

*Report
by the
Infant
Toddler
Working
Group*

*Prepared
for the
Connecticut
Early
Childhood
Education
Cabinet*

Connecticut's Infant Toddler Systems Framework



First Words, First Steps

The Importance of the Early Years

Special thanks to Dr. Edward Zigler, Sterling Professor of Psychology, Emeritus, Yale University, Director of the Center in Child Development and Social Policy; Zero to Three in Washington D.C.; the Center on the Developing Child at Harvard University; the National Center for Infant and Early Childhood Health Policy; and the Center for Healthier Children; and Families and Communities at the University of California, Los Angeles for resources and concepts utilized in this report.



October 16, 2008

Dear Colleagues:

The earliest years are the launching pad for the future. Social scientists concur that cognitive ability both informs and predicts health, educational attainment, employment status, and avoidance of community problems and criminal behavior. Cognitive ability begins and is shaped extensively in the first three years of life.

What was once considered ancillary to the economy and overall quality of life is now understood to be the primary ingredient for both. The first 1,000 days have been studied by the Infant Toddler Working Group of the Connecticut Early Childhood Education Cabinet. The scope was wide including maternal health, family support, physical and mental health, early care and education, child poverty and early literacy.

The overall goal is to ensure that all infants and very young children are optimally healthy and developmentally on track, meeting their full potential.

Through policy committees focused on the family and the earliest years, national interviews with scientists on recent neurological findings, a state early childhood summit, and parent focus groups, we offer this report and policy recommendations. It provides findings based on four common principles and policy directions.

1. Families must be served within the context of their families and communities, utilizing strength-based approaches and cultural competence.
2. Emphasis in the service continuum must be reoriented to prevention, which will reduce the need for more intensive and expensive intervention later.
3. Service delivery needs to be consumer friendly and easy to navigate. Services need to be simplified and organized into coherent programs and into a coherent system.
4. Accountability and data-driven decision making are paramount to public trust. Meaningful performance measures can help to ensure improved outcomes for children and families in both the public and private sectors.

We thank the Infant Toddler Working Group for its rigorous work over this past year. We thank the entire Connecticut Early Childhood Education Cabinet for understanding that school readiness does not begin at the kindergarten door, but at birth.

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Table of Contents

Twelve Essential Findings	2
I. Introduction	3
II. The Context	4
111. Building an Infant Toddler Comprehensive System	8
A. Maternal Health.....	8
B. Family Support	12
C. Child Health: Physical, Mental and Oral	13
D. Early Screening, Assessment and Intervention	18
E. Early Care and Education	19
F. Early Literacy	21
G Child Poverty Reduction	23
H. Systems Innovation.....	23
I. Data Development Agenda	25
Building an Infant Toddler System: Summary of Policy Recommendations	26



Twelve Essential Findings

The following findings emerged from both national and Connecticut determinations. The Early Childhood Education Cabinet worked with Matt Melmed of Zero to Three in Washington D.C., Jack Shonkoff at Harvard University and Neal Halfon at the University of California, Los Angeles. They offered information on the intersection between neuroscience and cognition and what factors protect or stress children.

These findings were mirrored by working groups in Connecticut who studied population trends and implications for our youngest children. The common variable in all the findings was the need for a strong and comprehensive system to hold up the infants, toddlers and twos programs and policies with accountability and strong outcomes.

1. Early experiences determine whether a child's brain architecture will provide a strong or weak foundation for all future learning, behavior and health.
2. Young children need consistent positive relationships, rich learning opportunities and safe environments, not quick fixes or magic bullets.
3. Access to health care for pregnant women and children can help prevent threats to healthy development as well as provide early diagnosis and appropriate intervention when problems emerge.
4. Of all the factors that operate in a young child's environment, the single most important determinant is the quality of the child's relationships with parents and caregivers.
5. Screening assessment and monitoring of children's health and development must occur where they are most likely to be seen and services must be available whenever needs are identified through these processes.
6. Children growing up in poverty often have severely compromised health, cognitive, and social development significantly affecting school performance. Family poverty must be reduced to ensure equitable child outcomes.
7. Factors that promote program effectiveness for very young children include highly skilled staff, warm responsive interactions between staff and children, language rich environments, small class sizes, high adult to child ratios, and age-appropriate curriculum.
8. Quality matters. Programs that cost less because they employ less skilled staff are not effective if they do not have the expertise needed to produce measurable results. Effective programs are implemented well with quality standards, evaluated regularly with data and improved continuously.
9. Forty years of research inform interventions for vulnerable children at risk of low school readiness and school failure. These interventions must occur early with the mother, even before the child is born, since her health is the foundation for the newborn's health. Post-natal care should be on a continuum that includes information, access to care, skilled home visitation, two generation programs with support for both parent and child, and center based quality early care and education.
10. Literacy begins in the earliest months of life as infants become familiar with the sounds of language. Frequent and consistent exposure to words and text are the precursors to literacy development and must start in infancy. Oral language and early literacy development begin at birth.
11. African-American, Hispanic and other minority children are dramatically impacted by limited access to health care, fewer resources, distressed neighborhoods, poorer performing schools and institutional racism.
12. There is not yet a cohesive system for young children that supports good child outcomes and meets customer need. Family support, physical and mental health, early care and education and literacy should be aligned and integrated with data driven planning.



First Words, First Steps The Importance of the Early Years

We know that the early years are critical to later success in school and in life, but there is no magic year that alone can ensure this success. Instead, young children need access to health care, strong families and positive early learning experiences from birth to five and beyond.

Zero to Three Policy Center, Washington, D.C.

I. Introduction

Advances in Brain Research

Promoting school readiness and closing the achievement gap is a national priority. Recent advances in brain research inform us of the importance of early brain development to school readiness, life-long learning and social adaptability. These scientific gains have generated a much deeper appreciation of the importance of early life experiences, as well as the inseparable and highly interactive influences of genetics and environment on the development of the brain and the unfolding of human behavior. Unlike the body, which takes 20 years to mature to 95 percent of its full size, the brain develops to 90 percent of its capacity in the first five years.

At birth, children's brains have almost all the brain cells or neurons they will ever need. However, these neurons are not yet linked into the networks necessary for learning and complex functioning. Between birth and school age, a process of "sculpting" occurs: some neural connections are made or reinforced and others die away. Early experiences affect brain structure because the brain operates on a "use it or lose it" principle. If a child does not have adequate emotional, physical, cognitive, and language stimulation, neurons can be lost permanently.

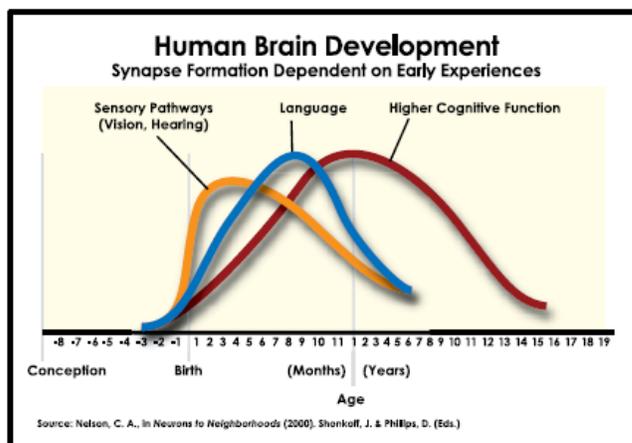
Infant and Toddlers are Capable Learners

The environment has the greatest potential to influence the child's developing brain during a child's first few years of life. The period between birth and three years is a time of rapid cognitive, linguistic, social, emotional, and motor development. Explosive growth in vocabulary, for example, starts at around 15-18 months and continues into the preschool years. The ability to identify and regulate emotions in oneself and others is well underway by the second year.



Every few months we are told of some new capacity among very young children to learn and make judgments. Researchers at Yale University's Infant Cognition Center report that babies as young as 6-10 months old show crucial social judgment skills before they can talk. Their acquisition of language and higher cognitive function is influenced and can be improved by their experiences during these years.

The early years are in fact where language begins and where the capacity to care for others begins. Moreover, caring influences cognition. For example, babies whose mothers provided them with opportunities to observe, imitate and learn, performed higher on IQ tests at age four than children who were not exposed to the same teachings starting at age one. Early experiences determine whether a child's brain architecture will provide a strong or weak foundation for all future learning, behavior and health.



II. The Context

Social, Economic and System Challenges

The Family Is Working

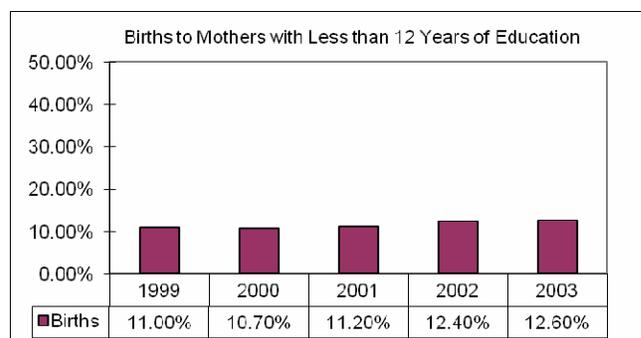
Parents are a child's first and most important advocate. No institution, public or private, can replace the primary family function of providing safe, nurturing, and loving relationships. Yet, there are fewer adults at home caring for children today. When parents and caretakers are at home, they are home for fewer hours and have more demands on that time. More families have both parents working. Many of them must work more than one job to pay their bills.

Traditionally, members of the extended family have been able to ease the burden on these families. But family members are less likely to be rocking their infant grandson in the living room or even live nearby. They live in other cities, are working themselves, or have problems of their own that make it less likely they can effectively buffer the strains on these young families.

The shortage of time and stressors facing family life inevitably affect children. More children are being raised in single families. In some instances, divorce breaks up the two parents. In other cases, marriage

never occurred. Additionally, increasing numbers of children are being raised by their grandparents. The youngsters' parents are ill, facing emotional stressors that impede quality parenting, or have passed away. In most cases, the grandparents were not planning on raising another generation of children and find their retirement years replaced by the job of raising another family.

Even when parents are at home, many have fewer personal resources and knowledge to provide the optimal environment for their child's growth and development. One indication of these stresses is the number of births to mothers without a high school diploma. The percent of births to women without a high school diploma is increasing. It stood at 12.6 percent, approximately 5,000 of children born in 2003.



These infants are less likely to arrive at school ready to learn and more likely to have both developmental and physical problems that will restrict their development.

Early Care Settings Are in Short Supply and of Questionable Quality

Children need to thrive while parents are at work or in training. If a parent must work, the early care system should offer a high standard of care with nurturance, connection, play and learning. Only language-rich and responsive care giving fosters healthy development during this period. Not all children have such experiences, particularly infants, toddlers and twos.



Child care is highly fragmented and characterized by marked variation in quality, ranging from rich, growth-promoting experiences to highly unstable and sometimes dangerous settings. The burden of poor quality and limited choice rests most heavily on low-income, working families whose financial resources are too great to qualify for state support, yet too low to afford quality care.

With changes in welfare, virtually all unskilled mothers are working. Their jobs often do not offer a living wage and they have become the growing working poor. The parent is neither out of poverty nor moving up an employment ladder. No parent is home with the child. The majority of parents in Connecticut who are just off welfare, select informal care for their children.

This care is less regulated and the providers are rarely trained in the learning and developmental stages of the child. Children receive fewer cognitive basics. When inadequate stimulation is provided or barriers to opportunities for productive learning exist, these can lead to early disparities in capability that generally persist in the absence of effective intervention.

The Rising Cost of Health Care

Families in Connecticut, like other Americans, face the growing problems of the high cost of health care as well as access to quality care in a timely manner. Families are spending more of their personal income on health care costs, almost 15 percent, the highest since the early 1990's.

As the economy shifts to more part time, low wage jobs, employer insurance plans are not an option in many cases. For those who lack health insurance, appropriate health care may be difficult to obtain. In Connecticut it is estimated that almost 400,000 residents have no health insurance. Hispanics and African-Americans make up a disproportionate share of those uninsured.

Fortunately, almost 300,000 children are enrolled in the State Medicaid Program. In the 2007 legislative session, eligibility for children and families rose to 185 percent of the federal poverty level and eligibility for pregnant women rose to 250 percent of the federal poverty level.



Obstacles to Good Health

Despite these efforts, children from low-income families, especially those from racial and ethnic minorities or children with special health care needs, who are at high risk for acute and chronic health problems, are the least well-served. These children face daunting obstacles to obtaining high quality care and are at-risk for sub-optimal health at entry into school. Poor health outcomes for these children can ultimately impact their ability to enter school healthy and ready to learn, and thus have a profound impact on all future aspects of their lives.

Insurance reimbursement to health care providers for critical early childhood services is often insufficient. This reduces the supply of providers, especially for low-income children, creating a significant barrier to access for needed services. Insurance-related disparities in oral health care are virtually tenfold those in medical health care. Further efforts are needed to enroll HUSKY-eligible children at each encounter in the health care, child care and social service systems.

Cultural and Social Barriers

Barriers to young children’s health care access include family mobility, lack of culturally competent providers, inconvenient office hours and locations, and language and “health literacy” (understanding medical language) problems. Care coordination is poor, as child care and family support services are not well linked to health care services, prevention services are not well coordinated, and many children are lost to the system when no longer eligible for services.

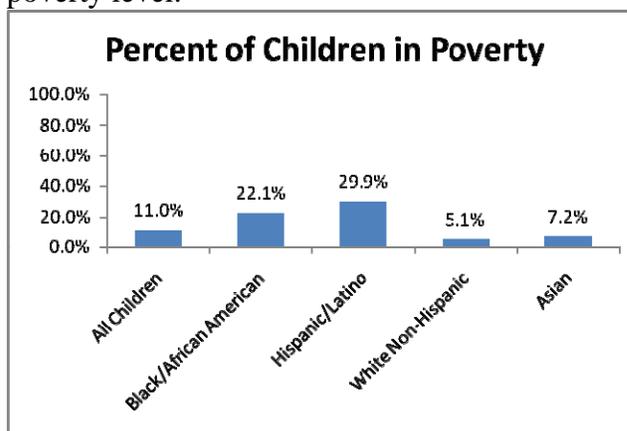
Comprehensive health services are the building blocks for optimal child development. Healthy children are less likely to get preventable illnesses or suffer from preventable diseases and are more likely to succeed in school and become productive workers. Connecticut’s health care system must aim for comprehensive, preventive and continuous health care for all children.



More Children Are Poor or Near-Poor

Adding to the challenges, more young children are poor or near poor, facing obstacles that impinge on their life choices before they ever open the kindergarten door. Connecticut has approximately 2,000 children in homeless shelters, the preponderance of them under five years of age. Poverty during early childhood may be more damaging than poverty experiences at later ages, notably with respect to academic success.

Nearly 89,000 children in Connecticut lived in poverty in 2006. Nearly one-quarter of our state’s children live in low-income households with income at or below 200 percent of the federal poverty level.



The children who make up the largest proportion of the achievement gap in our state are precisely those whose home environments have multiple, recurrent, and unrelenting challenges. Children who are poor often face extensive health problems and family stress factors. They are more likely to have health problems that include: bacterial meningitis, infectious disease, low birth weight, lead poisoning, dental cavities, asthma, anemia, stunted growth, and obesity. Poverty is a major risk-factor.

A Global Marketplace

Shifts in the economy increase the stakes for success and the demands on young children. An increasingly globalized economy allows jobs to go where the skills can be purchased at the best price. For children in Connecticut to grow up able to compete in this flat world, they must have critical thinking and communication skills, increased

knowledge in math and science and the resilience and flexibility to shift in a constantly changing work environment. Schools must ensure that children acquire these skills and have the capacity to keep learning and adapting throughout their lives.

Business leaders argue that the achievement gap and worker shortage necessitate sharp improvements in kindergarten through grade three education as well as improvements in the quality and availability of early care. By the year 2020, 50 percent of Connecticut’s workforce will come from its urban sector. Yet fewer than 50 percent of those in the urban sector are graduating from high school now. Outsourcing continues, and workers from other nations replace some in certain job sectors where skills are lacking.

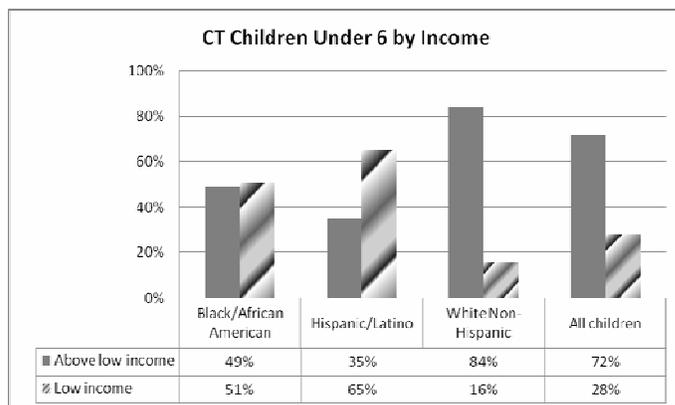
While the percentage of Connecticut’s students going on to post-secondary education is high compared to the rest of the country, our view of our success should be tempered by a downturn in reading scores for the state’s fourth-graders on both the national test and the state’s Mastery Tests. Moreover, last year, Connecticut ranked worst in the nation in poverty gap in proficiency on the national reading exams, the NAEP tests.

Ensuring third grade literacy means increasing the focus on oral language skills development and early reading success skills in the home and in early care settings. Oral language development and preliteracy are the bridge and precursors to language skills development in kindergarten and first grade. The economic gap between rich and poor is no longer affordable.

Population Changes and Growing Inequities

Growing numbers of young children in Connecticut are from different cultures. The fabric of diversity is strong but the disparities in income for children are also great. There are about 248,000 children under six years of age in Connecticut. As the chart below shows, 28 percent (69,440) live in low-income families (families earning less than twice the federal poverty level or less than \$40,000 for a family of four).

**Connecticut Children Under Six
Percentage and Number by Race/Ethnicity and Income**



Disparities are growing in health and developmental outcomes. Connecticut data highlights severe inequities in early child development, health and learning for many African-American and Hispanic children and their parents.

For example:

- White mothers are twice as likely as black mothers and three times as likely as Hispanic mothers to receive timely prenatal care.
- Infant mortality rates for Latino children and African-American children are two and three times higher than for white, non-Hispanic children.
- Black children were three times as likely to be hospitalized and three to four times as likely to visit emergency rooms for asthma compared to white children.
- Connecticut has the worst achievement gap in reading among the states. While 65 percent of white students met the reading goal in the most recent CMT, only 24 percent of black students and 23 percent of Hispanics did so.
- White neighborhoods have, on average, five times as many supermarkets as predominantly black neighborhoods. This impacts food choices, nutrition and health.
- Although African-Americans and Latinos combined account for less than one-fifth of Connecticut’s total population, these two groups account for nearly half of Connecticut’s poverty population of 348,050.

Changes in population growth among different cultures have not been met with equal access,

expectation, or inclusion. This harms the overall tenet of diversity and participation as core principles in our society. It impedes civic participation among young families and, of most importance, limits opportunity for certain young children.



III. Building an Infant Toddler Comprehensive System

Helping parents work and young children thrive is a paramount goal for the Connecticut family. The healthy development of young children is dependent on a set of forces that come together and influence children's development from the very earliest age, even during the prenatal period. The following Infant Toddler Comprehensive System includes maternal health, family support, community based services, early care and education and access to quality physical, mental and oral health care. These build on what research tells us promotes optimal healthy development and strong families.

To create a focus for its work, the Infant Toddler Working Group developed an overall goal to complement the Early Childhood Education Cabinet's *Ready by Five, Fine by Nine* goal: "All infants and very young children will achieve optimal health and development in safe, nurturing families and environments."

The Infant Toddler Working Group addressed its work by forming work groups in six key areas: 1) Maternal Health, 2) Family Support, 3) Physical

Summary

Public policy needs to catch up with its customers with the majority of both mothers and fathers working, growth in diverse populations, and greater demands on our children educationally to succeed in a global economy. Infants and toddlers require quality nurturance and learning while all of their parents attend school, job train or work. Helping parents work and children thrive is a paramount goal for the Connecticut family and its quality of life.

and Mental Health, 4) Early Care and Education, 5) Early Literacy, and 6) Systems Innovation. Each group was guided by a goal statement that helped to shape and focus its work.

A. Maternal Health

Results Statement All women will be healthy and ready for pregnancy and parenthood.

The importance of the health and well being of mothers as a means of ensuring children's healthy development cannot be overemphasized. Access to health care for women before, during and after pregnancy can help maintain the mother's health during pregnancy and prevent threats to the child's healthy development by ensuring her wellbeing after the birth. Access to healthcare for mother and child after the child's birth provides opportunities for prevention, early diagnosis and appropriate intervention for mother and child should problems emerge.

The Centers for Disease Control and Prevention's (CDC) includes access to healthcare through insurance for women of childbearing age before, during and after pregnancy as a critical strategy to achieving the four goals for improving birth outcomes in the United States:

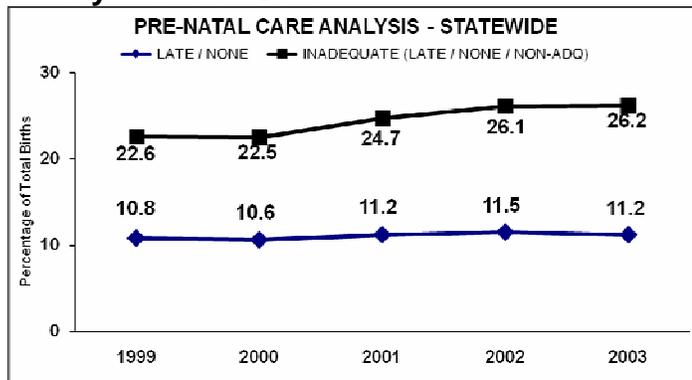
1. Improve the knowledge and attitudes and behaviors of men and women related to preconception health;

2. Assure that all women of childbearing age in the United States receive preconception care services
3. Reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period; and
4. Reduce the disparities in adverse pregnancy outcomes.



Continuous coverage helps ensure that women achieve early entry into prenatal care, are healthy prior to becoming pregnant and have the adequate number of prenatal and postpartum visits. Connecticut is making progress toward the goal of continuous coverage with Connecticut's latest expansion of coverage for mothers and newborns under the HUSKY and Charter Oak health plans, announced by Governor Rell in June 2008.

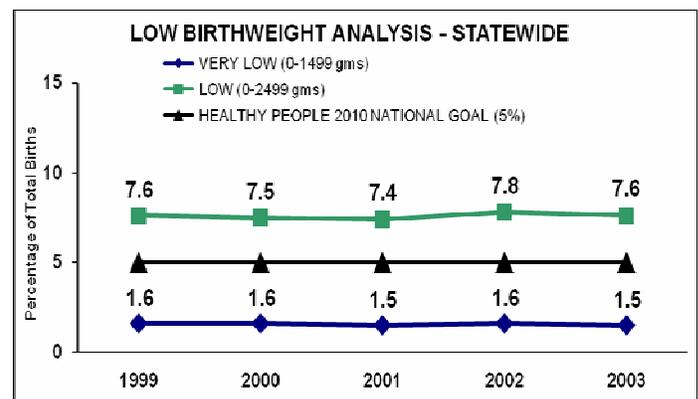
Timely Prenatal Care



Good prenatal care can detect potential problems early and prevent problems whenever possible through such simple steps as improving the mother's nutrition, increasing her exercise, and providing appropriate vitamin supplements. Prenatal care will also ensure a woman is directed to appropriate specialists, hospitals, etc. when necessary. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, and other preventable infant problems. As the graph above shows, 11 percent of births in Connecticut are to mothers who received late care, and 26 percent to mothers who received no pre-natal care. The data broken down by race is quite startling. White mothers are twice as likely as black mothers and three times as likely as Hispanic mothers to receive timely prenatal care.

Impact of Low Birthweight and Pre-term Births

In comparison to normal weight babies, low birthweight infants are more likely to experience physical and developmental problems, to require special education classes, or to repeat a grade. Low birth weight is defined as a weight of less than 2500 grams, and preterm birth is defined as a gestational age of less than 37 weeks. Low birth weight is the key risk factor for death or long-term illness and disability. Research suggests there are 2 factors most associated with the trajectory of a person's life- one's birth weight and socio-economic status. Low birth weight and preterm births have been extensively studied and several risk factors have been identified. Some of the most common risk factors for low birth weight and preterm births are: previous low birth weight delivery; race/ethnicity, with African Americans being the most at risk; teenage mothers; low socioeconomic status; unmarried status; significant maternal medical conditions such as pre-eclampsia, diabetes and renal disease; prenatal alcohol and or substance abuse; maternal smoking; maternal stress and depression; and lack of early or any prenatal care.



Maternal Depression

It is estimated that chronic depression affects approximately 10 percent of mothers of young children. In environments with high poverty and other risks, depression is at a much higher rate. Findings at enrollment from the national evaluation of Early Head Start indicate that nearly half of mothers reported enough depressive symptoms to be considered clinically depressed. Stress and depression during pregnancy has been linked to decreased fetal growth, preterm birth, and poorer neonatal health.

The consequences of maternal depression for the young child include withdrawal, anxiety, aggression, and poor language and cognitive development. Identifying the mother as early as possible and working with the mother and infant together is imperative for the child's wellbeing as well as the mother's.

Breastfeeding

Breastfeeding increases the likelihood that children are healthy and ready to learn, especially if the child was born pre-term or at low birthweight. Human milk is the optimal food to promote emotional, physical and intellectual development. Human milk and breastfeeding of infants provide advantages with regard to general health, growth and development while significantly decreasing risk for a large number of acute and chronic diseases. These include ear infections, gastrointestinal infections, serious lower respiratory tract infections and asthma. The American Academy of Pediatrics (AAP) suggests that women try to breastfeed for the first 12 months of life because of the benefits to both the mother and baby. These benefits to the baby are matched by a parallel set of physical and psychological benefits to the mother.

According to the AAP Policy Statement on Breastfeeding, women who don't have health problems should exclusively breastfeed their infants for at least the first six months of life.

Although there are many obstacles to the initiation and continuation of breastfeeding, the Centers for Disease Control and Prevention (CDC) have identified a number of evidence-based interventions. These include maternity care

practices, support for breastfeeding in the workplace, peer support, educating mothers, professional support and media and social marketing.

- Breastfeeding offers many benefits to the baby:
- Breast milk provides the right balance of nutrients to help an infant grow into a strong and healthy toddler;
- Breastfed infants, and those who are fed expressed breast milk, have fewer deaths during the first year and experience fewer illnesses than babies fed formula;
- Some of the nutrients in breast milk also help protect an infant against some common childhood illnesses and infections, such as diarrhea, middle ear infections, and certain lung infections;
- Recent government research suggests that breast milk contains important fatty acids (building blocks) that help an infant's brain develop. Two specific fatty acids, known as DHA and AA, may help increase infants' cognitive skills. Many types of infant formulas available in the United States are fortified with DHA and AA, and all formula available for preterm infants is fortified with these fatty acids; and
- Low birth weight babies who were fed breast milk had greater mental development scores at 30 months than did infants who were not breast fed.

Teen Pregnancy

The United States has the highest teen pregnancy birth rate in the industrialized world. Between 1991 and 2004 there have been more than 48,700 teen births in Connecticut, costing taxpayers a total of \$1.9 billion over that period considering lost income, incarceration of teen parents, child welfare and foster care and health care costs. (National Campaign to Prevent Teen Pregnancy). Teenage mothers experience more academic difficulty and failure when compared to children of older mothers. Many of the educational risks faced by the children of teen parents are the result of co-occurring poverty such as limited educational materials in the home, lack of a high school education and engagement in parental behaviors that hinder early learning opportunities.

Recommendations to Develop and Sustain a Comprehensive Maternal Health System

Maternal Health
Expand health insurance coverage for all women and teens to ensure access to and delivery of services and referrals during pregnancy, the preconception and inter-conception periods. Services to include but not be limited to WIC, lactation consultation, folic acid assessment, BMI and nutrition education, breastfeeding promotion and support, smoking cessation, family planning, Healthy Start, oral and behavioral health and preventive health services. Ensure reimbursement of such services through Medicaid and private insurance
Identify all pregnant women with physical and psycho-social risk factors associated with Low Birth Weight and other poor birth outcomes to ensure adequate follow up with referral to services including but not limited to high-risk home based nursing visits and high-risk case management through Healthy Start. Provide training, through the EPIC type model, to physicians and staff in all level II and III Neonatal Intensive Care Units in Connecticut and to the primary care providers as to the importance of breastmilk, lactation support and breastfeeding promotion for LBW babies and their mothers and ensure qualified professional community follow-up upon hospital discharge to continue provision of breastmilk.
Support pregnant and parenting teens so they may complete their secondary school education and beyond. State Department of Education to encourage school districts to develop strategies so that pregnant and parenting teens will have the option to stay in their home school, continue their education and graduate there. Strategies to include but not be limited to flexibility in attendance so that students can comply with medical and related visits for themselves and children without being penalized, flexibility in assignment deadlines and design of physical environment such as the need for larger desks during pregnancy.
Expand behavioral health screening and referrals within the primary care setting and expand the behavioral health provider network so that all women during pregnancy, the preconception and inter-conception periods can have their behavioral health needs identified and treated. Enhancement and expansion of such services to include expanding the number of visits, alternative forms of treatment and treatment options. Reimbursement for such services to be ensured through Medicaid and private insurance.
Expand Healthy Start to serve more Medicaid pregnant women and review the current assessment tool used to align with the Medicaid Program
Increase the initiation, duration and exclusive breastfeeding rates consistent with Federal guidelines by ensuring culturally competent training for all primary care providers and their staff through the EPIC type model as to the importance of breastmilk, lactation support and breastfeeding promotion; assuring education and compliance with breastfeeding support and the use of breastmilk in all level II and III Neonatal Intensive Care Units in Connecticut; tracking these breastfeeding rates using instruments such as PRATS, PRAMS and/or the National Immunization Survey.



B. Family Support

Results Statement All families will be stable, secure and knowledgeable for effectively raising and ensuring the well being of their families.

Of all the factors that operate in a young child's environment, the single most important determinant other than birthweight is socio-economic status. We often underestimate the protective value of secure stable home environment. When protective relationships with father and mother are not provided, levels of stress hormones can be higher and depression and other psychological stressors more likely.

All families at different times need support, assistance, and resources to thrive. Mothers and fathers must be served within the context of their families and communities, utilizing strength-based approaches and cultural competence. Parents function best when they have a dependable network of people they can turn to for advice and concrete help with child rearing. Most families can rely on relatives, friends, and neighbors to provide the backbone of their family support network.

Families benefit from access to a continuum of community-based, high quality services that strengthen and support them in their parenting and nurturing roles. This may include access to health and mental health care services, home visitation, quality child care, or temporary assistance in meeting a specific basic need.

Core strategies that support healthy child development can be employed within parenting and family support programs to improve the outcomes for children, especially vulnerable children. These include:

1. Policies and programs to ensure that families are economically secure and have access to basic supports, including food, health care, housing and transportation;
2. Child focused interventions that provide specific educational opportunities, such as early intervention services, or high-quality child care;

3. Parent focused interventions that provide child rearing information, guidance on child development, mentoring and emotional support, and assistance to secure needed resources; and
4. Strategies that build the capacity of mothers and fathers to participate in the civic life of the community. As advocates, parents can influence local and state policies that impact a child's life related to the health, safety and learning of children as well as influence the quality of community life.

Family Support System

Strong families and communities are essential to a positive future for all children. Children who have the support of both parents - their mother and their father - are more likely to thrive. The Family Support System in Connecticut must better reflect and address the needs of both parents and integrate these effective strategies into an integrated system of sustainable high quality services that strengthen and support families in their parenting and nurturing roles. Many of these strategies need to be linked to the existing array of child and family services. The most effective programs will reach out to and engage the highest risk families in ways that are responsive to families of varied socio-economic, educational, language and cultural backgrounds.

Neighborhood-based family support centers or hubs can provide a stable, accessible, comfortable-family friendly place where families of all backgrounds can receive needed services and be empowered to participate fully in the civic life of the community. The Family Support System will be linked to regional early childhood system of care services and the existing disparate family services will be better coordinated and aligned for an outcome driven system.

FACT: When parents are engaged in children's learning, children from all backgrounds tend to adapt well to school and attend regularly. They have better social skills and behavior and earn higher grades.

(Anne Henderson)

Recommendations to Develop and Sustain a Family Support System

Family Support
Integrate the current diverse sets of family support programs into a network of family supports that recognizes the strengths and needs of the child and family and ensures a comprehensive continuum of services.
Ensure families have access to home visiting within the first six weeks and through the first year of each child’s life and ongoing home visits as needed.
Provide access to parenting skills training for all first-time parents through education programs delivered by credentialed staff.
Establish a coordinated, statewide quality improvement program for kith and kin providers, including innovation grants to communities.
Include course work on child and human development for all students in high school to provide critical knowledge to prepare youth for parenthood.
Increase support to the Fatherhood Initiative to ensure fathers have access to services and programs that support their active participation in the life of the child and family.
Support the Parent Trust Act which provides grants to local communities to foster civic engagement by parents.
Support and expand neighborhood-based family support centers to provide a stable, accessible, comfortable-family friendly place where families can receive needed services.

C. Child Health: Physical, Mental and Oral

Results Statement Every child from birth to age six will have access to comprehensive, preventive continuous health, mental and oral health care.

The child health system is most likely the first interface that a child has with a formal structure beyond the family, giving child health providers unique and early access to young children and their families.

FACT: One out of eight children entering kindergarten without school readiness skills is in poor health. (Boyer)

Most children are born in hospitals. Their families remain dependent on the health care system for continued monitoring, identification and resolution of problems, guidance, and connection to other services, both within and beyond the healthcare system. Child health services are also an opportune setting for addressing growth and development because so many other systems that serve children require assurances that health is

being monitored. Well child visits include administration of immunizations, extensive screening and monitoring for physical growth and for cognitive and socio-emotional development. Cognitive, emotional and physical deficits can be significantly decreased through screening, early intervention and oral health and mental health consultation.

Key Indicators of Child Health

Access to Nutritious Food

Food provides the nutrients that infants and toddlers need to be healthy. For a baby, breast milk contains all the necessary vitamins and minerals. Formula imitates breast milk. Nutrition remains a top priority as toddlers transition to solid food. The diet quality of young children is important because their bodies and brains are in a crucial phase of growth. In addition, poor eating patterns established in childhood heighten the likelihood of obesity, contribute to certain diseases, and usually transfer to adulthood.

Food Security

A family’s ability to provide for its children’s nutritional needs is linked to the family’s “food security,” its access at all times to enough food for

an active, healthy life. Lacking a consistent food supply can lead to malnutrition, weight loss, fatigue, stunting, anemia, developmental and behavioral disturbances, and increased susceptibility to lead poisoning, as well as problems with learning, resulting in lower grades and test scores. Children who are hungry some or all of the time also are more likely to be anxious and irritable in the classroom, and more likely to be tardy or absent from school.

Nearly one in ten Connecticut households has experience hunger and 2.6 percent of Connecticut households have very low food security. Nearly 12 percent of Connecticut's children lack food security. Children in families with incomes below the poverty line are no more likely than children in families with incomes at or above the poverty line to have a diet rated as poor.

Prevention of Child Obesity

Early intervention with infants, toddlers and their parents is critical to change behaviors that lead to early obesity and tooth decay. Many children as young as 4-6 months of age consume too many calories and inappropriate foods. Large infants, or those who grow rapidly in the first two years of life are at increased risk of obesity as children and adults.

Several studies have shown a strong association between food insecurity and obesity among low-income women. The Special Supplemental Food Program for Women, Infants and Children (WIC) plays an important role in addressing the obesity epidemic in this population, as well as in increasing economic security and improving nutritional intake. A 2004 study concluded that WIC participation prevents overweight in young children by providing education and nutritious foods including promoting breastfeeding among participants. Increasing access to the WIC program helps young families with low incomes to establish healthy eating patterns.

As children and adults eat more and exercise less, obesity rates have steadily increased. One in four Connecticut high school students were either obese, 11.2 percent or overweight, 14.7 percent in 2005. Overweight children are more likely to

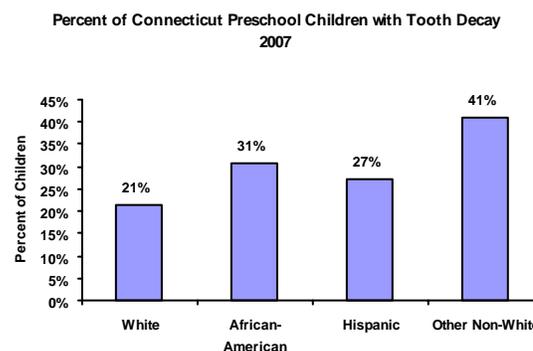
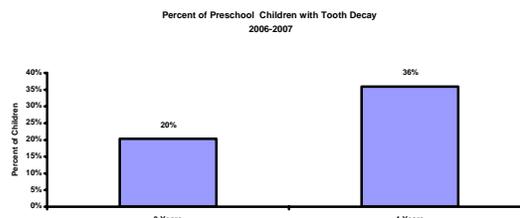
have significant health problems as children, remain overweight or obese as adults, and suffer early heart disease and death. Being overweight puts children at greater risk for developing asthma, Type 2 diabetes, high blood pressure, gall bladder disease, sleep disorders and depression.



Immunizations

Immunizations protect children from serious illness and disabilities, lower medical costs and save lives. They protect children from diseases that can inhibit children's health and their ability to learn. For this to happen, children must get their shots on time. On-time vaccinations prevent disease outbreaks, protect children through their first two years of life and beyond, and minimize the need to repeat doses. The immunization rate in Connecticut is one of the highest in the nation.

Oral Health



It is important for the overall health of children that oral disease is prevented and controlled as

early in life as possible. For prevention of early childhood tooth decay, the Academy of Pediatrics recommends youth decay risk assessment and the establishment of a dental home by age one. Less than three percent of children under age three had a preventive dental visit.

Children affected by tooth decay at an early stage are most likely to experience more oral health problems as they grow older. Tooth decay is the most common chronic infectious disease in children. Twenty percent of 3-year old and 36 percent of 4-year old preschool children in Connecticut have experienced tooth decay. Poor nutritional behaviors, prolonged exposure to sugary substances, use of nighttime bottle, ad lib feeding, promotes early childhood caries in children as young as one year of age.

Black and Hispanic women are twice as likely to suffer from tooth decay and gum diseases as the rest of the population. Oral infections of the teeth or gums can lead to difficulty eating and poor nutritional choices during pregnancy.

Women with tooth decay and gum disease can transmit bacteria to their infants putting them at higher risk of contracting tooth decay when teeth erupt around the sixth month of life. One in five children have tooth decay by age three. The percent of children with tooth decay differs by race and ethnicity and increases with age.

Social and Emotional Health

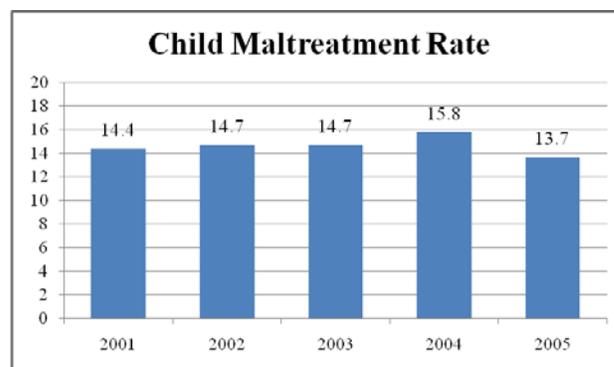
Social-emotional health is a strong predictor of later school success. To be able to learn, a child must be able to focus attention, regulate emotions, form secure relationships with both adults and peers, and be curious and motivated to explore the environment. These capacities are all learned in the context of a secure and nurturing relationship with a caregiver, beginning during early infancy. A child who is in a classroom and having emotional and behavioral problems is likely to be demanding significant time and focus from his teacher. He's not only be unable to benefit from the learning environment, but also disrupting the learning and play of his peers.

In a study in Connecticut, 68 percent of children who met the criteria for a psychiatric disorder in Kindergarten or first grade could be identified by screening in the first three years of life. Those children frequently live in families with the greatest challenges, especially maternal depression and other mental health disorders. Hence, it is critical to begin screening early and address these parental challenges, the parent-child relationship, and the child's relationship with all important caregivers, including the early care providers.

The children who make up the largest proportion of the achievement gap in our state are precisely those whose home environments have multiple, recurrent, and unrelenting challenges. It is clear that poverty is a major risk factor. When this is coupled with maternal depression, substance use, domestic violence, homelessness, child abuse and neglect and any number of other environmental stressors, this "toxic stress" disrupts brain development. These children are at incredible risk for poor social-emotional and academic outcomes. We have the knowledge to address these problems. We must now develop the will to restructure the systems and target resources to enable these children and their families to succeed.

Intentional and Unintentional Injuries

Abuse and neglect, either experienced or witnessed, cause severe physical and emotional harm and lasting problems with depression and anxiety for thousands of children in Connecticut.



Homicide is the fifth leading cause of death among children ages one - four in Connecticut. In 2000, Connecticut had the eighth highest rate of child abuse and neglect in the United States. More

than 7,400 Connecticut children less than eight years old were the victims of substantiated abuse and/or neglect. Children under three were more than three times as likely to be victims as 16 to 17 year olds.

In Connecticut, unintentional injuries are the fourth leading cause of death in infants and the second leading cause of death among children ages one - four. Falls and poisoning are the leading causes of hospital admissions due to unintentional injuries for children from birth to four years of age.

Environmental Health

The environment profoundly affects young children's health. Breathing and cognition are unintentionally hindered by environmental hazards.

- **Asthma** affects more than 10 percent of Connecticut children under age five who are insured by Medicaid. The asthma rates are highest for black children and for children in Connecticut's largest cities. Black children were three times as likely to be hospitalized and three to four times as likely to visit emergency rooms for asthma compared to white children.
- **Lead poisoning** is the number one environmental health disease impacting young children in the U.S. and Connecticut. Lead poisoning places young children at risk of permanent brain damage resulting in cognitive impairments, developmental delays, learning disabilities, attention deficits, concentration problems and may lead to school failure and even death. Currently only 48 percent of children are screened for lead poisoning, but starting in 2009, all children must be screened for lead at ages 12 months and 24 months. According

to the Connecticut Lead Poisoning Prevention Program, CLPPP, 65 percent of the children with elevated blood lead levels, (EBLL) were in Connecticut's five largest cities, New Haven, Waterbury, Hartford, Bridgeport and Stamford. Lead paint poisoning results from many sources including lead based paint primarily in pre-1950 homes, lead based pottery, and children's toys.



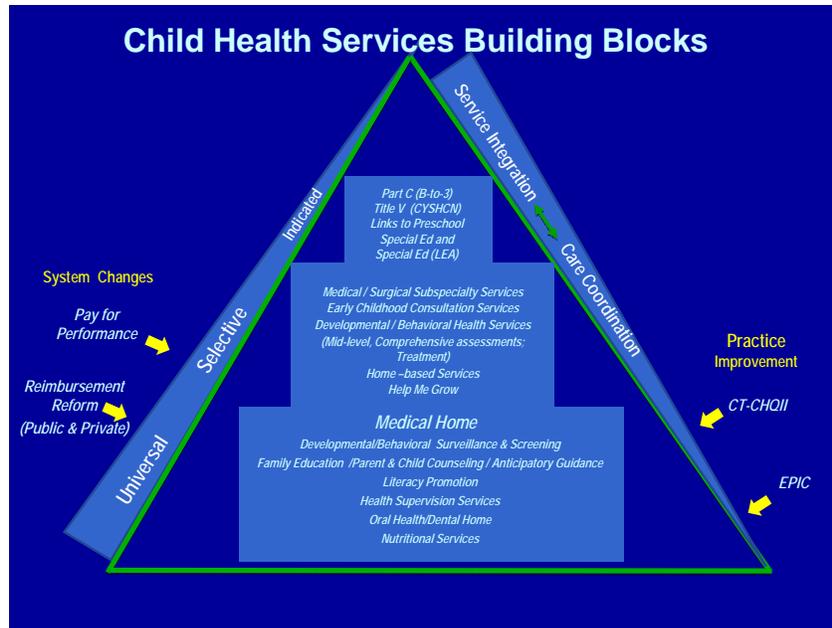
A Child Health System Framework

The framework for our systems' integration embraces national research that challenges us to move away from the current model of child health that is highlighted by an episodic, bio-medical, diagnose and treat model, to a more comprehensive and holistic approach to optimizing health development.

The new paradigm of service integration engages families as partners in the process of child health supervision and general utilization of services; supports the health care system in connecting children to needed health services and to early care and education and family support services; facilitates families' utilization of services; ensures the monitoring of children's service utilization and progress; and strengthens the base of community services available to children and families.

Building Blocks of the Framework

The child health service components of a comprehensive early childhood system to support healthy development includes linkage to early child care and education and family support.



The System includes:

- Universal preventive and primary health services provided to all children and families with an emphasis on early identification of health and developmental concerns;
- Early intervention services and referral services available to all children and families to address any health and developmental problems; and
- Intensive services provided to those children that have more complex needs.

Coordination of care is central to addressing children's needs within the health system and across service sectors, including early care and education and family support, at all three levels of the Framework.

Funding for children's programs is fragmented and categorical. The child is not treated as a whole and programs and services parce out a little treatment here and there. Financing streams unfortunately define service. The organization, administration and program implementation at all levels of government is necessary.

Recommendations for a Comprehensive Child Health Care System

Physical and Mental Health

Adopt the Child Health Services building block continuum of integrated services framework for a comprehensive health system.

- Support the implementation of the Medical Home model of primary care as recommended by the American Academy of Pediatrics and reimburse primary care providers for care coordination.
- Train primary health care providers to include developmental monitoring as part of well child services.

Ensure that children receive all of the well child services recommended by the American Academy of Pediatrics

- Disallow co-pays and deductibles for preventive pediatric services under commercial insurance
- Expand HUSKY eligibility and enrollment so that all children have health insurance coverage.
- Increase funding for transportation for families in HUSKY to primary care appointments.
- Reinstate continuous eligibility for HUSKY children to maintain continuity of care.

Fully implement EPSDT guidelines in Medicaid.

- Pay physicians for maternal depression screening and other family social risk factor identification.
- Change reimbursement policy to ensure payment based on medical necessity for mental health treatment rather than psychological diagnosis for infants and toddlers and two-year-olds.
- Provide and publicize payment for primary care providers to provide early preventive dental care and dental education.
- Improve reimbursement for sub specialty health services under HUSKY for children with special health care needs.

Improve the capacity to address social-emotional, behavioral, and mental health concerns through:

- Train early childhood providers in identification of social emotional problems.
- Increase the availability of services addressing social-emotional problems.

Expand early intervention services to high risk children and families to prevent developmental, learning and emotional problems. (e.g. Child First in Bridgeport Hospital)

Provide core coordinated services to maximize access and effectiveness.

D. Early Screening, Assessment and Intervention

Results Statement All children will receive timely, appropriate developmental screening and assessments as part of well-child service, including mental and oral health.

Identifying children's developmental concerns during infancy or preschool and providing early intervention services has a greater impact on outcomes for children and families than providing services at school age. The American Academy of Pediatrics recommends developmental screening of children at 9, 18, and 30 months. Their study shows that, despite the great variability of child and family function and the types and extent of services offered, most young children in early intervention programs improved in all domains of functioning.

The Connecticut Birth to Three System

The Connecticut Birth to Three System's data shows similar results. For a group of 883 children that entered Birth to Three, with 94 percent showing significant delay in one or more areas of development and who received at least six months

of service, 94-96 percent showed significant gains in one or more areas of development. Within that range, 55-60 percent improved to, or maintained, at age level performance. In tracking Connecticut children that received early intervention and were enrolled in kindergarten, 63.6 percent were not in need of special education services.

In Connecticut, 3.4 percent of all children under the age of three are receiving early intervention services. This is higher than the national average of 2.6 percent but lower than some of our neighboring states (New York - 4.2 percent, Rhode Island - 4.4 percent and Massachusetts, with extremely broad eligibility, 6.4 percent). Connecticut limits eligibility to children with significant delay or those with diagnosed medical conditions that have a high probability of resulting in developmental delay.

In response to the dramatic increase in the prevalence of children with autism spectrum disorders, the Birth to Three System now screens for autism in children referred who are 16 months of age or older. For those children screened, 250 children ages 18-36 months of age were identified with autism spectrum disorders. Where results

indicate concern, the family is offered an autism assessment to determine whether the child meets the criteria for the educational classification of autism founding the Individuals with Disabilities Education Act. The Department of Education uses these same criteria for children three and older. Families can access early intervention services in one of ten newly established autism-specific programs throughout the state.

Policy Direction - Expand eligibility for services for children with mild delays, children with challenging behaviors, and children at risk for developmental delay due to issues such as abuse and neglect, exposure to domestic violence, prenatal exposure to illegal substances, and those with elevated lead blood levels. Providing early intervention services can improve outcomes and offset the costs to taxpayers for more costly treatment in a child’s later years.

Recommendations for a Comprehensive Early Screening, Assessment and Prevention System

Early Screening Assessment and Intervention
Expand the Birth to Three program to include children birth to three with mild developmental delays and environmental risks.
Enhance the capacity of Child Development Infoline and Help Me Grow and support universal use of Ages and Stages Program.
Enhance early intervention services for children of mothers identified as depressed or exposed to violence.

E. Early Care and Education

Results Statement All families have access to high quality care and early education that meets the families and their children’s needs.

Early experiences determine whether a child’s developing brain architecture provides a strong or weak foundation for all future learning, behavior, and health.

-Dr. Jack Shonkoff

Children are born ready to learn. Children are naturally curious beings who are motivated to make sense of the world around them. The brain is the only organ that is not fully formed at birth. During the first three years, trillions of connections between brain cells are being made. A child’s relationships and experiences during the early years greatly influence how her brain grows.

The facts are uncontested that the underpinnings of a child’s self-esteem, and lifelong learning patterns are sewn together before kindergarten. Child care and early education is the pivotal opportunity to make sure that every child is guided to learning achievement as well as safety. Poor quality care is

the starter fuel for inequities in educational achievement.

Connecticut’s system of early care and education needs to provide those caring for and educating young children with a variety of supports and linkages to ensure these very young children’s lifelong successes. Communities that offer well-coordinated intergenerational support programs are most able to address the broadest range of adult’s and children’s needs in the community over time.

Connecticut’s current early care and education support system needs strengthening and expansion at the state and local levels. Families need sufficient choices for their youngest children. Of 173 countries, only four have no paid leave time for new mothers - Papua New Guinea, Swaziland, Liberia and the U.S.A. Yet businesses that recognize and accommodate the shifting needs of workers based upon their family responsibilities are retaining highly qualified employees and benefiting substantially. Research shows:

- Unpaid leave forces families back to the workplace before they or their children have securely bonded;
- There are not enough licensed child care facilities to care for Infants, Toddlers and twos;
- Many of the later learning disabilities can be screened for at this age and be eliminated before a child enters kindergarten; and
- Families experiencing multiple stressors can't be in multiple places to obtain services or knowledge for themselves or their children.

Family-friendly supports are needed at the policy levels, in the workplace and where children are receiving care and education. Parents, teachers and caregivers need education on two-generation strategies that can have a positive impact on changing parents' ability to support their child's learning as long as staff are highly knowledgeable and skilled.



Focus on Training and Capacity Building

Providers do not always have the knowledge about the best way to support the development of infants toddlers and twos. Most of all, many providers of care are not part of a formal network of providers. Some are friends or relatives who do not receive state funding, and are unaccounted for in the system. Some friends or relatives are receiving state funds and are part of the system although the standards of care are largely unregulated. Others are formal providers (e.g., Early Headstart) who care for infants, toddlers and twos but even among these care providers knowledge of infants, toddlers, and twos needs varies. Providing accessible training and education for all types of providers, regardless of setting is a crucial part of supporting care providers.

Many children need smaller, homelike settings in which they spend time away from their families. Family child care is an important but underutilized and under resourced setting. Yet, similar to families, family child care providers have varying knowledge, skills and needs. Individualized and consistent support can strengthen the quality of their home programs and improve the school readiness of children in their care. A support system should include: in-home education and coaching on intentional health and safety practices, quality learning experiences, and ongoing assessment of the whole child's development; and linkages to critical community resources that include health care, adult education, professional development, family child care licensing, credentialing and accreditation.

Recommendations for Comprehensive Infant Toddler Early Care and Education System

Early Care and Education
Implement Early Learning Guidelines for infants, toddlers, and twos in all publicly funded settings to bolster quality.
Align the reimbursement rates of state funded centers providing care for infants, toddlers and twos with school readiness programs to promote universal access to quality early care for our youngest children.
Expand the responsibility of the Early Childhood Education Cabinet Workforce Development Plan to include individual licensing, credentialing and other training efforts to prepare and sustain the infant toddler workforce.
Increase infant care slots. Develop and maintain family child care networks which would employ family child care providers, placing two providers in one home to care for up to six infants and toddlers and twos.
Provide a community based support system for unlicensed and licensed family child care providers.

Support curriculum and assessment training in publicly funded programs for infant toddlers and twos.

Expand opportunities for paid family leave to promote connection and nurturance between parents and new born babies and lessen the demand for formal infant care slots.

Promote physical and social emotional health and development by identifying and implementing funding mechanisms for health and mental health consultation in early care and education settings.

F. Early Literacy

Results Statement All children will understand and use language to help them learn to become good communicators and eager readers.

Almost all language and literacy experiences for children under three happen in relationships with those who care for them. When conditions allow attentive care and responsive interactions, relationships between adults and infants blossom.

J. Ronald Lally and Peter L. Magione
Learning to Read the World

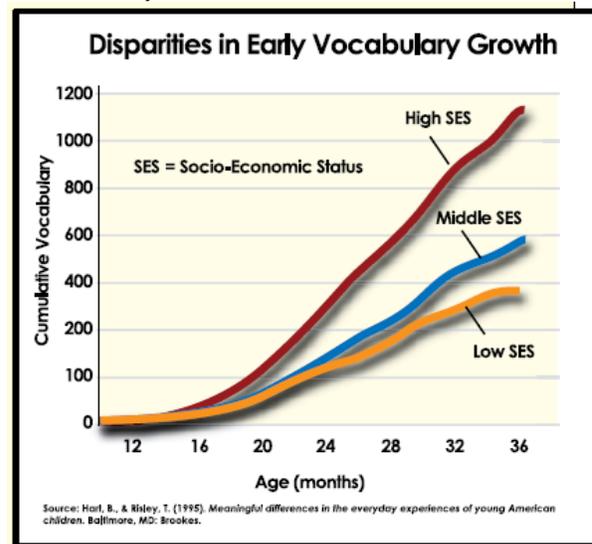
The success of literacy builds on a foundation that includes much more than just exposure to books or early training in letters and sounds. The foundation for success builds on a comprehensive system of services that meet the educational needs of parents and their children. Family literacy prepares parents to assume their role as their child's first and most important teachers.



The period between birth and three years is a time of rapid cognitive, linguistic, social, emotional, and motor development. Explosive growth in vocabulary, for example, starts at around 15-18 months and continues into the preschool years. Language-rich, nurturing, and responsive caregiving fosters healthy development during this period. Familiarity with the sounds of language and exposure to words and text bring the universe to a child. Reading opens doors to new worlds and probing questions. When a child has the capacity to speak, listen, and eventually read, the opportunities become limitless.

Research and experience have shown that the quantity and quality of talking with young children:

- develops their language, reading, and writing abilities;
- improves their ability to problem-solve;
- prepares them effectively for school. and
- demonstrates the link between vocabulary size, early literacy skills & comprehension. *Vocabulary is a major predictor of reading ability.*

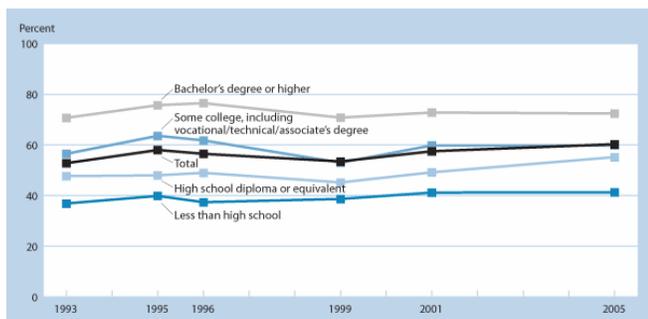


The size of each child's vocabulary correlates most closely to one simple factor: the number of words the parents spoke to the child. The importance of vocabulary development extends far beyond reading comprehension; it is a key component in achieving positive outcomes related to IQ scores, socio-emotional health, and school-readiness, among others.

The amount of reading and talking parents do with their children tends to differ based on parents' language, cultural background, and economic status. Research reports parents tend not to change how much they talk to their child as the child grows older. So it tells us to talk, talk, talk to children. Language begins at birth. A child's capacity to talk

and the size of their vocabulary when they enter kindergarten is predictive of success in school.

There is a high correlation between the literacy level of the mother and the literacy level of the child. Research shows the number of words used in homes and found strong correlations between the amount that parents talk to their children and socioeconomic status and children's vocabulary. Children's capacity for learning language is solidified by age three, and the cumulative effects of the environment are evident.



At about one year of age, children say their first word. They already comprehend several words and are able to point to objects and understand what they are. By two years of age children use hundreds of words, speak in sentences, ask about things and look at storybooks on their own. They can detect rhyme patterns and produce 'meaningful' messages through writing.

Language and literacy growth are shaped by environmental input at home and in early care settings. There is tremendous variability among children in their language and literacy skills just prior to formal school. These differences matter greatly as we predict children's future in school and society.

Early intervention may prevent or decrease the severity of language delays in preschoolers, enhance school readiness, and increase later academic success in school. Children with language problems in early care are likely to face poor educational achievement in school and are at increased risk to develop emotional and behavioral disorders.

Language and Literacy Skills

At the beginning of the 2006-07 school year, Connecticut kindergarten teachers reported that:

- Thirty-five percent of students did not begin the school year with the expected language skills;
- Thirty-eight percent of students did not begin the school year with the expected literacy skills; and
- for DRGs H and I, slightly more than 50 percent had expected literacy skills.

The National Early Literacy Panel

Recommendations for an Integrated, Coordinated Family and Early Literacy System

Early Literacy
Create a coherent and coordinated early literacy strategy to reverse the reading crisis in Connecticut. Utilize research based practices in developing a continuum of strategies from birth to third grade.
Develop training opportunities for parents and providers on how children learn to talk, develop vocabulary and learn proficient oral language skills.
Facilitate reading programs in state prisons so that both fathers and mothers can read to their children and give them books when they visit.
Include parents as partners in their child's education through support of opportunities and enhancement of family literacy skills such as Reach Out and Read in pediatric practices.
Promote two generational early literacy strategies that include both the child and parent through home visitation programs, libraries, child care providers, pediatricians and birth to three programs.
Expand the role of public libraries in outreach strategies to parents with infants toddlers and twos and informal and formal child care.
Allow parents who are not literate and on welfare to utilize adult literacy training as a portion of their required work hours.

G. Child Poverty Reduction

Results Statement Child poverty will be reduced by 50 percent within the next ten years.

Family poverty creates child poverty. About one quarter of Connecticut children, and 26 percent under the age of six, lives in low-income families below 200 percent of the federal poverty level. Children in poverty are more likely to have poor health, infectious disease, low birth-weight, stunted growth and hunger. Children growing up poor in Connecticut perform much lower on education tests than do higher home children. Children in poverty are up to three times more likely to die during children.

The data trends tell us that these problems are substantial and persistent despite the individual

efforts of many agencies and the modest trend in the state’s economic growth. The trends for low income families and their children are not going in the right direction.

Poverty along with low educational levels of mothers are important factors affecting children’s growth and development. Poverty and lack of education not only affects the parent’s ability to provide for themselves, it limits their ability to meet the basic needs of their children.

Attention to reduction of poverty must be integrated into all of the programs that touch families and is seen as a core component of the comprehensive infant toddler system.

Recommendations for Embedding Child Poverty Reduction in the Infant Toddler Comprehensive System

Child Poverty Reduction
Support and implement the priority recommendations of the Child Poverty and Prevention Council.
Establish a state wide initiative for first time parents on Temporary Family Assistance to assess educational needs and provide appropriate services to assist them to become economic self sufficiency.
Incorporate into the local capacity building grants specific child poverty reduction strategies.

H. Systems Innovation

Results Statement Create a comprehensive, coordinated system that partners with and supports families to promote optimal development of their children.

The Infant Toddler Planning Committee envisions a bold new comprehensive system for early childhood that integrates health, the family, community and early care and education. It strives to create a family centered system that will provide for easy entry, clear navigation, and appropriate supports for all families. It involves a system design that recognizes the inextricable links between state, regional and local partners.

The Infant Toddler Committee extends the work of the Early Childhood Education Cabinet in data, capacity building and quality standards to include infants, toddlers and two year olds. This creates a

coordinated birth to eight system for young children and their families.

The comprehensive system builds on the core values articulated in the Report, “Ready by Five Fine by Nine” issued by the Early Childhood Education Cabinet. They include:

- Families (and their children) are at the center of service delivery;
- Communities, including local service organizations, require support to develop their own strategic planning, service delivery and management capacity;
- Early involvement with families, coordinated case management, interagency agreements, and resource flexibility and leveraging are required at the state and local levels; and
- Preventive practice, proven strategies, data driven decision making and accountability need to be intentional and transparent to the public.

One promising and innovative method of creating a bridge across funding streams in different state agencies is the “master contract.” Master contracting pulls programs and departments together through a commitment to shared outcomes for children. It is an administrative tool that addresses many of the problems of categorical funding without fundamentally altering the funding stream, its appropriation language, or legislative intent. It summarizes what many state agencies are doing or could be doing together, through Memorandum of Understanding Agreements.

It allows entities to align their funding and service delivery goals strategically by combining multiple, uncoordinated programmatic contracts into a single agreement. While the core goal of master contracting is to simplify administration, the mechanism can also be used to increase local funding flexibility, strengthen accountability through use of shared performance outcome measures, and foster service integration.

Four common principles and emerging policy directions are embedded in the new system design:

1. Families should be served within the context of their families and communities, utilizing strength-based approaches, and ensuring that services and systems are culturally competent;
2. Focus on the promotion and targeting of prevention to reduce the need for more intensive and expensive intervention and treatment;
3. Establish service delivery pathways that are comprehensive and easy to navigate. Simplify the organization and delivery of services. Organize services into coherent programs and programs into coherent systems; and
4. Focus on meaningful performance measures. Ensure that both the public and private sectors deliver services that are accountable, effective, efficient, accessible, acceptable, and equitable.

The values and principles outlined by the Cabinet represent a shift in the framing and execution of policies and services designed to give children, through their families, the best start.

Recommendations for a Comprehensive Infant Toddler System

Systems Innovation
Establish interagency agreements among Departments of Health, Social Services, Education, Children and Families and the Children’s Trust Fund to ensure all at risk infants and their families have access appropriate services including pre-natal care, home visitation services, nutritious food and appropriate physical and mental health care for the mom and baby. Use as a model for master contract system’s change.
Establish an inter-agency collaborative management committee of the Cabinet to oversee the infant toddler system’s building and hire a project coordinator to staff the committee.
Set aside up to 10 percent of federal grant dollars for early childhood, child care, Head Start, maternal and child health and social services, to provide adequate supports to mothers and babies in the first three years.
Create a continuum of care that ensures universal service access supporting family strengths, including regional systems, or “hubs,” connected to local neighborhood sites.
Require the local capacity building plans and School Readiness District plans to include a research-based literacy strategy to promote oral language and early literacy development.
Establish a state and local family support continuum to support family strength and function.
Establish and fund health and mental health consultation system for early childhood in a variety of settings.

I. Data Development Agenda

The workgroups identified data needs that would help increase accountability and provide additional guidance for policy decision making. Many data issues were identified, but those listed below were most often noted as key to a better understanding of factors affecting the well-being of infants, toddlers, and twos.

One major gap in information is an understanding of the well-being of mothers. This adult research most closely links with the short and long-term success of the child. Two other data development areas were identified:

Data Development Agenda	
Establish annual administration of the Pregnancy Risk Assessment Monitoring Survey (PRAMS), a population-based surveillance system that measures maternal behaviors and experiences, such as vitamin use, experience of abuse, time of initiating prenatal care, experience of depression. PRAMS is currently administered in 37 states.	
Fund and implement the Promoting Healthy Development Survey (PHDS) in Connecticut as the state's tracking tool on the developmental experiences of families. PHDS is a parent survey that assesses whether young children age birth to three (under 48 months of age) receive nationally recommended preventive and developmental services.	
Support the development of the Help Me Grow referral services database as a tool for identifying gaps in local service delivery for infants, toddlers and twos.	
Establish a developmental surveillance and screening system to assure that children are screened for developmental, behavioral and mental health problems, as part of a statewide surveillance system.	
Improve the availability and alignment of data on the local and state levels on school readiness measures (i.e. implement a pilot demonstration of a child performance measure such as the Early Development Inventory, EDI).	



Building an Infant Toddler System: Summary of Policy Recommendations

Summary of recommendations from the Infant Toddler Planning Committee represent a growing consensus among practitioners, policy makers, consumers and researchers on what it takes to serve children and families effectively. They are based on the premises that all children are born wired for feelings and are ready to learn, that early environments significantly impact development and that nurturing relationships are essential



Denotes priority implementation

<p>Maternal Health Result: All women will be healthy and ready for pregnancy and parenthood. <i>Indicators:</i> <ul style="list-style-type: none"> <i>% of low birth weight and pre-term birth;</i> <i>% of all births to mothers without a high school diploma;</i> <i>% of women with prenatal care by the end of the first trimester;</i> <i>% of mothers reporting depression before, during or after pregnancy (data development);</i> <i>% of women still breast feeding at 6 months; and</i> <i>% of eligible pregnant women and parents enrolled and maintaining enrollment in HUSKY.</i> </p>	
<p>Expand health insurance coverage for all women and teens to ensure access to and delivery of services and referrals during pregnancy, the preconception and inter-conception periods. Services to include but not be limited to WIC, lactation consultation, folic acid, BMI and nutrition education, breastfeeding promotion and support, smoking cessation, family planning, Healthy Start, oral and behavioral health and preventive health services. Ensure reimbursement of such services through Medicaid and private insurance</p>	
<p>Identify all pregnant women with physical and psycho-social risk factors associated with Low Birth Weight and other poor birth outcomes to ensure adequate follow up with referral to services including but not limited to high-risk home based nursing visits and high-risk case management through Healthy Start. Provide training, through the EPIC type model, to physicians and staff in all level II and III Neonatal Intensive Care Units in CT and to the primary care providers as to the importance of breastmilk, lactation support and breastfeeding promotion for LBW babies and their mothers and ensure qualified professional community follow-up upon hospital discharge to continue provision of breastmilk.</p>	
<p>Support pregnant and parenting teens so they may complete their secondary school education and beyond. State Department of Education to encourage school districts to develop strategies so that pregnant and parenting teens will have the option to stay in their home school, continue their education and graduate there. Strategies to include but not be limited to flexibility in attendance so that students can comply with medical and related visits for themselves and children without being penalized, flexibility in assignment deadlines and design of physical environment such as the need for larger desks during pregnancy.</p>	
<p>Expand behavioral health screening and referrals within the primary care setting and expand the behavioral health provider network so that all women during pregnancy, the preconception and inter-conception periods can have their behavioral health needs identified and treated. Enhancement and expansion of such services to include expanding the number of visits, alternative forms of treatment and treatment options. Reimbursement for such services to be ensured through Medicaid and private insurance</p>	

Expand Healthy Start to serve more Medicaid pregnant women and review the current assessment tool used to align with the Medicaid Program.	
Increase the initiation, duration and exclusive breastfeeding rates consistent with Federal guidelines by ensuring culturally competent training for all primary care providers and their staff through the EPIC type model as to the importance of breast milk, lactation support and breastfeeding promotion; assuring education and compliance with breastfeeding support and the use of breastmilk in all level 11 and 111 Neonatal Intensive Care Units in Connecticut; tracking these breastfeeding rates using instruments such as PRATS/PRAMS(Pregnancy Risk Assessment Monitoring System and Pregnancy Risk Assessment) and/or the National Immunization Survey.	
<p>Family Support</p> <p>Result 2: All families are stable, secure, knowledgeable and have the resources to effectively raise (including literacy) and ensure the wellbeing of their families.</p> <p><i>Indicators:</i></p> <ul style="list-style-type: none"> <i>% of children in families spending more than 30 percent of their income on housing;</i> <i>% of children in foster care;</i> <i>% of teen parents;</i> <i>% of communities with a completed written plan for early childhood;</i> <i>% of children reaching language development benchmarks by age five; and</i> <i>% of children 0-3 with substantiated cases of abuse and neglect.</i> 	
Integrate the current diverse sets of family support programs into a network of neighborhood family support hubs that recognizes the strengths and needs of the child and family and ensures a comprehensive continuum of services.	
Ensure families have access to home visiting within the first six weeks and through the first year of each child’s life and ongoing home visits as needed. Expand the Nurturing Families Program home visiting program for first time parents.	
Allow parents who are not literate and on welfare to utilize adult literacy training as a portion of their required work hours.	
Provide access to parenting skills training for all first-time parents through education programs delivered by credentialed staff.	
Establish a coordinated, statewide quality improvement program for kith and kin providers including innovation grants to communities.	
Include course work on child and human development for all students in high school to provide critical knowledge to prepare youth for parenthood.	
Increase support to the Fatherhood Initiative to ensure fathers have access to services and programs that support their active participation in the life of the child and family.	
Support the Parent Trust Act that provides grants to local communities to foster civic engagement by parents.	

<p>Physical and Mental Health</p> <p>Result 4: Every child has access to comprehensive, preventive, mental, physical, and oral health care, including timely, appropriate developmental screening.</p> <p><i>Indicators:</i></p> <ul style="list-style-type: none"> <i>% of children 0-3 with all well-child visits;</i> <i>% of children 0-3 without health insurance;</i> <i>% of families with a Medical Home; and</i> <i>% of primary care physicians implementing a family survey to determine family need and well being.</i> 	
<p>Adopt the Child Health Services building block continuum of integrated services framework for a comprehensive health system.</p> <ul style="list-style-type: none"> • Support the implementation of the Medical Home model of primary care as recommended by the American Academy of Pediatrics and reimburse primary care providers for care coordination. • Train primary health care providers to include developmental monitoring as part of well child services. 	
<p>Ensure that children receive all of the well child services recommended by the American Academy of Pediatrics.</p> <ul style="list-style-type: none"> • Consider disallowing co-pays and deductibles for preventive pediatric services under commercial insurance. • Expand HUSKY eligibility and enrollment so that all children have health insurance coverage. • Increase funding for transportation for families in HUSKY to primary care appointments. • Reinstate continuous eligibility for children in the HUSKY program to maintain continuity of care. 	
<p>Fully implement EPSDT guidelines in Medicaid.</p> <ul style="list-style-type: none"> • Pay physicians for maternal depression screening and other family social risk factor identification. • Change reimbursement policy to ensure payment based on medical necessity for mental health treatment rather than psychological diagnosis for infants and toddlers and twos. • Provide and publicize payment for primary care providers to provide early preventive dental care and dental education. • Improve reimbursement for sub specialty health services under HUSKY for children with special health care needs. 	
<p>Improve the capacity to address social-emotional, behavioral, and mental health concerns.</p> <ul style="list-style-type: none"> • Train early childhood providers in identification of social emotional problems. • Increase the availability of services addressing social-emotional problems 	
<p>Support the Governor’s initiative to enroll all uninsured newborns in the state’s HUSKY program.</p>	

<p>Early Care and Education</p> <p>Result 3: All families have access to high quality care and early education that meets the families’ and the children’s needs.</p> <p><i>Indicators:</i></p> <p><i>% of quality, regulated infant/toddler slots per 100 children birth-3;</i></p> <p><i>% of children in top quartile of readiness at kindergarten entry; and</i></p> <p><i>% of all slots accredited (by 1 of 4 systems)</i></p>	
<p>Implement Early Learning Guidelines for infants, toddlers, and twos in all publicly funded settings to bolster quality.</p>	
<p>Align the reimbursement rates of state funded centers providing care for infants, toddlers and two-year-olds with school readiness programs to promote universal access to quality early care for our youngest children.</p>	
<p>Expand the responsibility of the Early Childhood Education Cabinet Workforce Development Plan to include individual licensing, credentialing and other training efforts to prepare and sustain the infant toddler workforce.</p>	
<p>Increase infant care slots. Develop and maintain family child care networks which would employ family child care providers, placing two providers in one home to care for up to six infants and toddlers and twos.</p>	
<p>Provide a community based support system for unlicensed and licensed family child care providers.</p>	
<p>Expand opportunities for paid family leave to promote connection and nurturance between parents and new born babies and lessen the demand for formal infant care slots.</p>	
<p>Support curriculum and assessment training in publicly funded programs for infants, toddlers and twos.</p>	
<p>Promote physical and social emotional health and development by identifying and implementing funding mechanisms for health and mental health consultation in early care and education settings</p> <p>.</p>	
<p>Early Literacy</p> <p>Result: All children will understand and use language to help them learn to become good communicators and eager readers.</p> <p><i>Indicators:</i></p> <p><i>% of children reaching language development benchmarks by age 5 years; and</i></p> <p><i>% of children ages 3-5 who were read to every day in the last week by a parent/caregiver.</i></p>	
<p>Create a coherent and coordinated early literacy strategy to reverse the reading crisis in Connecticut. Utilize research based practices in developing a continuum of strategies from birth to third grade.</p>	
<p>Develop training opportunities for parents and providers on how children learn to talk, develop vocabulary and other early language skills.</p>	
<p>Facilitate reading programs in state prisons so that both fathers and mothers can read to their children and give them books when they visit.</p>	
<p>Include parents as partners in their child’s education through support of opportunities and enhancement of family literacy skills such as Reach Out and Read in pediatric practices.</p>	
<p>Promote two generational early literacy strategies that include both the child and parent through home visitation programs, libraries, child care providers, pediatricians and birth to three programs.</p>	
<p>Expand the role of public libraries in outreach strategies to parents with infants toddlers and twos and informal and formal child care.</p>	

<p>Early Screening Assessment and Intervention</p> <p>Result: All children will receive timely, appropriate developmental screening and assessments as part of well-child service, including mental and oral health.</p> <p><i>Indicators:</i></p> <ul style="list-style-type: none"> <i>% of children with developmental screening at 9, 18, 24, and 30 months;</i> <i>% of children receiving blood lead level screening at 12 and 24 months; and</i> <i>% of children with on time and completed immunizations.</i> 	
<p>Expand the Birth to Three program to include children birth to three with mild developmental delays and environmental risks.</p>	
<p>Enhance the capacity of Child Development Infoline and Help Me Grow and support universal use of Ages and Stages Program.</p>	
<p>Enhance early intervention services for children of mothers identified as depressed or exposed to violence.</p>	
<p>Enhance outreach and training of pediatricians on universal lead screening mandate.</p>	
<p>Establish regional early childhood systems of care to promote screening, assessment and referral to local services to promote prevention and early intervention for families most at risk.</p>	
<p>Child Poverty Reduction</p> <p>Result: Child poverty is reduced by 50% in Connecticut by 2014.</p> <p><i>Indicators:</i></p> <ul style="list-style-type: none"> <i>% of families with income above 200% of the federal poverty level; and</i> <i>% of two-parent families, including those where two parents work.</i> 	
<p>Support and implement the priority recommendations of the Child Poverty and Prevention Council. Implement the Food Stamp and Employment (FSET) program.</p>	
<p>Establish a state wide initiative for first time parents on Temporary Family Assistance to assess educational needs and provide appropriate services to assist them to become economic self sufficiency.</p>	
<p>Incorporate into the local capacity building grants specific child poverty reduction strategies.</p>	
<p>Systems Innovation</p> <p>Result 5: There is a comprehensive, coordinated system that partners with and supports families to promote optimal development of their children.</p> <p><i>Indicators:</i></p> <ul style="list-style-type: none"> <i>% of local communities with a comprehensive membership, including parents, and a plan for coordinated, family focused service system;</i> <i>% of programs serving families using the same outcomes and reporting mechanisms regardless of funding;</i> <i>% of budget allocated to sustain programs identified as best practice; and</i> <i>% of system programs maximizing federal resources.</i> 	
<p>Establish interagency agreements among Departments of Health, Social Services, Education, Children and Families and the Children’s Trust Fund to ensure all at risk infants and their families have access appropriate services including pre-natal care, home visitation services, nutritious food and appropriate physical and mental health care for the mom and baby. Use as a model for master contract system’s change.</p>	
<p>Establish an inter-agency collaborative management committee of the Cabinet to oversee the infant toddler system’s building and hire a project coordinator to staff the committee.</p>	

Continue the Infant Toddler Committee to maximize opportunities, federal, state and local, in policy and budget.	
Set aside up to 10 percent of federal grant dollars for early childhood, child care, Head Start, maternal and child health and social services, to provide adequate supports to mothers and babies in the first three years.	
Replicate Child FIRST (Family Interagency Resource Support and Training) early childhood system of care for high risk parents with infants and toddlers.	
Require the local capacity building plans and School Readiness District plans to include a research-based literacy strategy to promote oral language and early literacy development.	
Establish a state and local family support continuum to support family strength and function through regional systems of care that link to neighborhood based family support services.	
Establish and fund health and mental health consultation system for early childhood in a variety of settings.	
Expand Help Me Grow and Educating Practices in the Community (EPIC)	
Establish a results based accountability process linking literacy for children birth to 8 with family literacy	
Data Development and Research Agenda	
Establish annual administration of the Pregnancy Risk Assessment Monitoring Survey (PRAMS), a population-based surveillance system that measures maternal behaviors and experiences, such as vitamin use, experience of abuse, time of initiating prenatal care, experience of depression. PRAMS is currently administered in 37 states.	
Fund and implement the Promoting Healthy Development Survey (PHDS) in Connecticut as the state's tracking tool on the developmental experiences of families. PHDS is a parent survey that assesses whether young children age birth to three (under 48 months of age) receive nationally recommended preventive and developmental services.	
Support the development of the Help Me Grow referral services database as a tool for identifying gaps in local service delivery for infants, toddlers and twos.	
Establish a developmental surveillance and screening system to assure that children are screened for developmental, behavioral and mental health problems, as part of a statewide surveillance system.	
Improve the availability and alignment of data on the local and state levels on school readiness measures (i.e. implement a pilot demonstration of a child performance measure such as the Early Development Inventory, EDI.)	
Extend the Pre-Kindergarten Inventory System unique identifier to all children 0-3 in publicly funded pre-school settings. (PKIS)	





Thank you

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