Labor

Office of Mental Health

Office of Mental Retardation and Developmental Disabilities

Division of Probation and Correctional Alternatives

Office of Temporary and Disability Assistance

Commission on Quality of Care and Advocacy for Persons with Disabilities

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Our Vision for New York State's Young Children

- Children are healthy and learning.
- Families have the knowledge, skills, confidence, support, and resources they need to raise children from birth to age 5 in healthy and nurturing environments.
- Communities have the resources and infrastructure they need to deliver services to children and their families, and to provide a safe and healthy environment in which to raise children.
- A coordinated and responsive system provides services and resources that support the physical, social, emotional, and cognitive health and development of all young children and their families.

Mission of the New York State Early Childhood Comprehensive Systems Partnership

To develop and implement, through a collaborative partnership of stakeholders, a five-year Early Childhood Strategic Plan for New York State that supports families and communities in nurturing the healthy development of children birth to age 5.

We will:

- Articulate common early childhood goals;
- Assess the capacity of the current systems serving young children and their families to achieve goals, and identify existing gaps or challenges;
- Identify and prioritize early childhood system objectives and indicators;
- Implement effective strategies for achieving these goals by designing mechanisms to develop and infuse best practices, and to strengthen and coordinate existing services and supports;
- Continually evaluate and update approaches as needed;
- Establish an interagency structure for implementing the plan, and for informing state policy development and overseeing policy implementation, and
- Engage participation and ongoing commitment of key stakeholders.

Ensuring a Great Start for Every Child

Why the Early Years Deserve Public Priority

Society has a compelling interest in the development of New York's youngest citizens. Evidence from both research and practice shows a strong link between early childhood experience and long-term life outcomes. Infants and toddlers raised in healthy, secure, nurturing environments grow up to have more productive lives, and impose fewer burdens on public services ranging from remedial education to welfare to criminal justice.

New York State has about 1.5 million children birth to age 5, representing 8 percent of the population. Many of these children subsist in vulnerable family environments. One in five lives in a household receiving public financial aid; one in three lives in a single-parent-or-grandparent household. No matter how fragile or sturdy their environment, all of New York's young children and their families can benefit from appropriate external supports.

New York's children currently receive supports and services through a patchwork of local, state, and federal health, education, and human-service programs. The public invests several billion dollars each year in these measures dedicated to young children and families.

The Early Childhood Comprehensive Systems Planning Initiative aims to ensure that this investment achieves maximum long-term impact. By improving service quality and access, the plan will enable the state to achieve the well-documented paybacks that arrive as future public revenue and lower costs. Such benefits will result near-term from reduced expense for health care and remedial education. Longer-term impact results from the increased earning power of the next generation of workers and declining levels of poverty, leading to lower per-capita spending for a host of government programs.

With these desired outcomes in mind, the New York State Early Childhood Plan focuses on birth-to-age-5 as a critical period of human development and recognizes the essential roles played by families and communities in nurturing the healthy development of children. It also recognizes that some families due economic status, education level, race and ethnicity face significant challenges and supports and services need to be designed and organized to meet their needs in ways that are strengths-based and culturally sensitive.

Origins of the Early Childhood Comprehensive Systems Planning Initiative

The Early Childhood Comprehensive Systems Planning Initiative involved three years of effort by a collaborative team of more than 50 participants. The team was convened by the Council on Children and Families and the Department of Health and included representatives from all relevant state agencies—Office of Children and Family Services, Office of Temporary and Disability Assistance, Education Department, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Department of State. The team also included many provider and advocacy organizations, colleges and universities, and parents. Funding for this effort came from the federal Maternal and Child Health Bureau within the US Department of Health and Human Services.

The product of this initiative, the New York State Early Childhood Plan builds on the foundation established by *New York's Action Plan for Young Children and Families*, a blueprint published in 2005 by the nonprofit Center for Early Care and Education as part of its Winning Beginning NY campaign. The new plan expands the earlier vision, by outlining development of a service system integrating health care, mental health, family support, and early care and education to be fully responsive to the multiplicity of family needs.

The planning process has already spurred action to implement the majority of strategies included in the Early Childhood Plan. The planning team hopes that the publication of the plan will help to stimulate action to implement the remaining strategies, while serving to organize all statewide efforts to address the needs of families with young children under a common framework.

Where New York State Stands Today

As the planning team worked, a consensus view emerged: New York has many quality services and programs in place, but they lack coordination. Uncoordinated efforts yield inefficiencies that mean we're not helping as many children as possible with the available funding.

The Early Childhood Comprehensive Systems Planning Initiative's premise is that with coordination and improved accountability, New York's collective investment in children's health and welfare can achieve more. This will improve the quality of life for more children today and reduce future public expense.

In short, we need to close the gap between *what is* and *what should be*. This challenge is neither small nor quickly resolved. Accordingly, the Early Childhood Plan takes a pragmatic view, outlining a phased, prioritized approach to achieving desired outcomes.

Getting Our Arms Around the Problem

Envisioning an integrated system of early-childhood service delivery encompasses four broad goals: healthy children, strong families, early learning, and supportive communities.

These goals reflect the multidimensional nature of positive child and family development and the interconnectedness of the issues involved. The Early Childhood Plan links each of these goals to a set of outcomes, and ties each outcome to an objective measure of success.

This conceptual framework can serve as basis for the evaluation, development, and prioritization of existing health and social welfare programs, and as a tool for inspiring and assessing future solutions.

The Early Childhood Plan's Pathway to Success

Each objective in the Early Childhood Plan relates to a strategy to build better systems, including action steps for implementation over the next three-to-five years. In developing and prioritizing strategies, the planning team considered several factors:

1. Evidence, theory, and practice base for proposed strategies.
2. Existing infrastructure and resources for carrying out strategies.
3. Feasibility for implementation, including resources, time, and staffing.
4. Meaningful impact on children and families.
5. Benefit of a collaborative system-building approach rather than single-program approach.

The Early Childhood Plan envisages four forms of action, to strengthen and coordinate current supports and services for young children and their families while infusing best practices:

1. Optimizing current services, starting by organizing and coordinating existing programs such as Head Start, Child Care, and Universal Prekindergarten.
2. Extending existing programs to unserved children and families—for example, bringing prenatal and postpartum home visiting programs to more parents.
3. Creating services where none now exist—for example, developing a statewide network of parenting education programs.
4. Infusing best-practice research to increase the quality and effectiveness of services, both existing and added.

Measuring Early Childhood Plan Outcomes

The plan builds in accountability by linking each of the four goal areas to a set of quantitative indicators. These indicators are detailed in a separately published document, the *NYS Early Childhood Data Report: The Health and Well-Being of New York's Youngest Children*.

Healthy children—19 major indicators, including birth weight, infant mortality rates, breastfeeding rates, insurance status of children birth-to-5, immunization rates, lead-poisoning incidence, and so forth.

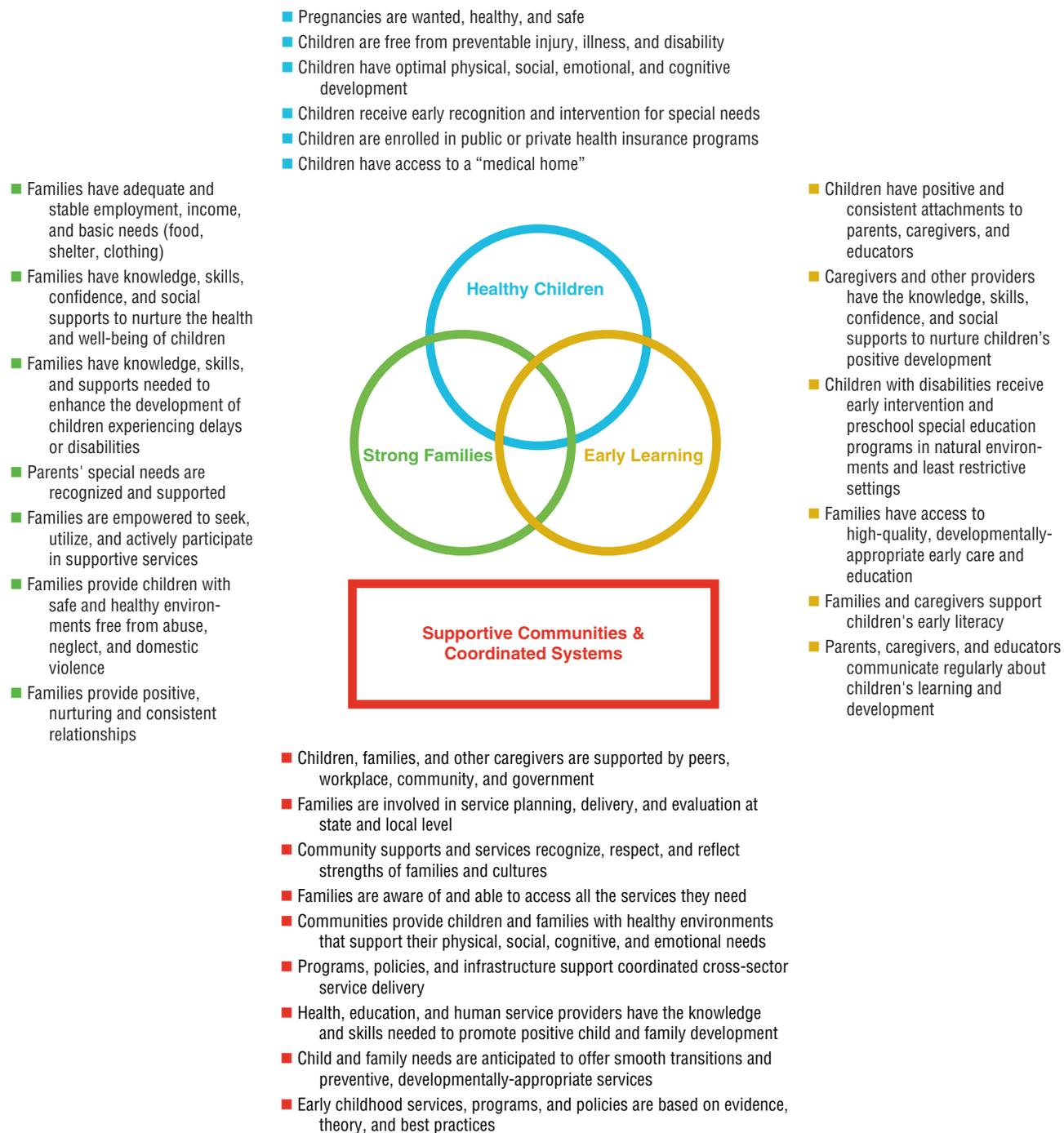
Strong families—11 major indicators, including poverty status, parental employment, public assistance and WIC rates, foster care rates, child abuse and neglect cases, domestic violence, and so forth.

Early learning—6 major indicators, spanning household English proficiency, preschool enrollment, and early intervention rates.

Supportive communities—3 major indicators, including community safety perception, supportive neighborhood perception, and community crime rates.

Framework of Priority Cross-Sector Goals and Outcomes

NYS Early Childhood Comprehensive Systems Planning Initiative



Goal 1: Healthy Children

The health of children is fundamental to their overall well-being, and to the vitality of families and communities. Health is a comprehensive concept that encompasses prevention and management of illness, injury, and disability; promotion of positive healthy behaviors; and optimal development in multiple domains, including physical, social, emotional, language, and cognitive development. Health is a basic universal goal, and all children should have access to high-quality, comprehensive health care services.

The foundation for a healthy childhood begins during and even prior to pregnancy. A woman's preconception health plays an important role in determining the pregnancy outcome for herself and her baby. The first requirement for a healthy pregnancy is to ensure that every pregnancy is a planned one. Prior to becoming pregnant, a woman should have access to comprehensive family planning and reproductive health care services, including advanced and effective birth control methods, as well as counseling that will enable her to optimize her health prior to conception. During pregnancy, high-quality prenatal care services should be available to all women, and during the postpartum period all women and their families should have continued access to education and support services encouraging the practice of healthy behaviors for themselves and their children.

Access to comprehensive, high-quality primary and preventive health care services is essential to promoting and protecting the health of children. Enrollment in adequate health insurance is a critical factor in access and use of health care services. New York State has been a national leader in expanding health insurance coverage for children. In 2007, Medicaid served more than 656,000 children under age 6 in New York,¹ and another 61,000 children were served by the Child Health Plus program.² Nevertheless, lack of health insurance remains a critical barrier to obtaining health care services for too many of New York State's children. Approximately 8.0 percent of children birth to age 5 in New York State were without insurance at some point during the year in 2006, compared to 11.3 percent nationally.³ Of all New York children eligible for publicly funded insurance (Medicaid

or Child Health Plus), 88.5 percent were enrolled in 2007.⁴

Among children with special health care needs age birth to 17 years in New York State, recent survey data show that 7.4 percent were estimated to be without health insurance at some point during the year, and 34.7 percent had insurance coverage that was inadequate to meet their needs. Preschool children with special health care needs are more likely than older children to need home health care, medical equipment, and health aids. Across all age groups, the most often cited needs for children with special health care needs are prescription medication (88%), medical specialists (50%), mental health care (25%), medical supplies (25%), and therapy services (such

Outcomes

- Pregnancies are wanted, healthy, and safe.
- Children are free from preventable injury, illness, and disability.
- Children have optimal physical, social, emotional and cognitive development.
- Children receive early recognition and intervention for special needs.
- Children are enrolled in public or private health insurance programs.
- Children's health, mental health, and oral health services are accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective (medical home).

Goal 1: Healthy Children

as speech-language therapy, occupational therapy, and physical therapy, 24%).⁵

Health insurance alone does not ensure access to care. All children should receive ongoing health care services in a medical home. In a medical home, health care services for children are accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Building on a foundation of high-quality, comprehensive primary care—including preventive health services, screening and health promotion, and management of acute and chronic medical conditions—a medical home can serve as a hub for a broad range of needed supports and services for children and families. This function is especially important for children with special health care needs—those children who have a chronic physical, developmental, behavioral, or emotional condition, and who require health care and other related services more than other children. National survey data show that while nearly 90 percent of New York State children birth to age 5 years have a personal health care provider, only 62.1 percent of children birth to age 5 receive health care that meets all the criteria of the American Academy of Pediatrics definition for medical home.⁶

Approximately 8.4 percent of New York State children birth to age 5 years have one or more special health care needs.⁷ Among parents who participated in the National Survey on Children with Special Health Care Needs, 22.7 percent reported having had difficulty obtaining a referral for their child for needed specialty care, and 13.5 percent reported their child had an unmet need. Nearly nine percent (8.6%) of New York parents of children with special health care needs reported spending 11 or more hours a week coordinating care for their children. Fewer than half (47.5%) of parents of children with special health care needs age birth to 5 years in New York State reported that their child receives health care that meets all the criteria of the American Academy of Pediatrics definition of medical home. Family-centered care, broadly defined as an approach to the planning, delivery, and evaluation of health care and related services for children with special health care needs that involves active participation between families and professionals, is central to the concept of the medical home.⁸

Comprehensive health care services must include attention to children’s oral health needs, including the importance of a “dental home” and coordination with other pediatric health care services. A growing body of scientific evidence shows that poor oral health is associated with adverse general health outcomes. Dental caries (cavities) are among the most common chronic childhood conditions, including an especially virulent form of early childhood cary that occurs in children under age 6.⁹ Dental caries have an impact on children’s functioning, including eating, sleeping, speaking, learning, and growth. Other dental conditions such as oral clefts and orthodontic problems can jeopardize children’s physical growth, self-esteem, and socialization.

Treatment of dental problems in young children is often extremely difficult and expensive, emphasizing the critical importance of preventing dental problems before they occur, whenever possible.¹⁰ However, access to preventive dental services remains a significant need in New York State, especially among low-income children.¹¹ Primary health care providers who see children frequently for routine well-child visits can play a significant role in reducing the impact of oral health problems by incorporating oral health risk assessment, counseling, early detection, and referral in routine pediatric care, consistent with recent recommendations adopted by the American Academy of Pediatrics.¹² The New York State Department of Health recently released practice guidelines for oral health during pregnancy and early childhood that can serve as a critical tool in implementing these recommendations.¹³

As an integral component of efforts to optimize children’s health, significant attention must be given to promoting and supporting children’s positive social-emotional development and mental health. Children construct knowledge about their world through social interaction, and throughout all phases of life this interaction and learning how to be around others is essential. For all children, and especially young children, mental health is strongly influenced by the quality of the adult relationships in the child’s life and the child’s care-giving environment. Young children’s development is closely tied to their parents’ mental health. Therefore, it is

critical that a comprehensive systems approach should emphasize primary prevention, early detection, and effective management of the social-emotional and mental health issues of children and their families. In doing so, it is especially important to take steps to prevent violence in families, both domestic violence and child abuse and maltreatment. Family violence is a significant factor in children experiencing social-emotional and mental health issues.

Finally, it must be recognized that assuring the health and safety of young children is not the job of health care providers and parents alone. Young children spend significant time in out-of-home child care and educational environments, including regulated center-based and family child care, exempt child care providers, Head Start/Early Head Start programs, special education programs, and other early care and education settings. In New York State, 83 percent of children under age 5 spend time in care, with 44 percent spending 35 or more hours per week in care.¹⁴ Whether inside or outside their homes, children should have physical environments that protect and promote their health, safety, and development.

OBJECTIVE 1: Increase the practice of healthy behaviors in the preconception, prenatal, and postpartum periods, including use of early and comprehensive prenatal care.

Strategy 1.1: Educate health care providers on the importance and methods for providing high-quality preconception care to all women of childbearing age and their partners at every encounter.

Because nearly half of all pregnancies in the United States are unintended, it is essential not only to provide preconception care to all women who seek medical care and consultation while planning a pregnancy, but also to provide education and screening to all women on an ongoing basis. This serves to identify potential maternal and fetal risks and hazards to pregnancy both prenatally and between pregnancies. Optimizing preconception care may act to improve pregnancy outcomes such as decreasing the rates of low birthweight and premature babies.

The three essential components of quality preconception care are risk assessment (screening), health promotion (education and counseling), and intervention or referral. Access to comprehensive family planning and reproductive health care services, including advanced and effective birth control methods, is also a critical part of the continuum of services for women of reproductive age and their partners, and should be linked to preconception care services.

Women of childbearing age suffer from a variety of chronic conditions that could potentially contribute to adverse pregnancy outcomes. Failing to intervene before pregnancy to detect, manage, modify, and control maternal behaviors, health conditions, and risk factors that contribute to adverse maternal and infant outcomes has caused the rates of improvement in pregnancy outcomes to decrease. Promoting preconception health to all women of reproductive age at each and every encounter with the health care system is an ideal way to improve pregnancy outcomes. Clinical practice guidelines have been developed for the following preconception risk factors which may adversely affect pregnancy outcomes:

Goal 1: Healthy Children

- Chronic medical conditions (e.g., diabetes management, hypothyroidism, phenylketonuria (PKU));
- Prescription drug use (e.g., oral anticoagulants, anti-epileptic drugs, isotretinoin—Accutane brand name);
- Health behaviors (e.g., use of folic acid, smoking, alcohol, obesity);
- Infections (e.g., STDs, HIV/AIDS, Hepatitis C);
- Immunizations (e.g., rubella, Hepatitis B, varicella);
- Domestic violence and social issues;
- Exposure to environmental toxins;
- Prior pregnancy complications;
- Poor oral health.

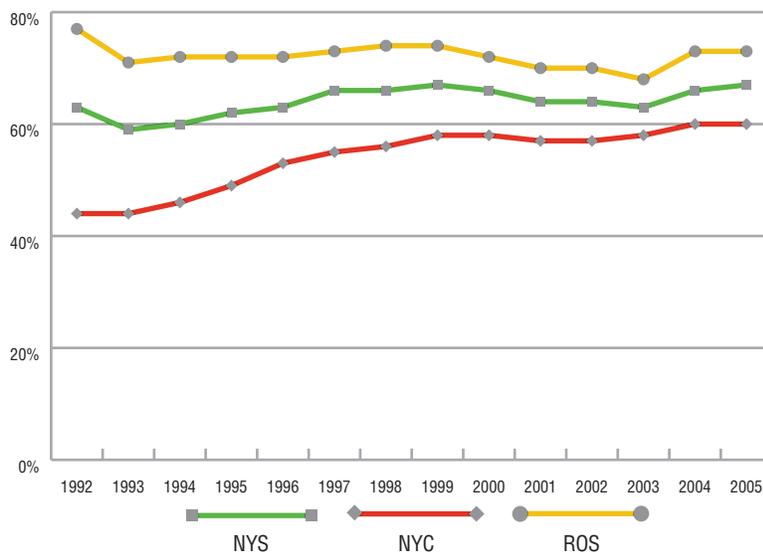
Communication among all health care providers for all women of reproductive age with a chronic disease

is essential to maximize reproductive outcomes. In particular, while providing optimal medical care to these women, primary care providers must consider the impact of medication on pregnancy, including possible teratogenic effects.

Strategy 1.2: Strengthen and expand education and outreach activities to engage pregnant women in early prenatal care, with an emphasis on reaching at-risk/vulnerable populations.

Increasing access to and use of early, comprehensive prenatal care is critical in reducing infant morbidity, prematurity, and low birth weight.¹⁵ Because critical fetal development occurs in the earliest weeks of pregnancy, it is essential for women to initiate prenatal care as early as possible. In 2003, 74.7 percent of pregnant women in New York State received early prenatal care, which is defined as care that begins in the first trimester of pregnancy.¹⁶ However, 6 percent of all women giving birth in New York State between 2001 and 2003 received no or late prenatal

**Adequate Prenatal Care for Mothers 15 to 44 Years:
NYS, NYC and ROS, 1992 to 2005**
(Source: NYS Department of Health, 2007)



The Adequacy of Prenatal Care Utilization (APNCU) Index measures prenatal care utilization (PNC) on two independent and distinctive dimensions: adequacy of initiation of PNC and adequacy of received services (Kotelchuck, 1994). Adequate prenatal care is defined as beginning in the fourth month with the expectant mother receiving 80-109 percent of expected visits.

care. New York State must continue to work toward the national Healthy People 2010 goal for early entry into prenatal care of 90 percent.¹⁷

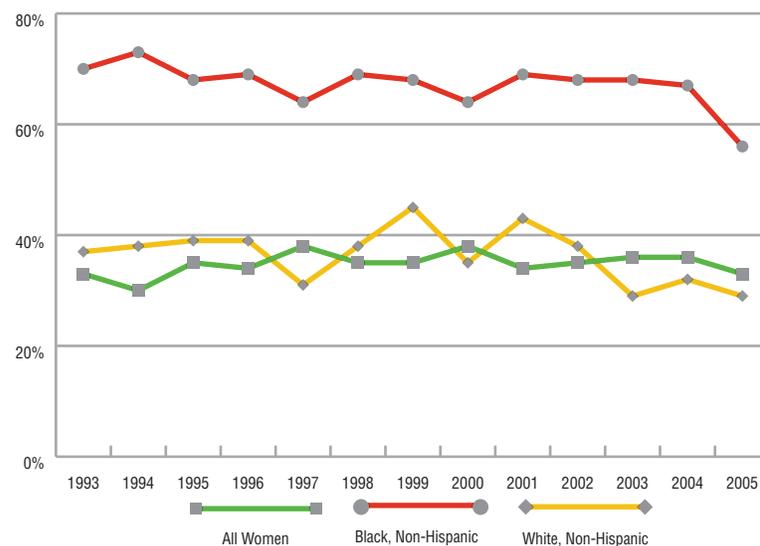
New York State is rich in the availability of health and human services for pregnant women and their families and has generous Medicaid benefits for pregnant women. However, access to and use of available services, particularly for at-risk and vulnerable populations, can be challenging. Women who are poor, unmarried, Black or Hispanic, have multiple children, are experiencing substance abuse, have low levels of educational attainment and/or are at extreme ages (under 15 or over 40) for giving birth have the lowest rates of prenatal care, but may be most in need of quality prenatal care services. Unfortunately, for women facing significant daily challenges of obtaining adequate food and shelter, caring for other children, and dealing with substance use or abusive relationships, obtaining prenatal care simply may not be the highest priority. Creative and culturally competent community-based approaches (e.g., Healthy Families New York and Community Health Worker programs) are needed to engage high-risk women and their families in early prenatal care and related services, and to make those services more accessible to the populations they serve.

Strategy 1.3: Strengthen the capacity of health care providers to deliver comprehensive prenatal care services that support the needs of at-risk/vulnerable women and families.

Prenatal and postpartum care provide a critical opportunity for health care providers to assess and address maternal and family risk factors related to domestic violence, compromised nutrition, chronic medical conditions, mental health problems, economic needs, and substance use, including smoking, alcohol and illicit drugs. For prenatal care to be most effective, health care providers must have the capacity to deliver comprehensive services that attend to women’s individual health, social, and cultural needs. Health care providers’ awareness, knowledge, skills, and tools related to both longstanding and emerging priority health issues should be continuously developed and strengthened. Continuing education, training, and quality improvement activities for health care providers can take place in a variety of educational formats and settings, and should reflect evidence-based methods and learning preferences of health care providers.

It is important that health care providers are able to support women and their families in addressing perinatal

**Live Births Resulting from Unintended Pregnancies by Race/Ethnicity:
NYS Excluding NYC, 1993 to 2005**
(Source: Public Health Information Group, 2007)



Goal 1: Healthy Children

depression and other mental health problems, domestic violence, alcohol and substance use, oral health, and chronic medical conditions. Current prenatal and postpartum care practices in each of these areas should be assessed, and specific educational strategies and practical clinical tools for health care providers should be developed and disseminated where needed to improve practices. Strategies should include components that can be incorporated into routine clinical practice, such as specific screening, counseling, and management tools.

Prenatal health care services ideally should be delivered as part of a comprehensive and continuous system of supports and services for women and families (see Objective 6 for additional detail). Community outreach, education, and other supportive services, including home visiting services targeted to families at risk for adverse birth outcomes, should be linked to health care services to help assure that all pregnant women are engaged in early prenatal care, and that families' ongoing individual needs are met. Continuing education and technical assistance for health care providers should include practical strategies for establishing and strengthening linkages and referrals between clinical providers and other community supports and services. In addition, services should be provided in a culturally competent manner including the delivery of services by providers who speak the same language as the family seeking services. Informational materials should be made available in eight or nine most-used languages in the state. Given the large size of foreign-born population in the state, it is important that women/children who need services the most and who do not speak English well are not overlooked.

It is also imperative for high risk women to have access to appropriate perinatal specialty services and delivery at a hospital with appropriate levels of perinatal care. Women at high risk for poor birth outcomes may benefit from consultation with a maternal fetal medicine specialist and delivery at a Regional Perinatal Center or a Level 2 or 3 perinatal hospital depending on the level of risk. Continuing education of providers and systems oversight is needed to ensure this occurs.

Strategy 1.4: Support efforts to eliminate Fetal Alcohol Spectrum Disorders (FASD) in New York State through universal screening of pregnant women.

Based on the current, best science available, we now know that alcohol consumed during pregnancy increases the risk of alcohol-related birth defects, including growth deficiencies, facial abnormalities, central nervous system impairment, behavioral disorders, and impaired intellectual development. No amount of alcohol consumption can be considered safe during pregnancy. Alcohol can damage a fetus at any stage of pregnancy. Damage can occur in the earliest weeks of pregnancy, even before a woman knows that she is pregnant. The cognitive deficits and behavioral problems resulting from prenatal alcohol exposure are lifelong. Alcohol-related birth defects are completely preventable.¹⁸

In utero exposure to alcohol has a pervasive effect across service systems. Young children may need multiple assessments to determine the cause of developmental delays, as well as intensive services such as early intervention and special education. 94 percent of children with an FASD are diagnosed with a mental illness at some point between the ages of 6 and 12 years, most often ADHD.¹⁹ Because of damage to the brain, commonly accepted therapeutic, pharmacological, and behavioral interventions may be ineffective and even counter-productive for a child with FASD. If the FASD is not identified, appropriate interventions may not be provided, resulting in poor adult outcomes. For example, 61 percent of adolescents and 58 percent of adults with FASD have been in legal trouble; 80 percent of adults with FASD have trouble with employment.²⁰

New York State created an FASD Interagency Workgroup in early 2008 to coordinate a collaborative response to FASD. Ten NYS agencies are currently participating in this initiative to address education and awareness, prevention and prenatal screening, diagnosis and screening of children, and interventions and treatment services.

Strategy 1.5: Increase protection, promotion, and support for continued breastfeeding when mothers return to the workforce.

Breastfeeding has long been recognized as the gold standard for infant nutrition. Human milk is uniquely adapted to the nutritional needs of infants, leading to optimal growth and development, and significantly reducing infants' risk of infections, from diarrhea and colds to meningitis and other life-threatening infections. Infants who are breastfed for three months or more make fewer medical office visits, receive fewer procedures, take fewer medications, and experience fewer hospitalizations. Beyond these short-term benefits, research has demonstrated that breast milk protects infants against a growing list of chronic diseases, including cardiovascular disease, cancer, diabetes, and both childhood and adult obesity. Breastfeeding also supports social-emotional development by promoting bonding and attachment.

In New York State, approximately 75 percent of mothers breastfeed their infants in the early postpartum period, which just meets the Healthy People 2010 target of 75 percent. However, breastfeeding rates at 6 months (50 percent for New York State) and at one year (25 percent for New York State) are considerably lower, again just meeting the Healthy People 2010 goals of 50 percent and 25 percent, respectively. This indicates that efforts need to be directed at women returning to work and school after giving birth to support continuation of breastfeeding. The Healthy People 2010 now has additional target goals for exclusive breastfeeding, indicating additional targets for improvement. At three months, 30 percent of US and 26 percent of NYS mothers are exclusively breastfeeding, compared to the Healthy People 2010 three-month target goal of 40 percent. At six months, 11 percent of US and 11 percent of NYS mothers are exclusively breastfeeding, falling short of the Healthy People 2010 six-month target goal of 17 percent.

In the United States, the sharpest drop in breastfeeding rates occurs between two and three months, and between three and four months for exclusive breastfeeding. This is usually when women return to work or school and need additional supports from their environment to continue breastfeeding. Studies consistently show

that full-time employment is associated with shorter periods of breastfeeding, and that the length of a mother's maternity leave is positively associated with the duration of breastfeeding. Government, child care, and workplace policies can play an important role in enabling women to achieve improved breastfeeding rates through paid leave, flexible scheduling, on-site child care, or provision of company-sponsored lactation programs that provide lactation rooms equipped with breast pumps and refrigerators.

Women enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are a special target group for breastfeeding promotion efforts. Since the inception of the New York State WIC Breastfeeding Peer Counseling Program in 1994 as a volunteer program, breastfeeding initiation among WIC recipients has doubled, demonstrating its effectiveness. In 2005, NYS WIC Program received funding from the USDA for an Enhanced Peer Counseling Program to pay peer counselors. There are now 55 peer counseling programs statewide and plans are to expand the program to all agencies in FFY 2009. The results from the first year are dramatic.

- 84 percent of women assigned a peer counselor initiated breastfeeding;
- 85 percent of women stated that the peer counselor was helpful with breastfeeding problems;
- 54 percent of women stated that contact with the peer counselor made a difference in their decision to breastfeed;
- 66 percent of women who received the services of a peer counselor plan to breastfeed beyond six months, and 33 percent beyond 12 months.

Hospitals need to be encouraged to support exclusive breastfeeding and programs must be established in the community to support continued breastfeeding once the mother returns to her home.

Extensive strategic planning work to promote breastfeeding was completed as part of the development of the NYS Strategic Plan for Overweight and Obesity Prevention, which includes a focus on breastfeeding

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promotion for the healthy physical development of children.²¹ This plan, a companion to the ECCS Plan, outlines an array of strategies to promote breastfeeding through support of breastfeeding mothers in the workplace. This important work, already underway, should be linked to the ECCS Plan to optimize the impact of both initiatives. Additional strategies to strengthen collaboration with child care providers and other family support programs around breastfeeding support practices should also be further developed.

OBJECTIVE 2: Increase the proportion of children, including children with special health care needs, who have adequate health insurance coverage and receive comprehensive health care services through a medical home.

Strategy 2.1: Establish and strengthen cross-system partnerships to increase enrollment of young children in available health insurance programs.

Recent data from a national telephone survey, based on parents' self-report, show that approximately 11.4 percent of children birth to age 5 in New York State were without health insurance at some point during the year in 2003, compared to 13.9 percent nationally.²² Among children birth to age 5 years at the time of the survey, 58.2 percent had private insurance, 38.4 percent had public insurance (Medicaid or Child Health Plus), and 3.5 percent were uninsured. Of all New York State children eligible for Medicaid, 87.5 percent were enrolled in 2001, up from 83.1 percent in 1999.²³

With the support of the Governor's Children's Cabinet and Cabinet agencies, the Department of Health is working to ensure that all children in New York have health care coverage. The plan to increase enrollment among eligible-but-uninsured children has several components at various stages of development. The components include simplifying enrollment and conducting marketing and outreach. In January and February 2008, the Department of Health implemented two important initiatives that will make it easier for families to get and keep health insurance for themselves and their children. Those enrolled in Medicaid no longer have to document their income and residency when they renew their Medicaid coverage. The state will verify continued eligibility through existing databases.

Also, children may be presumptively enrolled in Medicaid to ensure that they obtain immediate care for any medical needs prior to completing the full enrollment process. The

Community Health Centers, for whom uninsured children account for one-quarter of their clients and receive a full range of health care services, were the first qualified providers able to conduct presumptive eligibility. Other providers will be added over time.

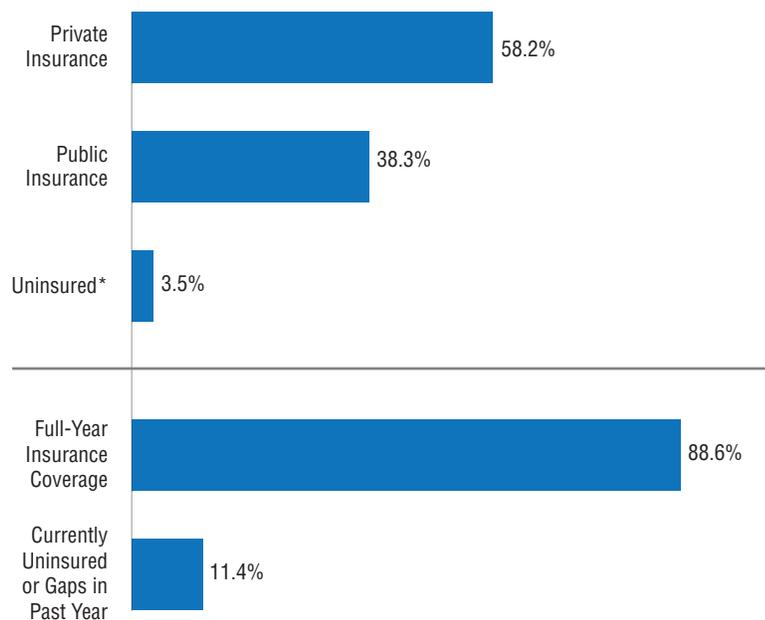
In addition, the Department of Health has engaged several national experts to help identify further opportunities for simplification of the rules governing the program and for better coordination across the three public health-insurance programs (Medicaid, Family Health Plus, and Child Health Plus). The goal is to create more accessible, consistent, and efficient public health-insurance programs.

Attesting to New York's commitment to ensuring that all children have health insurance, the 2008-09 Budget funds

the federal share of the Child Health Plus expansion to make affordable health insurance available to every child. The expansion will permit an additional 70,000 children to be eligible and enrolled in Child Health Plus. The Department of Health is working diligently to plan and implement outreach activities that will ensure that parents and caregivers are aware of the expanded eligibility requirements.

Building linkages between public health and other family service providers offers an effective and feasible approach to enrolling more children in health insurance programs. All community providers who interact with families of young children should be aware of the importance of health insurance, and should have basic

Insurance Status of Children Birth to 5 Years by Type and Coverage Level: NYS, 2003
(Source: Child and Adolescent Health Measurement Initiative, 2005a)



*Fewer than 50 respondents selected this option in the survey. Use caution interpreting this data.

Private health insurance, as defined by the U.S. Census Bureau (2005), is coverage by a health plan provided through an employer or union, or purchased by an individual from a private health insurance company. Public health insurance includes plans funded by governments at the federal, state, or local level. The major categories of public insurance are Medicare, Medicaid, the State Children's Healthy Insurance Program (S-CHIP), military health care, state plans, and the Indian Health Service. New York has two health insurance programs for children: Medicaid and Child Health Plus. These programs provide comprehensive health insurance for a wide range of children's health care and dental needs (The City of New York, 2007).

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knowledge regarding resources within their community for enrollment in public insurance programs including Facilitated Enrollment. Providers need to be aware of public health-insurance resources for children (Medicaid, Child Health Plus) and for adults (Medicaid, Medicare, Family Health Plus, and Healthy New York). Providing families with basic information and referral services for health insurance may be especially effective when conducted in settings where families are accessing other services, such as economic assistance, child care subsidies, family resource centers, or WIC nutrition services. In addition, non-traditional settings such as food banks and soup kitchens, neighborhood stores, and others should be targeted to engage hard-to-reach families. Faith-based entities also offer promise for engaging hard-to-reach families. The Office of Children and Family Services and the office of Temporary and Disability Assistance have developed a curriculum for faith and community entities to increase their awareness on how to work with government. It is important to make use of all of these strategies in identify and enrolling uninsured children.

Early care and education settings, including child care and Head Start/Early Head Start programs, and early intervention and preschool special education programs and services, have been identified as key potential partners for such a cross-systems approach.²⁴ Working with early care and education providers and with municipalities responsible for local administration of early intervention and preschool special education programs and services to enroll children in health insurance can build upon existing relationships between parents and providers, and has the efficiency of reaching families of young children in natural community settings. Additional benefits may be gained by enrolling eligible child care staff and their families in health insurance programs.

Strategy 2.2: Strengthen the capacity of community health care providers and statewide health care systems to provide high-quality, comprehensive health care services, consistent with the medical home model, for all children, including children with special health care needs.

Improving access to high-quality, comprehensive health care services for children, including children with special

health care needs, is a longstanding priority of the NYS Department of Health and a major emphasis of federal maternal child health directives. All children should receive the highest quality care that achieves the ideals of a “medical home,” the model of care that is widely endorsed as the standard for delivery of comprehensive, integrated, family-centered care for all children. Yet data from recent national studies indicate that while 95 percent of New York State children age birth to 5 have a personal health care provider, only 55.9 percent of all children birth to age 5, and only 47.5 percent of children with special health care needs birth to age 5, receive health care that meets all the criteria of the American Academy of Pediatrics definition for medical home.²⁵

Assuring delivery of the highest quality, up-to-date preventive services—including health screenings, immunizations, and health education counseling—is key to protecting and promoting the health of all children. Yet survey data indicate that nearly 8 percent of children birth to age 5 years in New York State received *no* preventive medical care visits in the previous 12 months.²⁶ Moreover, children who are uninsured or have public health insurance, who live in low income families, or who are members of racial or ethnic minority groups, were even more likely to receive no preventive medical care.

Equally important is assurance that children with chronic medical conditions receive high-quality, ongoing care in accordance with current standards to promote optimal health and life outcomes. Approximately 8.5 percent of NYS children under 5 years old have one or more special health care needs, representing over 126,000 children. Only 45.2 percent of children with special health care needs in NYS receive care that meets all the defined characteristics of a “medical home,” and one-fourth of families of children with special health care needs indicate that community service systems are not organized for ease of use by families. Again, children who are uninsured or have public health insurance, who live in low income families, or who are members of racial or ethnic minority groups fare even worse on these key measures.

Improving capacity at both provider practice and systems levels is key to successful implementation of the medical home model.²⁷ While increasing basic awareness and

knowledge of medical home among both families and providers is an important initial step, effective strategies for changing practice also must address relevant attitudes, skills, and competencies of providers, in conjunction with changes in policy and health care systems. There are a number of promising approaches to improving quality of care, including learning collaboratives and other practice-based models for developing, implementing, and evaluating incremental quality improvement changes in medical practices.

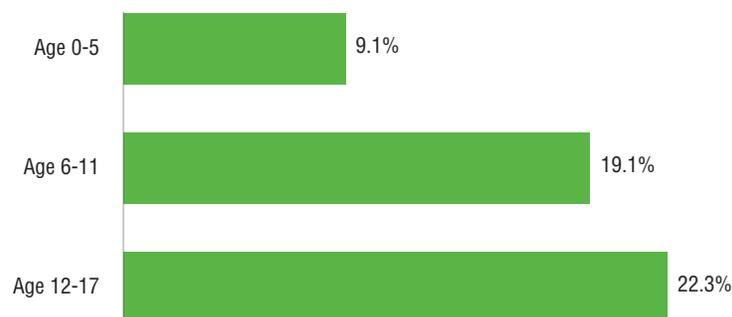
However, widespread and consistent implementation of such intensive quality improvement models in a state as large and diverse as New York—with more than 22,000 pediatric health care providers and huge geographic, cultural, and economic diversity, as well as multiple programs and service systems—is a significant challenge. Infrastructure and experience is needed at state, regional, community and clinical practice levels to support identification and prioritization of children’s health needs, provision of ongoing education and technical assistance for community health care providers, development and dissemination of effective and feasible clinical quality-improvement tools, and coordination and financing of services for children with special health care needs. A multi-level approach to improving child health is needed to connect state level policies and public health programs and resources with community practitioners and families. Our current approach to delivering preventive care and meeting the special health needs of children with chronic medical conditions must evolve from one of individualized gap-filling services to one that focuses on

building infrastructure and systems for prevention, quality improvement, and coordination of care.

Under the leadership of the Department of Health and many partner organizations, an array of program-specific and time-limited activities have been implemented to improve children’s health care, including preventive health practices (such as immunizations and health education), early identification (such as screening for lead poisoning and developmental delays) and management of chronic health conditions (such as asthma, diabetes, and obesity). New York also has several longstanding programs to provide information, referral, financial support, and other gap-filling and supportive services to children with special health care needs and their families, including: Children with Special Health Care Needs program grants to local health departments to provide information and referral services for families; gap-filling financial supports for families to support diagnosis, evaluation and treatment of health needs through the Physically Handicapped Children’s Program; establishment and implementation of standards for specialty centers to follow up, diagnose, and treat infants with positive newborn screening tests and other specific health conditions, and Early Intervention Program services to enhance the development of infants and toddlers with disabilities and/or developmental delays, and the capacity of families to meet their children’s special needs.

However, there are important gaps in the consistency and adequacy of some services statewide, such as payment for

Children with Special Health Care Needs by Age: NYS, 2003
 (Source: Child and Adolescent Health Measurement Initiative, 2005a)



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gap-filling services, provision of care coordination, and performance of pediatric quality improvement. Additional system-building activities are needed to expand and integrate these activities to create a more effective, efficient, and durable approach for improving children's health. Improved state-level coordination in policy and program work and a stronger regional infrastructure are needed to better serve families and support community health care providers in delivering the highest quality care to children, to disseminate state-level policy and program resources to community health care practices, and to provide feedback to the state level from families and providers.

To help accomplish these goals, for the past two years, the NYS Department of Health Title V (Maternal Child Health) Program has received competitive grant funding from the federal Maternal Child Health Bureau. Examples of initial grant-related projects include completion of a quality improvement collaborative related to developmental screening in pediatric practices, development of a new portable health summary tool and other consumer information resources for families of children with special health care needs, implementation of policies to support expanded access to follow-up specialty care for children with positive newborn screening results, development of a funding proposal to improve regional infrastructure for child health improvement, and participation in a national learning collaborative to improve access to care for children with epilepsy, with meaningful family participation in all activities.

Building on all of this important work, additional systems-building is needed to simultaneously expand and streamline these programs and activities, while better integrating them with other child health improvement strategies that focus beyond the traditional "children with special health care needs" population and program models. The Department of Health and its partner organizations will apply the lessons learned and experience gained from the systems-building and quality-improvement strategies conducted to date to develop and implement health promotion strategies for all children, with an emphasis on the early years as a public priority.

OBJECTIVE 3: Increase the capacity of early care and education, child welfare, health care, family service, and mental health providers to promote children's social-emotional development, prevent mental health problems in children and families, and intervene with children and families who are affected by mental health disorders.

Strategy 3.1: Raise awareness of the importance of promoting social-emotional development and positive mental health in young children among the public, professionals, and policymakers through implementation of The Children's Plan.

Early childhood mental health is the social, emotional, and behavioral well-being of children birth through age 5 and their families, including developing the capacity to experience, regulate, and express emotion; form close, secure relationships; and explore the environment and learn. Factors that influence early childhood mental health include the characteristics of the young child; the quality of the adult relationships in the child's life; the child's care-giving environment(s); and the community context in which the child and family live.²⁸ The Zero to Three Policy Center recommends that infant and early mental health be integrated into all child-related services and systems.²⁹

Social-emotional development involves progressive change in the way that children relate to their social world and their ability to differentiate and express emotions and perceive emotional states of other individuals. Social development refers to relating to others; the degree and quality of a child's relationships with parents and caregivers; feelings about self; and, social adjustment to a variety of interactions over time. Emotions reflect an individual's attempt or readiness to establish, maintain, or change the relationship between self and the physical and social environment. Emotions become more differentiated as children develop, and children's strategies for

regulating their emotions and behaviors change over time.

Developing social and emotional skills and competencies are critical to children’s success in school and in life. The early relationship experiences that infants and young children have with parents and/or caregivers form the basis for all later relationships.³⁰ During the early years, children primarily interact with their family, caregivers, and limited numbers of peers. These relationships play an important role in fostering children’s social-emotional development. Secure relationships with parents and other caregivers afford children a sense of well-being, and allow children to explore their physical and social environments, and make the most of learning opportunities.³¹ On a national level there is much emphasis on the goal of ensuring that children are “ready for school.” If children do not achieve early social and emotional milestones, they will not do well in the early school years. They are also at higher risk for school problems and juvenile delinquency later in life.^{32,33}

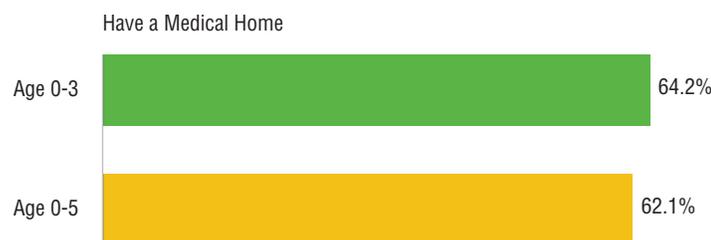
Through the leadership of the Office of Mental Health and multiple state agencies and stakeholder perspectives, including direction from the State Education Department, The Children’s Plan has been developed. This plan provides concrete steps for raising the awareness of social-emotional/mental health needs of young children and their families. However, more needs to be done before a system of supports and services is available to meet these needs, and this will require greater public awareness efforts.

Strategy 3.2: Build capacity in all child-serving systems to prevent mental health problems by identifying and responding to the social-emotional and mental health needs of young children and their families.

The U.S. Department of Health and Human Services 1999 report, *Mental Health: A Report of the Surgeon General*, in its chapter “Children and Mental Health,” describes several guiding assumptions that underpin the current understanding of children’s mental health and illness. The basic tenets are based on the “premise that psychopathology in childhood arises from the complex, multilayered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school and community factors, and the larger social cultural context), and the specific manner in which these factors interact with and shape each other over the course of development.”

Other key principles identified in the Surgeon General’s report as necessary to understanding children’s mental health and illness include: understanding the innate tendencies of the child to adapt to his or her environment (some, but not all, pathological behavioral syndromes may be adaptive responses to difficult or adverse circumstances); the importance of age and timing factors (a behavior that might be quite normal at one age can be a symptom or indicator of mental illness at another age); the importance of the child’s context (particularly his or her caretaking environment); and, understanding that normal and abnormal developmental processes are often separated only by differences of degree (differences

Children Birth to 5 Years Receiving Health Care Within a Medical Home: NYS, 2003
 (Source: Child and Adolescent Health Measurement Initiative, 2005)



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between normal and abnormal behavior may be better understood by accounting for differences in amount or degree of a particular behavior, or the degree of exposure to a particular risk factor).³⁴

Among the 12 conclusions drawn about children's mental health in this report, two are especially pertinent to systems that provide services to young children and their families:

- Mental health problems appear in families of all social classes and all backgrounds; however, there are children who are at greatest risk by virtue of a broad array of factors, including physical problems; intellectual disabilities; low birth weight; in-utero alcohol exposure; family history of mental and addictive disorders; multi-generational poverty; and caregiver separation or abuse and neglect.
- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social-emotional development. Examples of effective preventive strategies include educational programs for young children, parenting education programs, and home visiting programs.

The Children's Plan calls for a series of recommendations aimed at building capacity for promoting the social and emotional well-being of young children and their families and preventing the development of mental health challenges. Two key recommendations focus on the need to enhance capacity within the child-serving systems and within communities, particularly communities of color where services to address mental health issues are often lacking or are unresponsive to cultural beliefs and differences or the trauma caused by life within impoverished areas. They include incorporating social emotional development and learning concepts into early learning educator and teacher preparation and continuing education; and educating and training caring adults (e.g., parents, caregivers, early childhood teaching assistants, paraprofessionals, support staff) on the normal developmental milestones (e.g., trust, autonomy, separation/individuation) and other knowledge, skills, and supports necessary to nurture child and youth health, safety, and positive emotional, social, and cognitive growth and development.

The challenge is to build this capacity collaboratively and successfully across systems of care, in families and in communities so that:

- Young children develop the competencies needed for success in school and life.
- Children and youth are nurtured and encouraged to become contributing members of their schools, homes and larger communities.
- Families are supported in their abilities to enhance their children's social emotional development and learning.
- Early education educators, school administrators, teachers, student support services, and support staff develop the professional competencies necessary for promoting each child's social and emotional well-being.
- Community groups partner with early learning settings and schools to affect the lives of young children, school-age children, and youth³⁵.

Strategy 3.3: Develop and implement a comprehensive and integrated approach to identify and intervene with children and families affected by mental health disorders.

There is growing concern among parents, early care and education providers, early interventionists, and other early childhood providers about social-emotional problems, challenging behaviors, and mental health needs among young children. A recent national study found that young children are expelled from preschool settings at three times the rate of children in kindergarten through 12th grade.³⁶ Particularly troubling is that the rate of expulsion from preschool, just as the rate of expulsion from K-12, is significantly higher for minority children. Data from the National Survey of Children's Health demonstrate that parents report 7.6 percent of children age 3 to 5 years in NYS have moderate or severe difficulty in at least one of the areas of emotions, concentration, behavior, or ability to get along with others.³⁷

Research indicates that early detection and intervention can interrupt the negative course of some mental illnesses and in some cases may lessen long-term disability associated with mental health disorders.³⁸ For young

children, assessments and interventions must occur in the context of family and other caregivers. One of the many factors that can affect the mental health of young children is the mental health status of their parents. For example, depression among young mothers has been shown to influence the mental health of their young children. Conditions like maternal depression, anxiety disorders, bipolar disorders, alcoholism, etc., can result in parents being less able to provide stimulation and parent-child relationships that are developmentally appropriate. Further, infants of mothers who are clinically depressed often withdraw, and this can affect their language, physical, and cognitive development. Older children whose mothers are depressed demonstrate poor self-control, aggression, poor peer relationships, and school difficulties.

The 1999 Surgeon General's report concludes that a range of efficacious psychosocial and pharmacologic treatments exist for many mental disorders in children, including for those mental disorders that can be identified in young children (such as attention-deficit hyperactivity disorder, depression, pervasive developmental disorders, etc.). The report also concludes that primary care and educational programs are important settings for the potential recognition of mental disorders in children, but trained staff and options for referral to specialty care can be a barrier to care. Further, the multiple problems associated with mental health disorders are best addressed with a systems approach in which multiple service sectors work in an organized collaborative way and where families are essential partners in the delivery of mental health services for children.¹⁸

The Office of Mental Health, through its *Achieving the Promise for New York's Children and Families* initiative and The Children's Plan, strives to achieve statewide transformation in children's mental health services through the implementation of a comprehensive strategy (i.e., Child and Family Clinic Plus) of early recognition, early intervention, improved access, evidence-based treatment, and in-home services and supports for families. Decades of research support that mental health problems can be recognized as early as preschool; scientifically validated tools for early recognition exist; and there is a range of effective intervention programs with a strong

scientific base. *Achieving the Promise* offers an important opportunity to focus on the mental health needs of young children and their families. Moreover, The Children's Plan broadens *Achieving the Promise* through the recognition that investments in the social emotional well-being and mental health of young children when there is "a critical window of opportunity"³⁹ yields successes and avoids long-term and costly failures.

OBJECTIVE 4: Provide children with safe and healthy environments in which to grow and develop.

Strategy 4.1: Support efforts to eliminate childhood lead poisoning in New York State.

Lead is the leading environmental poison of young children in New York State. Lead poisoning is associated with serious and lifelong negative health, developmental, and cognitive outcomes—including reduced IQ, learning and behavior problems, and criminal activities—that are completely preventable. Although lead exposure may be harmful for people of any age, young children are most likely to be exposed to lead and are most vulnerable to its harmful effects due to their normal hand-to-mouth exploratory behavior and developing brains. The majority of children with lead poisoning are exposed to lead from deteriorating lead paint and lead dust in their homes. New York State has the largest number and percent of pre-1950 housing of all states in the nation. Additional sources of lead exposure may include lead-contaminated soil, imported food, pottery and cosmetics, traditional medicines, and some imported children's toys and jewelry. Children may also be exposed to lead if their parents or guardians have occupations or hobbies that expose them to lead.

Under current NYS Public Health Law and regulations, health care providers are required to screen all children using blood lead tests at or around age 1 year and again at or around age 2 years, and to test all children at risk for lead exposure at least annually up to the age of 6 years. Early identification of children with elevated blood lead

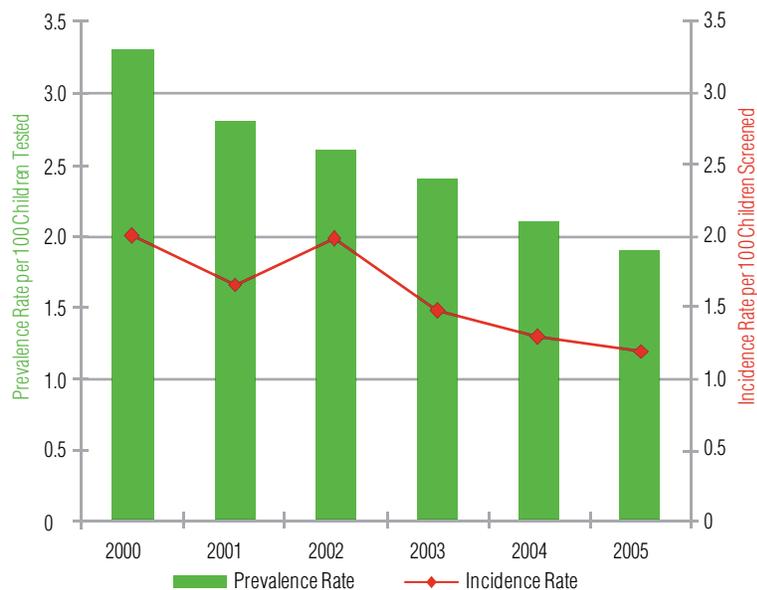
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levels through routine blood lead screening is essential to assure coordination of medical, educational, and environmental follow-up services to minimize harmful effects and prevent further exposure to lead. However, because medical treatment options for lead poisoning are limited, it is critical that children be protected from lead exposure in their environments through primary prevention strategies *before* they become lead poisoned.

New York has made significant progress towards reducing both the incidence and severity of childhood lead poisoning, as defined by the Centers for Disease Control and prevention (CDC) as a blood lead level ≥ 10 mcg/dL. Despite this success, childhood lead poisoning remains a serious public health problem, with nearly 5,000 children diagnosed with new cases of lead poisoning each year. Lead poisoning disproportionately affects socio-economically disadvantaged and minority children, and there is evidence that these children may be even more vulnerable to lead's harmful effects. Moreover, a growing body of scientific evidence emphasizes that there is no threshold for the harmful effects of lead, with blood lead levels below 10 mcg/dL associated with learning and behavior problems, including reduced IQ.

New York State is committed to achieving the goal of eliminating childhood lead poisoning by the year 2010 as an essential step to improving the lives of children and families in New York State. Achieving elimination of childhood lead poisoning requires a multi-pronged public health approach that combines universal and targeted primary and secondary interventions and strategic partnerships with a wide range of programs, agencies, and organizations at the state and community levels. As part of this effort, Governor Paterson recently signed into law the Children's Product Safety and Recall Effectiveness Act, which will help ensure that toys that include lead will not reach the hands of children in New York State. Extensive and ongoing strategic planning has occurred as part of the development and implementation of the NYS Strategic Plan for Elimination of Childhood Lead Poisoning and New York City Plan to Eliminate Childhood Lead Poisoning.⁴⁰ These plans, as companions to the ECCS Plan, outline an array of objectives and strategies to eliminate lead poisoning that should be linked to the Early Childhood Comprehensive Systems Plan to optimize the impact of both initiatives.

Prevalence and Incidence Rates of Children Under 6 years Identified With Elevated Blood Lead Levels ($> 10\mu\text{g}/\text{dL}$): NYS Excluding NYC, 2000 to 2005
(Source: Bureau of Child and Adolescent Health, 2007)



Strategy 4.2 Strengthen and expand current efforts to promote health and safety in early care and education settings through further development and implementation of standards, training and education, and consultation activities.

The federal Maternal and Child Health Bureau, as part of its national Healthy Child Care America initiative, has outlined three essential approaches for promoting the health and safety of young children in early care and education settings:

- Assuring quality through standards;
- Building infrastructure through the development of a network of health consultants; and
- Improving access to medical homes and health insurance through early care and education providers.⁴¹

These approaches are consistent with the recommendations of a study conducted for the Robert Wood Johnson Foundation, which identified effective strategies for linking child care and health systems. They include directly providing preventive health services and development screenings within child care settings; delivering education to parents and child care providers on child health, safety, and development; and using child care centers as an access point for enrolling children in health insurance.⁴² (See Strategy 2.1 for additional detail on health insurance).

New York State has strong systems in place to assure health and safety in child care, and upon which to build additional health and safety promotion activities in early care and education settings. Under the oversight of the NYS Office of Children and Family Services, current regulations and licensing requirements provide important standards for assurance across the broadest range of health assurance and disease prevention issues, from immunization to nutrition to environmental health to areas such as active play and the control of infectious diseases.

All new family-based child care providers are required to successfully complete comprehensive competency-based training on health and safety practices and standards as a prerequisite for licensure. A state certified health

and safety trainer must provide training. All providers are also required to have an approved health plan which covers a broad scope of health promotion and disease and infection prevention.

Regulations enacted in 2005 require child care providers who administer medication either to have the authority to administer medication through a professional license or complete an approved training that includes best practice techniques for the administration of reliever or rescue medications. Under these regulations, child care providers also are required to have a health care consultant who reviews and approves the child care program's health care plan. The Medication Administration Training is only available through a certified network of health care professionals (registered nurses and nurse practitioners) that have been approved to offer this training. Training is available in multiple languages and in every county in New York State.

To make health care consultants more readily available, the Office of Children and Family Services has provided funding to its statewide network of child care resource and referral agencies to add health care consultancy to the required core services provided by the agency. More than 3,200 programs have an active agreement with a health care consultant. More than 1,000 registered nurses, physicians, physician's assistants, and nurse practitioners are currently active as health care consultants to one or more of these programs.

In addition, each year the Office of Children and Family Services provides grants to programs to make the changes needed to meet health and safety regulations. Funds are available to all modalities of care. The Office of Children and Family Services also supports a video teleconference training network that maximizes the ability to reach the regulated child care community with high-quality training. Health and safety issues are a regular focus of training.

The Office of Children and Family Services collaborates extensively with the NYS Department of Health to ensure the health and safety of children in child care settings. As a key example, through this collaboration New York State has maximized resources under the Child and Adult Care Food Program (CACFP) to optimize the nutrition of children in child care. CACFP serves more than

Goal 1: Healthy Children

158,000 children birth through age 5 in New York State and sets minimum nutrition standards for meals served in child care settings. Participating programs receive cash reimbursement for the meals and snacks that meet specific menu guidelines. Research has documented that CACFP-participating programs are more likely to serve low-fat milk and vegetables, and less likely to serve fats and sweets^{43,44} The quality of the meals and snacks served in CACFP-participating child care programs is especially significant because 81 percent of young children served by New York CACFP live in very low-income households, defined as those with a family income at or below 130 percent of the federal poverty level.⁴⁵

CACFP has implemented several obesity prevention efforts in participating child care centers, including *Eat Well Play Hard in Child Care Settings*, which promotes targeted dietary and physical activity practices for young children through interactive lessons and demonstrations with staff, parents, and children in child care settings. During FFY 2009, NY CACFP expects to expand this effort to low-income family day care home providers and the children and families that they serve.

Four percent of infants and toddlers, birth to age 3 years, and nearly 8 percent of preschool children age 3 to 5 years, participate in early intervention and preschool special education programs and services, respectively. The Federal IDEA requires that early intervention services be provided in natural environments (settings that are natural or normal for the child's age peers who have no disability) to the maximum extent appropriate to infants and toddlers, and in the least restrictive setting for preschoolers.⁴⁶

Although the vast majority of early intervention services are delivered in home settings, many families with young children with disabilities also rely on and need access to licensed child care providers to care for their infants, toddlers, and preschoolers while they work. Early care and education providers need access to training, technical assistance, and consultation to assist them in providing a healthy and safe environment for young children with disabilities and special health care needs.

In addition, many infants, toddlers, and preschoolers receive early intervention or preschool special education programs and services on-site in an approved early

intervention or preschool special education program facility. While many early intervention and preschool special education provider sites are also licensed child care providers, there are providers of services in both arenas (including group/classroom services) that are not subject to child care licensing laws and regulations. Health and safety standards and monitoring protocols have recently been issued by the Department of Health for the early intervention program to ensure the health and safety of children who receive early intervention services in these settings. These standards were primarily based on the OCFS standards for child care providers.

Finally, some early childhood providers are authorized by multiple state agencies to provide services. Interagency efforts are needed to reach agreement on the health and safety standards that apply to early childhood providers under the authority of multiple state agencies, and delineate clear lines of authority for monitoring these early childhood providers.

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Goal 2: Strong Families

In this plan, families are defined in the broadest possible terms as any combination of two or more persons who are bound together over time by ties of mutual consent, birth, and/or adoption or placement. This inclusive definition of family emphasizes not only what families look like, but equally what they do in assuming responsibility for care, socialization, and support of one another. It is a definition that acknowledges and respects heterosexual and same-sex couples; lone-parent families; extended patterns of kinship, step-families, and blended families; couples with children and those without.

There can be no doubt about the important role that families play in a child's early life, and that they are the foremost influence on development. Children's health, development, and overall well-being are inextricably linked to the ongoing support and nurturing they receive from parents, and, in turn, the protection of strong and stable family relationships. Thus, the presence of strong families that provide consistent and supportive relationships is a vital element in the healthy development of children.

By age 5, most children should have acquired the fundamental skills critical for school readiness and future developmental success. Essential to this foundation is the interrelationship between family, community, and state-level support systems. While families provide the basis for healthy development, the support and positive reinforcement that external elements can provide enable parents and families to build and maintain a secure, nurturing, and learning environment for their children.

Although more marked among the poor, changing family structure is a trend that cuts across class, race, and religion.¹ Over the last four decades, the number and proportion of children born outside of marriage, coupled with a rise in divorce rates, has resulted in a significant increase in children being raised in single-parent households. Cohabitation of unmarried couples and stepparent families has also increased, and grandparents raise a growing number of children. Data from the 2000 census show that in New York State, 143,014 grandparents lived with and were responsible for the care of their

grandchildren ages birth to 18. The majority of these grandparents (89.9 percent) cared for their children for one year or more.² Nationwide, same-gender unmarried partners are living in nearly every county in the United States, and nearly one-quarter of these same-gender

Outcomes

- Families have adequate and stable employment and income so that their basic needs (food, shelter, and clothing) are met.
- Families have the knowledge, skills, confidence, and social supports to nurture the health, safety, and positive development of children.
- Families whose children experience delays or disabilities that affect development and functioning have the knowledge, skills, and supports needed to enhance their development
- Parents' special needs are recognized and supported, including health, mental health and substance abuse.
- Families are empowered to seek, use, and actively participate in supportive services.
- Families provide children with safe and healthy environments free from abuse, neglect, and domestic violence.
- Families provide children with positive, nurturing, consistent relationships.



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couples are raising children.³

Concern for children’s well-being has spawned a growing body of research regarding the effects of family structure on the development and overall well-being of children. While our knowledge in this area has grown dramatically, there is still much more to be learned. Research is complicated by the strong interrelationship between family structure and poverty, by the dynamic nature of family structure over children’s lifetimes (i.e., children experiencing more than one type of living arrangement over the course of their childhood), by the use of varied definitions of family across studies, and by the many unique characteristics of families that may contribute to their success.

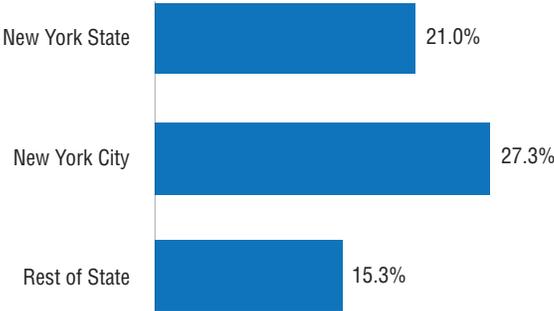
Overall, most researchers agree that the current body of knowledge supports the premise that children are most successful when raised by their two married, biological (or adoptive) parents who have low-conflict relationships.⁴ It is clear that there are objective benefits to marriage that have an impact upon children, such as increased access to health insurance and tax advantages. However, it is also clear that the *quality* of that marriage, or any two-parent committed relationship, whether biological or not, matters tremendously. A low-conflict, financially responsible, and cooperative two-parent home has been shown to have the most positive impact on the overall development and well-being of children.

Positive developmental interactions with parents and family members have the ability to improve young children’s social competencies and their overall capacity to learn. For many families, the realization of healthy outcomes is challenged by the presence of numerous financial, physical, or emotional stresses. All families need the basic knowledge, skills, and support to raise and nurture children. Parenting education can provide parents with the specific knowledge, child-rearing skills, and confidence that are necessary to create a healthy and learning environment for their child. Similarly, family support options help families to meet their basic needs for materials and social support, which, in turn, foster the provision of a richer environment for children to grow and learn.

Children’s development is affected by the health and well-being of their parents, and when financial and emotional stresses act on parents, it can adversely affect the relationship parents have with their children and with each other. Therefore, access to comprehensive and coordinated services for parents’ own special needs, including health, mental health, and substance abuse, are equally important for a strong family.

Vulnerable families are those that face obstacles that surpass the normal stressors of raising young children. These obstacles come in numerous forms—from having children with special health care needs, to living in

Children Birth to 5 Years Living in Households with Incomes Below the Poverty Level: New York State, New York City, and Rest of State, 2005
(Source: 2005 American Community Survey, 2007a)



poverty, experiencing malnourishment, being recent immigrants or illegal aliens, having parental low-literacy levels, mental health needs, or drug and alcohol addictions. In these families, the need for parental support and strong, comprehensive, and integrated systems is magnified. Children in vulnerable families require a level of attention and care above the norm and they often face larger and more numerous hurdles than other children. For example, children living in families where a parent has a mental illness or a drug addiction typically require and access more health care services—both highly specialized and ancillary services. The additional challenges that these and other needs create for families have the potential to be enormous. Figure 1 (Page 31) illustrates a framework for considering a multidimensional approach to supporting the diverse needs of families, including both universal and targeted services.

New York State provides a comprehensive package of income supports for families. New York is a national leader in collecting child support from non-custodial parents. In 2007, the state collected more than \$1.6 billion for children and their custodial parents. The state provides one of the nation's most generous Earned Income Tax Credits, in addition to the federal credit, and also offers a state child care tax credit. New York's public health-insurance programs guarantee that all children in the state have access to health insurance. In addition, the state's Family Health Plus and Healthy New York programs offer low cost insurance to millions of low-income New Yorkers who are not eligible for Medicaid or Medicare and do not have employer-sponsored health insurance.

The Office of Temporary and Disability Assistance has created a website called "Resources for Working Families" (www.otda.state.ny.us) to assist working families in accessing comprehensive economic work supports. In addition to information about OTDA-administered benefits such as food stamps and the Home Energy Assistance Program (HEAP), this website includes information about accessing health insurance, child care, tax preparation assistance, unemployment insurance benefits, and veterans' benefits. OTDA continues to expand and refine this vital source of information for

working families. To further expand and facilitate access to needed benefits, OTDA has created a single Internet portal to allow pre-screening and online applications for multiple public benefits. The website portal is called *myBenefits* (www.myBenefits.ny.gov). A pre-screening tool for food stamps, EITC, and school meals, and an on-line food stamp application were the first programs available; additional pre-screening tools and on-line applications will become available through *myBenefits*.

Goal 2: Strong Families

OBJECTIVE 5: Increase opportunities for all families to gain the knowledge, skills, confidence, and social supports needed to nurture the health, safety, and positive development of children.

Strategy 5.1: Increase the availability, quality, and scope of parenting education activities.

Parenting education presents an opportunity to optimize how parents interact with their children. Parenting education is intended to increase parents' knowledge of how their actions affect their child's development and to increase parental skills to aid in their child's healthy development and school readiness.⁵ The Commonwealth Fund's Survey of Parents with Young Children,⁶ which is the first nationally representative survey of parents with children from birth to age 3 to focus on factors shown by research to be important in determining child health and developmental outcomes, shows that parents have a strong desire to learn more about parenting. Findings from this survey show that parents are eager for information on child-rearing, especially from their primary health care provider, yet they do not access classes to prepare them for parenting and thus are missing out on opportunities to stimulate their infant's brain development.²³

Evidence-based parenting education, both community and state-based, can benefit all parents; however, certain populations may experience an even greater positive outcome from this type of service, including teen parents, parents of children with special health care needs, foster parents, grandparents raising children, and single fathers. Just as each of these populations may need tailored information, it is crucial to understand that all parents may not access this education in the same manner. Thus, providing parenting education in consumer-friendly formats in both school and community settings can provide family life skills and parenting education and address parents' needs for education and support on several levels.

The New York State Parenting Education partnership has been established to strengthen and expand parenting education in New York State. A collaborative of parenting educators, parents, representatives of state agencies, public education, early care and education programs, and others, the Partnership is seeking to normalize obtaining parenting education, promote its availability, and improve the quality of services, among other activities. The Partnership is developing strategies for ensuring that parenting education programs are informed by current research on effective parenting approaches and for supporting the use of evidenced-based practices.

Strategy 5.2: Support youth as they develop into their future role as adults and potential parents.

Youth development, as an extension of parenting education, functions to address the needs of adolescents as current or future parents. Youth development employs an asset-based approach defined by several points. It acknowledges that the prevention of negative risk behaviors alone is limited in its ability to facilitate a successful transition from adolescence to adulthood; it recognizes that youth require developmental supports and opportunities to gain the necessary skills and attributes to be healthy and contributing members of society; it values the role of youth-adult relationships as a strategy to encourage positive development; and it involves youth in authentic leadership and decision-making capacities in order to enhance psychosocial development, civic engagement, and positive attitudes.⁸

Due to positive findings regarding youth development, and specifically its use in the prevention of adolescent pregnancies,⁹ the ECCS workgroup emphasized the importance of youth development as a model to prepare youth for their future role as parents. The goal is to create environments rich in supports and opportunities that foster youth self-esteem and asset-building. Some principles of these education/motivation programs are:

- Promote development of intrapersonal and interpersonal skills that create a sense of dignity, self-worth, and community connectedness.
- Teach youth to recognize inner values and have a healthy respect for others' values.

- Teach taking responsibility for and understanding the consequences of one's own behavior.
- Teach communication, decision-making, and refusal skills necessary to choose healthy behaviors consistent with family and community values.
- Encourage youth to develop and maintain healthy, respectful relationships and avoid abusive or manipulative ones.
- Encourage community support and reinforcement of key messages by adults, i.e., mentoring programs.
- Provide supports necessary for optimal educational achievements.
- Provide community-wide support for parental educational opportunities and parent/youth communication skills building.

New York State has a solid foundation of programs supporting youth development including those funded by the Office of Children and Family Services (e.g., Youth Development and Delinquency Prevention, Advantage Afterschool programs), Office of Substance Abuse Services (e.g., Coalition Development), Department of Health (e.g., Act for Youth, Adolescent Pregnancy and

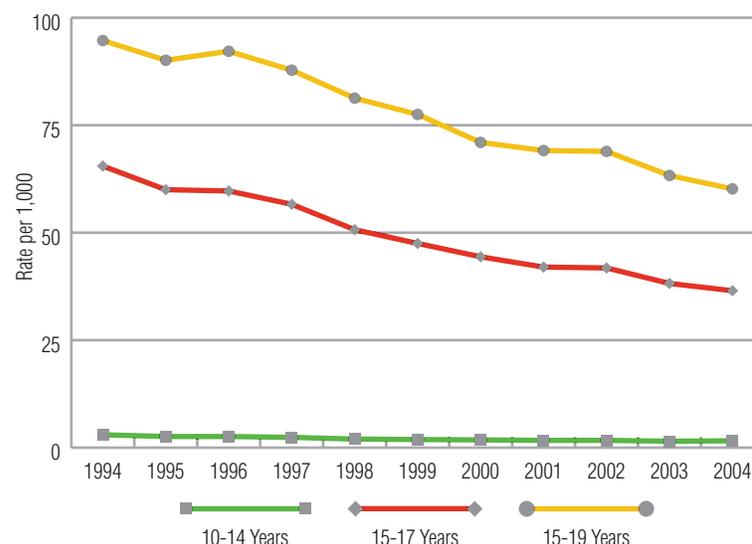
Preventive Services), State Education Department (e.g., 21st Century Community Learning Centers) that can be built upon to prepare youth for their eventual role as parents.

Strategy 5.3 Establish an interagency workgroup to support father involvement in the lives of their children.

In New York State, a new initiative called *Strengthening Families Through Stronger Fathers* creates incentives for non-custodial parents, who are most often fathers, to increase their earnings, payment of child support, and involvement in their children's lives. The basis of this initiative stems from the idea that being unable to provide financial support may limit father-child interaction in the short run and hinder child development in the long run.

The initiative offers a tax credit for low wage workers in the form of an enhanced state earned-income tax credit. Earned-income tax credits have been one of the largest efforts in helping numerous families move off of welfare and into the workforce. The initiative offers this benefit to a group of New Yorkers who have not been previously eligible—men not living with their children. By allowing low-wage non-custodial parents at least 18 years of age to claim an earned income tax credit if they

Adolescent Pregnancy by Age: NYS, 1994 to 2004
(Source: Kids' Well-being Indicators Clearinghouse, 2006)



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are current in their child support payments, an important incentive is provided to get more young men connected to their children and complying with child support orders. This initiative is a multifaceted approach to working with non-custodial parents in an effort to increase parental involvement. Other components of the initiative include a pilot program in five locations to impart employment and related services, including parenting education, job training and placement, and other family-member services to low-income non-custodial parents (predominantly fathers).

However, becoming a responsible, engaged, and accessible father does not end with a child support payment.

Father presence is an important component for a child's healthy development. Regardless of what role a father plays in a child's life, any role is better than none. To support statewide efforts to involve fathers in the lives of their children, the Office of Temporary and Disability Assistance and the Office of Children and Family Services have established an interagency workgroup to ensure the successful implementation of the *Strengthening Families Through Stronger Fathers* initiative and to develop and implement other strategies for increasing father involvement. Such strategies will look at innovative ways for connecting fathers with their children, including efforts aimed at specific populations such as incarcerated fathers.

The workgroup is charged with expanding the current work the two agencies are doing and identifying opportunities to put a "fathers count" message into programs and policies. Current efforts include expanding current mentoring programs for at-risk children to include mentoring/parenting training of young men in residential programs and Office of Children and Family Services facilities; using the curriculum designed by Office of Children and Family Services for the Engaging Fathers Toolkit to expand the current training capacity; and better coordinating outreach efforts to reach a broader population. A fall fatherhood conference is being planned.

Strategy 5.4 Improve coordination and access to community-based family supports and services.

All communities should provide families with places where families can come together and talk and play with other families and receive both formal and informal

education and services from trained staff. At various times, most families will require supports or services to help them deal with a problem or prevent a problem from occurring. Often the services needed do not have to be formal or intensive. In many cases, simple advice, assurance or an opportunity to interact with other families in a supportive environment is all a family needs to address a problem or concern. New York State has a wide range of supports and services available to meet families' needs. However, the supports and services, as well as the provider organizations, vary from community to community. Consequently, it is often difficult for families to locate the assistance they need.

There are several existing statewide resources that New York State can build on to make family supports and services more accessible to families. These include:

Family Resource Centers—Family Resource Centers provide a single location offering essential supports and services. Since its creation in 1984, the NYS Children and Family Trust Fund has promoted the family resource center as an effective strategy for supporting and strengthening families. The creation of a network of centers began in 1995, and currently the Trust Fund supports 22 centers statewide. Family resource centers are places in a community where all families can come to talk and play with other families, and to receive both formal and informal education and services from trained staff. By design, family resource centers offer culturally competent community-based services for all families, emphasizing education and social support in informal settings to promote positive parenting, healthy child development, and family self-sufficiency.

One Stop Centers—Supported by the Department of Labor, One-Stop Centers provide people looking for employment a single location to obtain job training, job-seeking skills, information on educational programs, and a full range of support services for individuals and their families.

Literacy Zones—Supported by the Departments of Education, Literacy Zones provide a range of supports and services to help parents and other adults to obtain the skills they need to find and maintain employment. In addition

to job training and referral services, these programs provide family literacy, adult education, GED preparation, assistance finding child care, and other services.

Other community organizations—Other community based organizations including neighborhood/settlement houses, Early Head Start and Head Start programs, home visiting programs such as Healthy Families New York, Nurse Family Partnership, and Parent Child Home Program, libraries, Schools for the 21st Century—provide a range of supports and services for families across the state. Faith-based and community entities are also an important resource for serving families. The Office of Children and Family Services and the Office of Temporary and Disability Assistance have developed a curriculum for faith and community entities to increase their awareness on how to work with government. These are important resources in identifying and serving particularly hard-to-reach families.

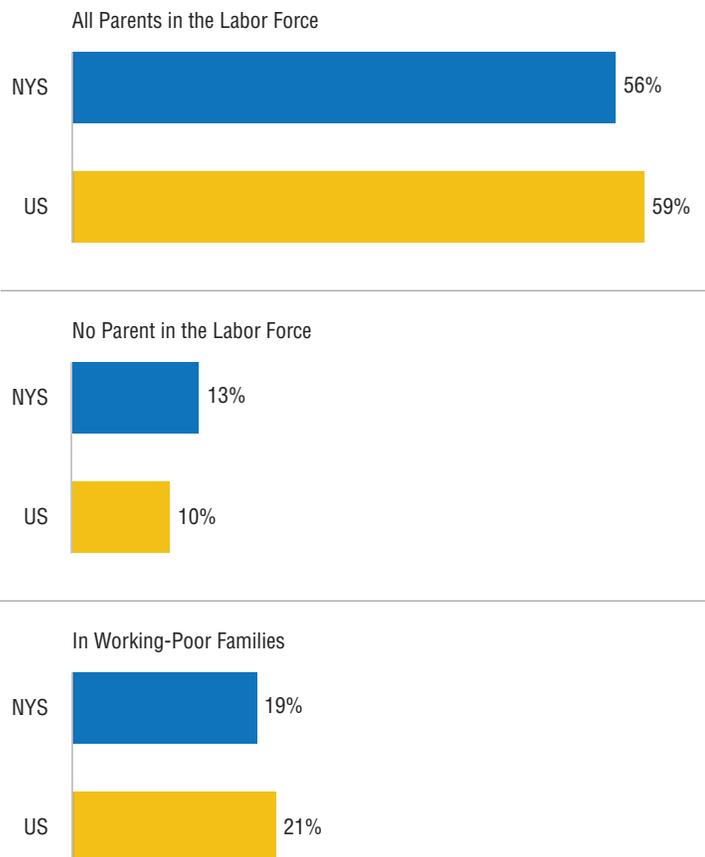
New York State needs to build on these and other resources to ensure that families have easy access to the range of supports and services they need.

Strategy 5.5: Support community efforts to help families develop protective factors that serve to prevent child abuse and neglect.

High-quality family support programs (i.e., family resource centers, early care and education programs, parenting education providers) actively develop supportive relationships with families. These relationships are important because staff of family support programs can become an important source of support for families. These relationships can benefit families in several ways including:

- Establishing intimate and trusting relationships with families that allow them to share concerns and hopes for their children;

Parental Employment Status of Children Under 6 Years: US and NYS, 2004
(Source: The Annie E. Casey Foundation, 2006)



Goal 2: Strong Families

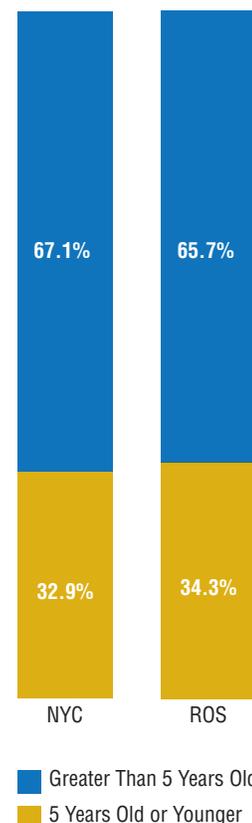
- Providing parents with encouragement and education;
- Serving as an early warning and response system allowing for interventions before problems occur or get worse; and
- Building resiliency in children.¹⁰

Recent research has identified several protective factors that, when present in families, reduce the likelihood of child abuse and neglect and other problems. These protective factors include:

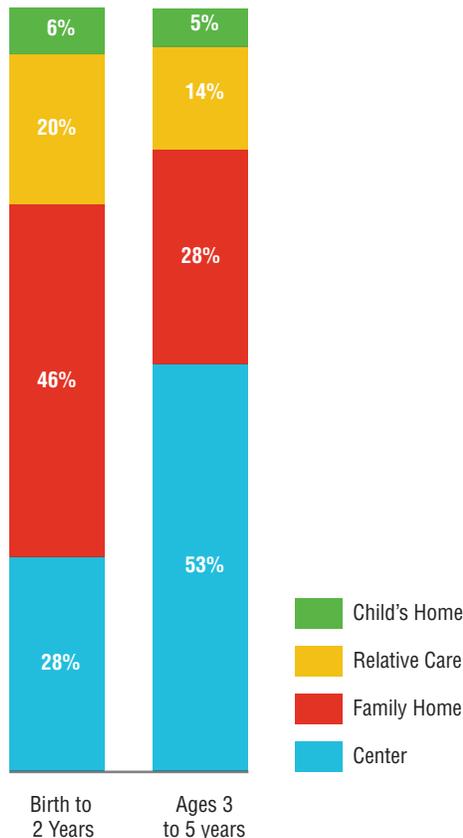
- **Parental resilience**—ability to maintain a positive attitude, creatively solve problems, and address issues in their lives;
- **Social connections**—strong positive relationships that can be relied upon to provide ongoing support and social interaction, and creation of shared standards for childrearing;
- **Knowledge of parenting and child development**—appropriate expectations of childhood behavior, awareness of children’s needs, and ability to respond to those needs appropriately;
- **Support in times of need**—access to material resources that help families cope with stressful situations; and
- **Children’s healthy social and emotional development**—access to high-quality early care and education that promotes self-regulatory behavior, cooperation with and attachment to adults, positive peer relationships, and social skills.¹¹

High-quality family support programs are well-positioned to help families in developing each of these protective factors and in so doing help prevent child abuse and neglect. Recognizing this, several communities have developed initiatives to strengthen families as an approach toward reducing child abuse and neglect. New York State has joined this effort by obtaining support for a train-the-trainer program from Zero to Three: National Center for Infants, Toddlers and Families. The Preventing Child Abuse and Neglect (PCAN) Training for Trainers program has allowed the state to develop a cadre of 40 trainers across the state who in turn train staff of child care, Early Head Start, and

Unique Children with Confirmed Allegations of Abuse or Maltreatment by Age: NYC and ROS, 2004 (Source: Office of Children and Family Services Data Warehouse, 2007)



Children Under 6 Years in Subsidized Child Care by Setting: NYS, 2004 (Source: National Center for Children in Poverty, 2007)



Child care subsidies enable low-income families to pay for the care and education their children need while parents work and/or participate in education and training (Kreader, 2005). Supported through a mix of federal, state and local funding, child care subsidies are designed to support both parental employment and children's development.

others involved in providing early care and education services to infants/toddlers and their families. New York should look to expand this effort to other age groups and programs.

Strategy 5.6: Ensure that children in child-only public assistance cases have the supports and services required to support their positive growth and development.

“Child-only cases” have become an ever-increasing proportion of public assistance case load and now represents over 40 percent (statewide average) of the people receiving public assistance (approximately 140,000 children). Child-only cases are temporary assistance cases where a child is living with a non-parent caretaker, or with parents who do not receive temporary assistance because they either are on SSI or are ineligible for benefits because of their alien status.¹² Due to the often-unique set of circumstances, this segment of the caseload present a different set of challenges to child welfare staff. Studies and a survey revealed that a significant portion of children in child-only cases suffer from trauma, parental abuse and neglect, and poor physical and emotional health. They often have school-related problems, as well as parents who are substance abusers or are incarcerated. Their non-parent caretakers may be elderly, low-income, and/or have health problems.

All children need safe, permanent homes and have well-being needs that must be attended to, whether they are in foster care, living with a non-parent caretaker, or living with their own parents. To address these issues, the Office of Children and Family Services and the Office of Temporary and Disability Assistance are working together to provide for the safety, permanency and well-being of these children. This has and will continue to include conducting joint regional technical assistance sessions; distributing information on successful county practices; jointly producing and analyzing data on this population; and drafting informational brochure for caregivers regarding their options to be foster parents versus having direct custody or guardianship of children who are not their own.

Goal 2: Strong Families

OBJECTIVE 6: Increase the proportion of vulnerable/at-risk families that are identified and provided with needed supports and services.

Strategy 6.1: Develop a system of universal screening and expand assessment activities to identify families in need of additional supports and services at the earliest possible point.

For more than three years, the Schuyler Center for Analysis and Advocacy has led an initiative to look at the needs of vulnerable families and identify strategies for meeting those needs by providing comprehensive services through home visiting. These meetings have resulted in the development of two strategies included in this plan.

Vulnerable, or at-risk, families are those with needs beyond those of the general population. These needs may reflect a range of issues and vulnerabilities including physical or mental health needs, substance abuse, economic insecurity, homelessness, violence, age, and immigration status among others. Imperative for these families is the identification and assessment of their need for supports, followed by their receipt of such services. Identifying families as early as possible is key to the success of efforts to intervene and support the family.

A first step in creating such a system is to ensure that every effort is made to identify pregnant women and to connect them to prenatal care. (See Strategy 1.2 for additional detail on this topic). Establishing processes for screening pregnant women and new families, once they are in prenatal care, can initiate a process that links them to the supports and services they need to give birth to healthy children and develop a stable and healthy family environment. Using birth records, families that were not screened during the prenatal period can be identified, screened, and referred for services.

The identification of vulnerable families at later stages of child development is not an easy undertaking. Families and children that are the most in need of supports and

services may not actively seek out such resources. Thus, effective outreach and a “no wrong door” policy have the potential to have a significant impact on these families. The existing network of service providers is a prominent starting point for outreach and assessment activities to continue and expand. In addition, community awareness of this network and a more informal presentation of supports and services, such as through faith-based organizations and other community-based facilities, can provide greater opportunities for families in need. By enabling vulnerable families to access the supports they need regardless of where or when their first contact with this system occurs, the likelihood that these families will be properly assessed and, in turn, benefit from services will increase.

The primary goal of a comprehensive system is to connect those in need of services to the services that can help them. An effective and dynamic assessment procedure that can be employed at various times, in various scenarios, and by various professionals, is one of the most important components of an effective system. Without it, the available services may not be appropriately provided to those in need. Implemented properly, assessment results would refer children and families to the appropriate intensity of community supports and services ranging from universal parenting/family support community resources (e.g., family resource centers, breastfeeding support, etc.) to more intensive programs (e.g., specific home visiting programs, Early Head Start, Even Start, domestic violence services, WIC, Medicaid/PCAP/MOMS/TANF, etc.) that may be available within the community. The development of uniform comprehensive assessment instruments will strengthen the capacity of health, education, and human service providers to identify and appropriately refer families at risk for specific outcomes.

Strategy 6.2: Develop a system for providing comprehensive home visiting services for vulnerable pre- and post-natal women and families.

Home visiting programs represent a comprehensive model of service delivery that, when properly designed, includes the four components of a comprehensive system (see the

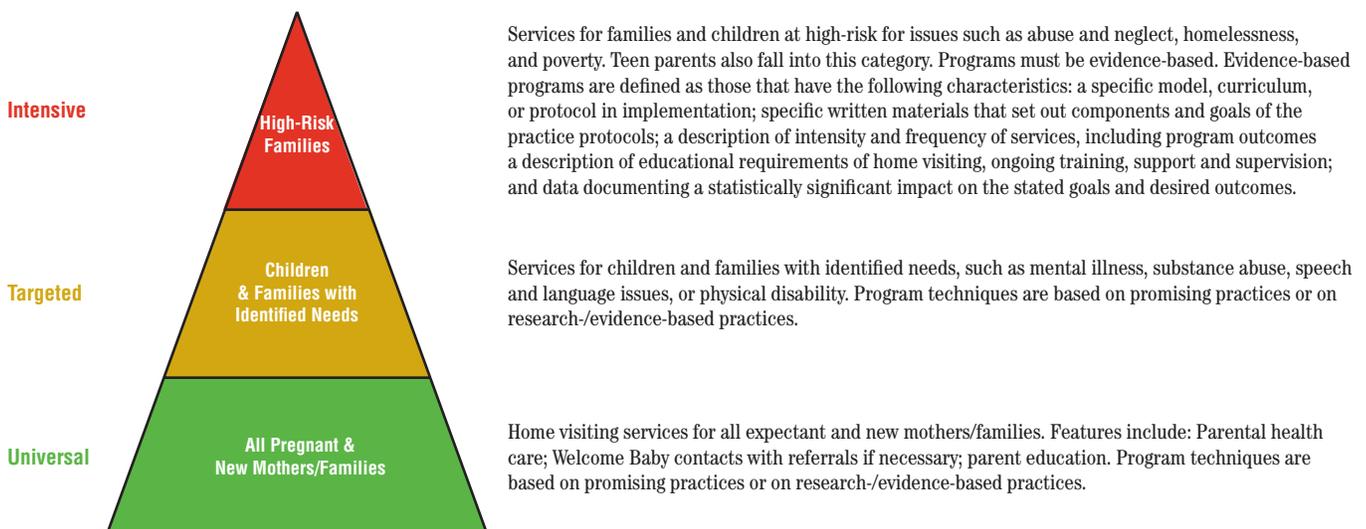
Framework of Priority Cross-Sector Goals and Outcomes, Page X) and focuses on the health and safety of children while concurrently supporting families. Home visiting increases the potential to obtain a wide-angle perspective of the home environment and family relationships. It is also an opportunity to link families with adequate and appropriate services and supports. As shown in Figure 1 (Page Y), used as a preventive strategy, home visiting may include assessments and problem identification, early childhood education, parent education, family support services, case management, mental health and counseling services, care coordination, and referral services. Current home visiting programs, such as those in local health departments, Early Head Start, Healthy Families New York, Nurse Family Partnership, Parent-Child Home Program and the Community Health Worker Program, have been shown to have a significant positive effect on children and parents. Establishing a system of home visiting services by further strengthening, expanding, and coordinating these programs could generate a much greater impact.

Evaluation findings from a randomized trial in three counties across the state have shown that the Healthy Families program has aided parents in developing healthier parenting attitudes and a better understanding

of child development. It has also resulted in parents engaging in more appropriate limit-setting for their children, which acts to reduce the use of abuse and neglectful parenting practices.¹³ These findings are similar to longitudinal research conducted on the Nurse Family Partnership, which was initially developed in upstate New York and the federally developed Early Head Start program. Research on the Nurse Family Partnership program has found that it is successful in achieving improved health outcomes and reductions in child abuse and neglect, rapid consecutive pregnancies, and use of welfare.¹⁴ Early Head Start programs have also shown significant impact on parents' progress toward self-sufficiency, subsequent births, support of language and cognitive development, and on fathers' parenting skills.¹⁵

Currently in many New York State communities, each of the aforementioned home visiting programs and others function independently of one another. In order to better coordinate and expand these programs, interagency planning for the delivery of services, the inclusion of elements of cross-training for home visiting staff, and the development of diversified funding sources is a primary goal. In addition many communities either do not have home visiting programs or lack sufficient home visiting services to meet the demand for services.

Figure 1. A Comprehensive Home Visiting System



Goal 2: Endnotes

- 1 Ooms, T. (2002). *Couples and Marriage Series: Marriage and Government: Strange Bedfellows?* Center for Law and Social Policy; Policy Brief. No.1. Available at www.clasp.org.
- 2 US Census Bureau, Census 2000 Summary F3 (SF3).
- 3 Pawelski, J.G., et al. (2006). *The Effects of Marriage, Civil Union, and Domestic Partnership Laws on the Health and Well-being of Children*. In *Pediatrics* 118(1):349-64.
- 4 Parke, M. (2003). *Are Married Parents Really Better for Children? What research says about the effects of family structure on child well-being*. Center for Law and Social Policy. Available at www.clasp.org.
- 5 Zepeda, M., Varela, F., and Morales, A. (2004). *Promoting Positive Parenting Practices through Parenting Education*. In: Halfon, N., Rice, T., and Inkelas, M. (Eds.) *Building State Early Childhood Comprehensive Systems Series, No. 13*. National Center for Infant and Early Childhood Health Policy.
- 6 The Commonwealth Fund. (2006). *The Commonwealth Fund Survey of Parents with Young Children, 1996*. Retrieved May 18, 2006 from www.cmwf.org/surveys/surveys_show.htm.
- 8 ACT Center for Excellence of Mount Sinai Adolescent Health Center. (2005). *In Brief: The Case for Youth Development*.
- 9 The Assets Coming Together for Youth (ACT for Youth) Center for Excellence, an initiative designed around the principles of positive youth development, has released program evaluation data of ongoing youth development programs showing that strategies used in programs build strengths and abilities among adolescents while reducing negative behaviors and outcomes. One project in particular, The Children's Aid Society/Carrera Model, which helps teens to avoid pregnancy by empowering them to develop and reach personal goals by providing them with information on abstinence and contraception, and allowing them to explore individual interests and talents, has been shown to have a significant impact. A three-year evaluation found that female participants delayed sex longer, had fewer sexual partners, and were three times more likely to have used effective contraception at last intercourse than non-participants.
- 10 Center for the Study of Social Policy. (2004). *Protecting Children by Strengthening Families: A Guidebook for Early Childhood Programs*. Center for the Study of Social Policy: Washington, DC.
- 11 Ibid.
- 12 Child-only cases can be generally divided into three distinct types of living arrangements:
 - Non-parent caregivers: relatives raising children whose parents are no longer able to care for them (often due to substance abuse). Frequently these are grandparents caring for grandchildren.
 - Parents receiving Supplemental Security Income (SSI): parents who are disabled and therefore not eligible to receive TANF, but whose children are eligible.
 - Immigrant parents: families in which the parent is an immigrant who is not eligible for TANF, but whose children are U.S. citizens and are eligible.
- 13 New York State Office of Children and Family Services. (2005). *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts*. Report to Governor and Legislature, February 2005. Albany, NY: Author.
- 14 Kitzman, H., et al (2000). *Enduring Effects of Nurse Home Visitation on Maternal Life Course: A 3-year follow-up of a randomized trial*. In *The Journal of the American Medical Association*, 283, 1983-1989.
- 15 Administration for Children and Families, U.S. Department of Health and Human Services. (2002). *Early Head Start Benefits Children and Families*. Washington, D.C.

Goal 3: Early Learning

Early experiences set a critical foundation for future learning. Early learning includes cognitive development and skills as well as social-emotional development, emphasizing the essential roles and relationships with parents and other caregivers. Early experiences set a critical foundation for future learning. Early learning includes cognitive development and skills as well as social-emotional development, emphasizing the essential roles and relationships with parents and other caregivers.

While parents remain children’s earliest and most important teachers, the significance of early care and education services—including both center-based and family-based child care, Head Start/Early Head Start programs, preschool programs, and other settings—continues to grow as parents of young children spend more time in the workforce. There is abundant research that shows that early care and education has both short- and long-term benefits for children.¹

In New York State, research compiled by the Center for Early Care and Education found that making quality prekindergarten available to the state’s 4-year-olds would pay back 41 to 62 percent of the investment. This benefit would occur from reductions in costs for special education services, grade repetition, teacher turnover, classroom disruptions, and school vandalism.²

While all children can benefit from participation in a high-quality early care and education program, children living in poverty, which is approximately 20 percent of the population in New York State, can benefit even more. Several studies have shown that increased positive developmental outcomes are associated with care that meets quality standards. These studies also demonstrate that investments in quality early care and education programs for low-income children provide benefits worth up to three times as much, in terms of public dollars saved for special education, social welfare, and criminal justice programs.³

During the last 10 years, several initiatives have been established in New York State to improve the availability of high-quality early care and education programs.

Among them are the Universal Prekindergarten program designed to provide a quality preschool to all 4-year olds, financial aid to child care providers to pursue professional development opportunities through the Educational Incentive Program, and establishing two credentials, the Infant/Toddler Early Care and Education and Children’s Program Administrator.

Outcomes

- Children have positive and consistent attachments to parents, caregivers, and educators.
- Caregivers and other providers have the knowledge, skills, confidence, and social supports to nurture the health, safety, and positive development of children.
- Children with developmental delays and/or disabilities receive early intervention and/or preschool special education programs and services, in natural environments and least restrictive settings, to the maximum extent appropriate.
- Families have access to high-quality, developmentally-appropriate early care and education.
- Families and caregivers support children’s early literacy.
- Families, caregivers, and educators communicate regularly about children’s learning and development.

Goal 3: Early Learning

Decades of research have demonstrated that access to early intervention and preschool special education programs and services can significantly improve the developmental and educational outcomes of young children experiencing developmental delays and diagnosed conditions with a high probability of resulting in developmental delays. The federal Individuals with Disabilities Education Act (IDEA), which provides for a free appropriate public education (FAPE) for all children and youth with disabilities, includes provisions for states to implement statewide, comprehensive systems of early intervention services (Part C of IDEA; participation is discretionary to states); and, a requirement on all states to provide access to FAPE to children with disabilities by 3 years of age. In New York State, the Department of Health is the lead agency responsible for state-level administration and oversight of the Part C Early Intervention Program. The State Education Department, as the state's local education agency, is responsible for implementation of the Part B special education system, including preschool special education programs and services.

In New York State, 4 percent of infants and toddlers, birth to age 3 years, and nearly 8 percent of preschool children age 3 to 5 years participate in early intervention and preschool special education programs and services, respectively. These data indicate that the state is successful in identifying and ensuring access to early intervention and preschool special education programs and services for children and families who need these services to mitigate against the impact of delays and disabilities on children's development and education.

Learning is not the exclusive province of early care and education programs and schools. Parents play a significant role in the education of their children. There are a variety of programs available that support development of the skills and attitudes that parents need in order to support the healthy development of children. While significant progress has been made to improve the quality of programs serving young children and their families, additional efforts are needed. The following objectives include several strategies designed to further improve the quality of early care and education programs and to better support parents in their role as the child's first and foremost teacher.

OBJECTIVE 7: Increase the proportion of children who have access to high-quality, developmentally appropriate early care and education.

Strategy 7.1 Implement the phased-in statewide expansion of the Universal Prekindergarten Program.

The Universal Prekindergarten Program is one of the building blocks of New York's early care and education system and is intended to promote school readiness for all 4-year-olds throughout the state, irrespective of their socioeconomic status, disability status, or level of English proficiency. There is widespread commitment to the completion of its phased expansion by 2010-2011. During the 2007-2008 school year, school districts and their collaborative partners will serve an additional 30,000 4-year-olds in the Universal Prekindergarten Program. New York State has already taken steps to address expansion and implementation barriers by allowing school districts that plan to operate UPK programs to access planning grants. In addition, joint public-private efforts are currently underway to better understand the unique barriers in each district and to develop and conduct targeted outreach to school district superintendents.

Strategy 7.2 Establish a Quality Rating and Improvement System for New York in order to improve quality across diverse early care and education settings statewide.

Building upon the work of the New York State Child Care Coordinating Council's Quality Rating and Improvement System Committee, the New York State Office of Children and Family Services (OCFS) is leading an initiative to develop a quality rating and improvement system (QRIS) for New York. As of July 2008, 17 states had quality rating and improvement systems.⁴

Quality rating and improvement systems facilitate quality improvement across diverse early care and education settings by aligning provider incentives, state

agency administration/regulation, and parental demand. According to Anne Mitchell (2005), quality rating and improvement systems typically contain the following five components⁵:

1. Standards;
2. Accountability (assessment and monitoring);
3. Program and practitioner outreach and support;
4. Financial incentives specifically linked to compliance with quality standards; and
5. Family/consumer education.

A given program's rating serves as an indication of quality to parents, a quality improvement opportunity for that provider, and an opportunity for relevant state entities and their not-for-profit partners to provide targeted and timely technical and financial assistance.

New York will launch a multi-site QRIS pilot in late 2008. It is anticipated that programs will be rated using a scale of one through five stars, with five stars indicating the highest level of overall quality across multiple domains.

As New York works to establish its QRIS, we will learn from the experiences of other states. We will also benefit from the collective expertise of our own cadre of early learning practitioners and advocates, some of whom are represented on the Children's Cabinet Advisory Board Workgroup on Quality Early Learning Programs, which has selected QRIS as its focus.

Strategy 7.3: Develop a competency-based professional development system for people working in early care and education settings to ensure that children are adequately prepared for success in school.

The years from birth through 5 are the most extraordinary period of growth and development in a child's lifetime. Children enter the world completely dependent on adults, and within a period of five years they grow to walk, talk, and interact with the people around them. There is increasing pressure on early care and education programs to demonstrate that they are adequately preparing children for school. A key factor in preparing children

for school is the competencies of the staff and providers in early care and education settings to provide a rich environment for children to grow and develop.

In 1998, The NYS Career Development Initiative developed the *Early Care and Education Core Body of Knowledge Framework*, which establishes the competencies that people working with young children should have to provide quality services. The *Core Body of Knowledge* is widely used to as a vehicle for guiding professional development and providing a context for how training and educational programs will support the development of competencies in specific areas. However, its value in driving a system of professional development has not been fully realized.

New York State will build on the *Core Body of Knowledge* to develop a professional development system that will support early care and education staff and providers in obtaining the training and education they need to provide quality services and prepare children for successful school experiences. This system should include the following:

- Structured professional assessment and development tools that support staff and providers in moving to increasingly higher levels of competency.
- A system that provides career advisement, training, mentoring, and coaching to support professional development.
- Director's institutes for new and experienced program directors, licensors, CCR&R staff, family child care network staff, trainers, mentors, and coaches to provide the skills needed to support staff professional development and identify, develop, and implement program curriculum tied to staff competencies.
- A staff training registry to allow providers to track their professional development.

Goal 3: Early Learning

Strategy 7.4: Support regional networks to develop local strategies for making high-quality comprehensive infant and toddler services more available, and for increasing access to these services for infants and toddlers with disabilities.

Evaluations of the Early Head Start program demonstrate that the provision of comprehensive services to low-income families with children birth through 3 years of age can have significant positive benefits for both the child and the parents. Program models that used home visiting to provide supports and services to parents and offered center-based early care and education programming to the child were particularly effective. Through this two-generational approach, children were found to perform significantly better than a control group on a range of measures of cognitive, language, and social-emotional development. Likewise, parents scored significantly higher than control group parents on many aspects of home environment and parenting behavior. Additionally, the program also showed a significant impact on parents' progress toward self-sufficiency, subsequent births, support of language and cognitive development, and on fathers' parenting skills.⁶

New York State has taken several steps to meet the needs of infants and toddlers in child care and other early education programs.

- The NYS Association for the Education of Young Children has developed and implemented the Infant/Toddler Care and Education Credential designed to provide staff of early care and education programs serving infants and toddlers the competencies needed to provide quality care.
- NYS Office of Children and Families has funded a network of Infant/Toddler consultants to support family, group family and center-based child care programs and settings provide to provide high-quality services.
- The New York State Child Care Coordinating Council and the Cornell University Early Childhood Program sponsored two statewide conferences that focused on the lessons learned from and the application of Early Head Start research. An important part of these events were workshops and seminars on the development of

strategies for using Early Head Start as a model for building a system of comprehensive supports and services for low-income families with young children.

- The NYS Head Start Collaboration Project has supported the establishment of regional groups to develop local strategies for making comprehensive infant/toddler services available.
- The Head Start Collaboration Project, NYS Child Care Coordinating Council, and New York Network are working together to produce a series of video conferences on building community collaborations to support quality infant and toddler programs. The first, a live 60-minute videocast, highlighted a successful cross-systems early education and intervention initiative in Chemung County, New York. The videocast reached more than 200 persons in 17 locations across New York State. A second videoconference will focus on using data effectively to design, develop, and evaluate services.

These steps offer examples of future actions that should be taken to improve the quality of infant and toddler services.

Strategy 7.5: Increase efforts to ensure that children with specific vulnerabilities—including children in foster care, children in homeless families, and children whose parents are struggling with addiction, mental illness, and/or domestic violence—have access to high-quality early care and education programs and, when needed, early intervention and preschool special education programs and services.

Children in foster care, homeless children, and children whose parents are struggling with addiction, mental illness, and/or domestic violence are at high risk for experiencing developmental delays and disabilities and school failure. While all children could benefit from quality early care and education programs, these children are particularly in need of services.

The federal Child Abuse Prevention and Treatment Act (CAPTA) and IDEA Improvement Act of 2004 include new requirements to ensure that infants and toddlers involved in indicated cases of child abuse and neglect are screened to determine whether a referral to the Early

Intervention Program is needed. For infants, toddlers, and preschoolers who are experiencing a developmental delay or disability and who are in foster care, early intervention services and preschool special education services are essential to support their development while in foster care and as part of the permanency planning process. To address this issue, the Department of Health and Office of Children and Family Services issued a joint protocol to coordinate early intervention services and foster care services for infants and toddlers with disabilities.

At the same time, the federal McKinney Education of Homeless Children Act requires that school district homeless liaisons develop procedures for linking homeless children to early care and education programs. Each of these pieces of federal legislation supports increased attention to the early care and education of children living in difficult circumstances, but more needs to be done.

The Strengthening Families Illinois Project has developed a comprehensive strategy for linking foster care and homeless children to early care and education programs that includes policies and procedures for case managers and professional development for staff of foster care, homeless shelters, and early care and education programs. This initiative can serve as a model for similar efforts in New York State.

Strategy 7.6: Increase opportunities for preschool children with disabilities to have earlier access to early care and education programs and inclusive educational settings.

The federal IDEA requires that preschool special education services be provided to eligible children in the least restrictive settings (settings where typically-developing peers participate and that offer access to general education), including early care and education programs, the home, and part-time early childhood/early childhood special education settings. The Committee on Preschool Special Education (CPSE) makes recommendations for preschool students with disabilities. The CPSE is required by law to first consider the appropriateness of providing related services only; or special education itinerant teacher services (SEIT) only;

or related services in combination with SEIT services; or a half-day preschool or full-day preschool program. The CPSE is also required to first consider providing special education services in a setting where age-appropriate peers without disabilities are typically found, prior to recommending the provision of special education services in a setting that includes only children with preschool disabilities.

While there has been significant improvement in providing special education services to children in integrated settings (the rate of integration has nearly doubled over the past decade), additional work needs to be done to ensure that children with disabilities receive special education and related services in settings with their typically developing age peers. The Temporary Task Force on Preschool Special Education included in its report several recommendations designed to ensure that children with disabilities have access to integrated settings. These steps should be taken to ensure that children with disabilities have the opportunity to grow and develop with their peers.

Strategy 7.7 Establish a literacy development program for early care and education providers with low-literacy.

New York State can be proud that it has some of the highest regulatory standards in the nation for people providing early care and education in licensed or registered child care programs and settings. Despite these standards, many people working as classroom assistants and family child care providers lack the literacy skills needed to provide quality services. While numerous training programs exist to help providers meet licensing standards, providers with low literacy skills cannot fully benefit from these trainings if they are unable to read and communicate effectively.

To address the literacy needs of these providers, a program will be established in partnership with Literacy New York (formerly Literacy Volunteers of New York State) and other adult education programs to develop a training program that uses existing early care and education training curricula as the context within which to provide adult literacy instruction.

Goal 3: Early Learning

Strategy 7.8 Develop an early care and education trainer's certification program.

New York State has taken several steps (i.e., Educational Incentive Program, New York State Association for the Education of Young Children's credentialing programs) to emphasize college credit-bearing coursework and credentialing programs as the preferred forms for early care and education career and professional development. However, there remains a significant role for non-college based training for both program quality improvement and individual providers' professional development. In response to this need, a wide array of training opportunities has been developed. Unfortunately, the quality of these training opportunities varies as much as the type of training available.

This forces programs and individual providers to struggle with determining what training program and which trainer will meet their needs. Too often the training chosen is of poor quality and valuable resources are misspent. To help programs and providers identify quality training opportunities, a trainer credential will be established. The certification will include specific qualifications that individuals will have to possess in order to become certified. The credential will be multi-level to address the extensive mix of people who provide training. This would allow people with less education, but substantial experience, to be certified as trainers, while people with higher qualifications would be eligible for certification as a master trainer, etc.

OBJECTIVE 8: Parents support children's early learning.

Strategy 8.1: Develop community-based strategies to support positive parenting practices that enhance early learning.

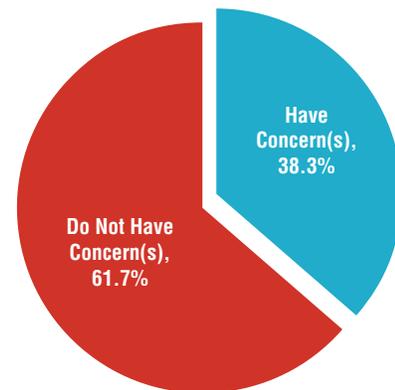
Children's success in learning is grounded by a family environment that encourages learning. Even when young children spend most of their waking hours in childcare, parents remain the most influential adults in their lives.⁷ Families provide the important relationships and experiences that stimulate and nurture young children's learning, including cognitive and language development and emerging literacy. Because young children's learning experiences unfold in the context of relationships, they are linked to, and dependent on, social-emotional development. Families with young children who are experiencing developmental delays or disabilities may require additional specific information, education, and support to enhance their children's cognitive, language, and social development as a foundation for early learning.

Early literacy encompasses all the experiences children have had with language, books, and print, beginning in infancy. Children who experience literacy activities, such as frequent and varied book reading, and interesting conversations with adults involving new and unfamiliar words, have been shown to demonstrate higher-level skills in language and literacy development at the kindergarten level.⁸ Recent data from the National Survey of Children's Health show that more than 20 percent of parents of children age birth to 5 report that they read aloud to their child two or fewer days per week, with nearly 10 percent reporting not reading to their child any days.⁹

Strategies developed at the community level make it possible to support families of all economic levels in nurturing their children's early learning. Building on the family-centered, evidence-based initiatives present in many communities, such as Even Start Family Literacy Partnerships, Head Start, Family Resource Centers, libraries, parenting education, and home visiting interventions (e.g., Healthy Families New

York, Community Health Worker Program, Parents as Teachers), and in coordination with statewide programs such as the Early Intervention and Preschool Special Education Programs, communities can implement additional activities that support family's efforts to support young children's development and early learning experiences to prepare their children for success in school and life. Numerous communitywide literacy development and other early learning projects exist in New York and other states that can serve as models for these efforts.

Children Under 6 Years Whose Parents Reported Having at Least One Concern About Their Children's Learning, Development, Behavior or Ability to Get Along with Others: NYS 2003-2004 (Source: U.S. Department of Health and Human Services, 2005)



Goal 3: Endnotes

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Goal 4: Supportive Communities and Coordinated Systems

It is not enough to have available a set of supports and services designed to address the needs of young children and their families. The supports and services need to be easily accessible, coordinated, and effective. Not all families seek help when it's needed. In some cases, outreach efforts are required to identify children and families in need and connect them to the appropriate services.

Because children and families often have more than one need, supports and services must be coordinated so that it is easy for families to address multiple problems without having to independently seek out every support and service they require. If services are not effective, then needs are not met. To ensure that services are of the highest quality, a variety of structural supports are necessary. Staff providing the services must have adequate training and education; programs need to be monitored and evaluated; and services should be designed based on research and best practice.

Infrastructure at the state and community level is critical for the effective and efficient delivery of supports and services to young children and families. It is the lynchpin that reduces fragmentation and ensures quality. Access to services; development and maintenance of a qualified workforce; provision of safe and healthy environments; strengthening of social networks and social supports for families; strong leadership; and coordination of policy, programs, and service delivery are all essential functions of a state and community infrastructure supportive of child and family health and development.

When functioning well, state and community service systems provide children and families with positive external supports that enable and reinforce the families' primary role in nurturing the healthy development of children. When not functioning well, child and family needs are not met and the long-term repercussions can have costly effects in terms of child and family well-being and in future need for health, education, and human services.

Outcomes

- Children, families, and other caregivers are supported by peers, workplace, community, and government.
- Families are involved in service planning, delivery, and evaluation at state and local levels.
- Community supports and services recognize, respect, and reflect strengths of families and cultures.
- Families are aware of and able to access all the supports and services they need.
- Communities provide children and families with healthy, safe, and thriving environments to support their needs for physical, social, cognitive, and emotional growth.
- Programs, policies, and infrastructure support coordinated cross-sector service delivery.
- Health, education, and human service providers that serve children and families have the knowledge and skills needed to promote positive child and family development.
- Child and family needs are anticipated and supports and services are available that focus on preventive, intervention, and developmentally appropriate services.
- Early childhood services, programs, and policies are based on evidence, theory, and best practices.

Goal 4: Supportive Communities and Coordinated Systems

Therefore, workgroup members felt that it was critically important to address the need for supportive communities and coordinated systems of services in the development of the Early Childhood Comprehensive Services plan. For workgroup members, supportive communities/coordinated systems explicitly articulates outcomes related to infrastructure not directly addressed by the State Early Childhood Comprehensive Systems critical components, including workforce development, environmental health concerns, and capacity for informed and responsive policy development.

OBJECTIVE 9: Increase the knowledge, skills, confidence, and support of staff and administrators of health, education, and human services so that they are able to promote the health, safety, and positive development of young children and their families.

Strategy 9.1 Develop training for health, education, and human service program staff on health and development of children birth through 5 years of age and the array of community resources available for children and families.

The critical importance of supporting children and families in the earliest years is increasingly recognized across many otherwise distinct disciplines and program areas, including education, criminal justice, economic and workforce development, maternal and child health, chronic disease prevention, mental health, and others. This recognition lays the groundwork for the development of new partnerships and strategic system-building approaches.

To build a seamless system of child and family services, it is not crucial that all services are available under one roof, but it is important that there are no wrong doors. A family coming into contact with health, education, or human service providers represents a unique opportunity

to support positive parenting, identify and refer children who may have a disability or delay, and address potential health and safety problems. It should not matter which organization a family comes into contact with first. Every organization that works with a family should be able to help them identify goals and service needs and connect them to appropriate resources in the community.

The Early Childhood Comprehensive System Planning Initiative was valuable in that it brought together representatives from a broad range of health, education, and human service programs for the first time. An unintended benefit of the planning process was that members learned about the broad array of programs and services that are available to children and families. Given the breadth of programs represented on the workgroup, each member learned about programs and services of which he or she was previously unaware. Workgroup members felt certain that their colleagues working in programs across the state could more effectively serve children and families if they knew more about the range of supports and services that are available, eligibility criteria, whom to contact for information, and how to make a referral for services.

Goal 4: Supportive Communities and Coordinated Systems

OBJECTIVE 10: Increase the capacity of state and local government to provide leadership and support efforts to improve the quality and accessibility of services for young children and their families.

Strategy 10.1: Establish by executive order or legislation a state-level interagency group responsible for the coordinated planning and provision of comprehensive services for young children and their families.

Depending on individual circumstances, families with young children can have a wide range of needs for supports and services. Building systems to meet these needs is a complex process that requires coordinated policy and program development at both the state and local level.

At the state level, over the past 20 years, numerous groups and initiatives have been established to address issues related to early care and education. During that period, the breadth of issues addressed by these groups has gradually expanded. Beginning in 1985, the Child Care Commission issued reports that focused specifically on issues related to child day care. Gradually, the definition of the services and supports that are included under the rubric of early childhood has expanded to include nursery and preschools, prekindergarten programs, Head Start, Early Intervention and Preschool Special Education, and most recently home visiting, family leave, maternal and child health, parenting education, mental health services for young children and families, parenting education, and substance abuse services.

Members of both the ECCS leadership and workgroups recognized the immense value of bringing together representatives of the wide variety of state-level programs that have been established to meet the needs of young children and their families. The opportunity that the ECCS planning process provided to identify, discuss, and address common problems was unique in terms of the scope of issues included. The need for an ongoing body at the state level to implement the strategies contained in the

ECCS planning document and to continue collaborative efforts to strengthen and expand services for young children and their families was considered imperative.

Strategy 10.2: Establish within this state-level interagency group an early learning workgroup charged with maximizing resources, and improving the planning, coordination, and quality of all early childhood settings.

The implementation of the Universal Prekindergarten has produced significant benefits for the broader early care and education system of services, including:

- Providing children and families with new opportunities to benefit from quality preschool programming.
- Developing strong partnerships between early care and education programs and school districts to address the educational needs of preschool-age children.
- Providing a significant infusion of new funding for early care and education programs that has allowed community-based providers of Universal Prekindergarten the opportunity to extend the day and year of services and/or enhance the quality of their program.

While the benefits of Universal Prekindergarten implementation have been significant, there is potential for an even greater impact on the quality and accessibility of early care and education programming for preschool-aged children.

To ensure that New York State achieves those benefits, an early learning workgroup should be established. The workgroup should be charged with:

- Determining strategies for maximizing new and existing funding and for ensuring that the implementation of Universal Prekindergarten does not negatively effect the ability of other early care and education programs (i.e., child care and Head Start) to maintain enrollment and offer quality services;
- Aligning program standards and eliminating regulatory barriers that makes it difficult for programs to blend funding from several sources to provide quality full-day, full-year services; and

Goal 4: Supportive Communities and Coordinated Systems

- Developing uniform mechanisms for program oversight, data collection, assessing children’s progress, accountability, and quality improvement.

Strategy 10.3: Support local efforts to coordinate services to young children and their families.

The need to coordinate the planning and provision of supports and services to families is also critical at the local level. New York is a state-administered, county-operated system of services. The types of issues and the resources available to address those issues vary tremendously across the state. To be effective, many of the strategies proposed in this planning document require local involvement.

Consequently, focusing coordination efforts at just the state level will not have the desired impact. Similar structures are needed at the local level if a truly coordinated comprehensive system of services is going to be developed. For example, if people working in early childhood programs are going to be able to advance in their careers, it is important that a full range of training and educational opportunities are available. This includes ready availability of early childhood credential programs (i.e., Children’s Program Administrator Credential, Infant/Toddler Credential, and the Child Development Associate Credential), one-year early childhood certificates, and associate, bachelor’s, and master’s degree programs with appropriate articulation agreements. Because of the size and complexity of New York State, building the relationships necessary to put this network of training and educational opportunities together can only occur at the local level.

Workgroup members noted the importance of expanding availability and capacity of technology that can be used at the community level to enhance the feasibility of many collaborative system building approaches, including communication, education, coordinated intake and referrals, and cross-training. New York’s Comprehensive Children’s Services Initiative and Systems of Care Communities are examples of two evidenced-based approaches that can serve as models for this effort. In addition, several communities (e.g., Rochester/Monroe County, Syracuse/Onondaga County, Broome County,

Chemung County, and Dutchess County) have established local initiatives designed to improve the quality and coordination of services for young children and their families. Each of these efforts can be used to inform ongoing efforts to promote comprehensive service provision.

Strategy 10.4: Develop an interagency resource to encourage public investment at the federal, state, and local level in evidence-based strategies for addressing the needs of families with young children.

Significant best practice research exists on the wide range of services that are provided to young children and their families. However, not all programs that provide services to young children and families have access to or make use of this information. In addition, state and local governments do not uniformly use this research to guide program funding and policy decisions. Using evidenced-based strategies to meet the needs of children and families is critical to efforts to improve the quality of services and maximize funding. It is also important for discouraging funding of strategies not demonstrated to be effective. Yet, no comprehensive mechanism has been put in place to ensure that state and local governments require research-based strategies for the funding they provide and that programs are informed and making use of best-practice research.

Some state agencies have begun to address this need. For example, the Office of Children and Family Services has provided technical assistance to counties to support outcomes-based contracting and to strengthen their capacity to identify and measure performance targets. OCFS also has established an effective-practices web page that links users with evidenced-based programs and research. These efforts need to be built on and expanded in order to ensure that services that New York State provides its children and families is evidenced-base and of the highest quality possible.

Goal 4: Supportive Communities and Coordinated Systems

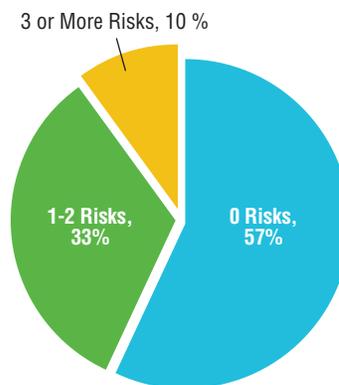
Strategy 10.5: Develop a series of data reports on early childhood health and development to track progress toward accomplishing plan objectives and strategies.

By establishing a set of outcomes across four domains, the leadership and workgroups clearly articulated a vision for what they wanted for young children and families and described the components and features of a comprehensive system of services. To measure progress toward achieving these outcomes, it is important that indicators be established and data collected on routine basis, and made available. To meet this need, a special Touchstone/Kids Count data report on child health and

development has been prepared and will be updated on a regular basis.

The initial report includes more than 60 indicators of child, family, and community well-being. Efforts have been made to identify one or more indicators for each of the outcomes. However, for many outcomes, particularly outcomes in the coordinated systems/supportive communities' domain, no indicators were identified. Thus, an important function of these reports is to stimulate data development. The reports will also be used to increase awareness of policy decision-makers about early childhood issues and support program planning and development.

Young Children's Exposure to Multiple Risk Factors: NYS, 2006 (Source: National Center for Children in Poverty, 2007)



A risk factor is any circumstance that increases the likelihood that a child will experience non-optimal outcomes, such as engaging in risky behaviors like substance abuse or delinquent conduct. Risk factors are not necessarily causal of such outcomes, but are correlational (Helping America's Youth, 2007).

Appendix A: ECCS Planning Partners

Interagency Leadership Group

Affiliations reflect status at the time of workgroup participation

Deborah Benson	NYS Council on Children and Families
Wayne Borek	NYS Office of Mental Retardation and Developmental Disabilities
Rachel de Long (project Co-Chair)	NYS Department of Health
Julie Elson	NYS Department of Health
Robert Frawley (Project Co-Chair)	NYS Council on Children and Families
Cynthia Gallagher	NYS Education Department
Judy Gallo	NYS Office of Children and Family Services
Evelyn Harris	NYS Department of State
Judy Gallo	NYS Office of Children and Family Services
Barbara McTague	NYS Department of Health
Fred Meservey	NYS Office of Alcoholism and Substance Abuse Services
Lorraine Noval	NYS Office of Temporary and Disability Assistance
Suzanne Sennett	NYS Office of Children and Family Services
Nancy Wade	NYS Department of Health
David Woodlock	NYS Office of Mental Health

Appendices

Appendix A: ECCS Planning Partners (continued)

Workgroup Members

Affiliations reflect status at the time of workgroup participation

Mary Applegate	Bureau of Women's Health, NYS DOH	Bernadette Johnson	Healthy Families New York, NYS OCFS
Ephraim Back	NYS Academy of Family Physicians	Ira Katzenstein	Cattaraugus & Wyoming Counties Head Start Program
Lee Beals	Mid-State Student Support Services, NYS Education Department	Brenda Knudson- Chouffi	Early Intervention Program, NYS DOH
Debra Blog	Immunization Program, NYS DOH	Jennifer Krokey	Astor Services Early Head Start
Lucy Bouldin	Adolescent Pregnancy Parenting Services, NYS OCFS	Christopher Kus	Division of Family Health, NYS DOH
Christina Brady	Bureau of Child and Adolescent Health, NYS DOH	Margarita Mayo	Business Council of NYS
Allison Campbell	Bureau of Children and Families, NYS Office of Mental Health	Fred Meservey**	NYS Office of Alcoholism and Substance Abuse Services
Sharon Chesna	Mothers and Babies Perinatal Network	Terrie Nelson	Bureau of Early Childhood Services Regional Office, NYS OCFS
Moncrieff Cochran	Cornell University Early Childhood Program	Lorraine Noval**	NYS Office of Temporary and Disability Assistance
Kenyette Currie	Parent Representative	Margaret Pavlos	Bureau of Early Childhood Services, NYS OCFS
Rachel de Long*	Bureau of Child and Adolescent Health, NYS DOH	Pat Race	Nutrition Policy and Health Promotion Unit, Division of Nutrition, NYS DOH
Barbara Dennison	Bureau of Health Risk Reduction, NYS DOH	Carol Rasowsky	College of St. Rose
Julie DeMeyers	Parent Representative	Judy Richards	William B. Hoyt Memorial Children and Family Trust Fund, NYS OCFS
Peggy DiManno	Albany County Health Department	Patricia Ryan	Parent representative
Evelyn Efinger	NYS Child Care Coordinating Council	Sandy Rybaltowski	NYS Education Department
Julie Eisele	Bureau of Injury Prevention, NYS DOH	Ruth Singer	Early Education and Reading Initiatives, NYS Education Department
Julie Elson	NYS Office of Medicaid Management, NYS DOH	Andrew Stern	Office of Managed Care, NYS DOH
Peter Endryk	Child Health Plus, NYS DOH	Suzanne Syzdek	Bureau of Injury Prevention, NYS DOH
Azra Farrell	Permanent Judicial Commission on Justice for Children	Linda Thornton	Perinatal Health Unit, Bureau of Women's Health, NYS DOH
Marcia Fazio**	Division of Children and Families, NYS Office of Mental Health	Sandra True	Bureau of Infant, Maternal and Reproductive Health, NYC DOHMH
Robert Frawley*	NYS Council on Children and Families	Kay Victorson	Schuyler Center for Analysis and Advocacy
Judy Gallo**	Bureau of Policy Analysis, NYS OCFS	Ruth Walden	Family Voices of NYS
Foster Gesten	Office of Managed Care, NYS DOH	Bridget Walsh	Schuyler Center for Analysis and Advocacy
Joy Griffith	Healthy Families New York, NYS OCFS	Mimi Weber	Health Services for Children, NYS OCFS
Susan Hager	NYS United Way	Meredith Wiley	Fight Crime: Invest in Kids New York
Lois Hainsworth	Western Regional Office, NYS DOH		
Tom Hoke	Prevent Child Abuse New York		
Mary Huber	Healthy Children New York, NYS DOH		

*Workgroup Co-Chair

** Also served as a member of the ECCS Interagency Leadership Group

NYS DOH—New York State Department of Health

NYS OCFS—New York State Office of Children and Family Services

NYC DOHMH—New York City Department of Health and Mental Hygiene

Appendix B: Children’s Cabinet Advisory Board

Noilyn Abesamis-Mendoza	Health Policy Manager	Council on Asian American Children and Families
Kenneth Adams	President and CEO	Business Council of New York State
Steven Blatt, M.D.	Associate Professor of Pediatrics	SUNY Upstate Medical University
Eric Brettschneider	Consultant	
Geoffrey Canada	President and CEO	Harlem Children’s Zone
Marie Cannon	Executive Director	Holy Cross Head Start
Evelyn Castro	Associate Dean, School of Education	Long Island University
Janice Charles	Executive Director	The Children’s Clinic
Robert Compani	Director of Strategic Campaigns	Civil Service Employees Association
Patricia Donohue	Community Corrections Representative	NYS Division of Probation and Correctional Alternatives
Pat Fahy	Director of Federal Relations & Policy	NYS Department of Labor
Julie Gates		Parent representative
Susan Hager	President and CEO	United Way of New York State
Lisa Harris	Executive Deputy Director	NYS Consumer Protection Board
Ann Harrison	Division of Public Affairs and Education	NYS Department of Environmental Conservation
Sally Herrick		
Wayne Ho	Executive Director	Coalition for Asian American Children and Families
Lourdes Iglesias	Executive Director	Hispanos Unidos de Buffalo
Mark Jasinski	Director of Early Childhood Programs	Ithaca City School District
Carolyn Karins	OTDA/CEES Director of Systems	NYS Office of Temporary and Disability Assistance
Judith S. Kaye	Chief Judge	NYS Court of Appeals
Jane Knitzer	Director	National Center for Children in Poverty
Nancy Kolben	Executive Director	Child Care Inc.
Richard Kreipe, M.D.	Chief, Adolescent Medicine	University of Rochester Medical Center
Dina Lieser, M.D.	Interim Executive Director	Docs for Tots New York
Jennifer March-Joly	Executive Director	Citizen’s Committee for Children of New York
Anne Mitchell	President	Early Childhood Policy Research
Elba Montalvo	President	Committee for Hispanic Children and Families
Margaret Moree	Director, Federal Affairs	Business Council of New York State
C. Warren Moses	CEO	Children’s Aid Society
Maria Neira	First Vice President	NYS United Teachers
Gwen O’Shea	President and CEO	Health and Welfare Council of Long Island
Jennifer Rojas	Deputy Director	The Children’s Defense Fund
Carol Saginaw	Executive Director	NYS Child Care Coordinating Council
Chuck Santelli	Director of Policy & Program Development	NYS United Teachers
Karen Schimke	President and CEO	Schuyler Center for Analysis and Advocacy
Mary Shaheen	Vice President	United Way of New York State
Elaine Gallina Spaul	Executive Director	The Center for Youth Services
Angelica Velazquez		The Committee for Hispanic Children and Families
Nancy Wackstein	Executive Director	United Neighborhood Houses of New York
Michael Weiner	Commissioner	Erie County Department of Social Services
Meredith Wiley	State Director	Fight Crime: Invest in Kids New York
Peggy J. Wozniak	Superintendent	Binghamton City School District
Patsy Yang	First Deputy Commissioner of Health	Westchester County Department of Health



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