# Linking the Child Care and Health Care Systems:
## A Consideration of Options

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## INTRODUCTION

In 2000, 18 percent of children under three years old lived in poverty, and poverty rates for African American and Hispanic children were three or more times higher than those for non-Hispanic white children. Thirty-five percent of African American children and 30 percent of Hispanic children were poor in 2002, compared to 10 percent of all white, non-Hispanic children.[1] Poverty has significant deleterious effects on children's physical and cognitive growth: Poor children have higher rates of asthma and more untreated dental problems. They also have lower rates of immunization and are less likely to have a regular source of health care.[2] In addition, poor children are far more likely to have learning disabilities[3] or to show other lags in cognitive development.

The Robert Wood Johnson Foundation (RWJF) has provided a grant to Public/Private Ventures (P/PV) to identify interventions that link children's health services with existing community-based services, especially those for which there is the possibility of funding through federal or state sources. The goal of the intervention would be to improve access to and the quality of health care for very young children from vulnerable populations. After speaking with experts, who identified the child care system as a useful point of entry into preventive health care for young children, P/PV, in consultation with staff members from RWJF, focused on exploring interventions that link health services with early childhood education and care services.

To carry out the effort, P/PV has conducted a review of federal family policies to identify potential funding sources for such an undertaking; we spoke with 18 experts in family policy, health or child care, and searched the literature for evaluations of efforts that link child care and health services. This report summarizes our findings and identifies the potential opportunities and challenges that such an effort might involve. Section 1 briefly discusses the findings from the literature, Section 2 discusses the potential benefits and challenges of linking child care with health care, and Section 3 provides recommendations. Two appendices are attached. Appendix A contains a summary of federal family policies, their target population and funding flexibility. It also includes some innovative state strategies to

improve the health and well-being of young children and their families. Appendix B provides a list of people with whom we spoke.

## SECTION 1: THE LITERATURE

The literature on child care and health includes two major bodies of work: The first provides information about the health outcomes for children in child care centers; the second is evaluation literature on child care interventions that include specific efforts to improve children's health and well-being.

Many medical researchers have investigated health outcomes for children in child care centers. Overall, the literature indicates that children in child care have more upper- and lower-respiratory tract infections (such as allergies, ear infections, colds and pneumonia), more gastroenteritis, and more infections caused by viruses such as hepatitis A than other children. And children in center-based care are at greater risk of contracting these illnesses than are children in other forms of child care. The literature finds both positive (in terms of improved immunity and decreased asthma rates) and negative (in terms of long-term hearing loss resulting from chronic ear infections) long-term health consequences of center-based child care for children.[4]

In contrast to the wealth of information about the overall health of children in child care, there is limited evaluation literature on child care centers' efforts to improve either children's access to health care or their health outcomes.

Through our talks with researchers, advocates and practitioners around the country, we found five strategies that link child care with health services: 1) early surveillance and assessment for developmental delays or health problems in centers; 2) preventive health care services in child care centers; 3) parent education about child health and development; 4) provider education in child health and safety; and 5) child care centers as an access point for enrolling children in health insurance. Of those five strategies, the two that seem to have been employed most frequently in recent years are provider education in child health and safety, and using child care as an access point for enrolling children in health insurance. There is, however, a rich evaluation literature for only one of those two strategies—providing education in child health and safety to child care staff.

A number of positive results have been observed in efforts that provide health education and guidance to providers in child care centers. For example, in one study of a Pennsylvania-based effort that provided child care center staff with early childhood education consultants, staff at centers substantially improved their feeding and diapering practices.[5] A leadership training program in Head Start, which focused on the directors of child care centers, also showed improvements in the health and safety of child care environments.[6] A number of other studies have indicated that provider education is linked to improvements in child care center environmental ratings scores, including assessments of the health and safety practices within centers.

In contrast, few evaluations have been conducted regarding the effectiveness of using child care as an access point for enrolling children in health insurance. There is also limited evaluation literature about whether or not interventions that link health services with early child development and care can improve children's overall health outcomes.

Important exceptions to the paucity of evaluations regard the Head Start, Early Head Start and North Carolina's Smart Start initiatives. These interventions have attempted to raise children's immunization rates, improve dental care, and help families find a regular source of medical care for children in centers. Head Start has also tried to provide education to parents about such issues as when to take a child to a doctor and how to treat mild illnesses. In general, the evaluations indicate that the efforts have a positive impact on children's health or families' health behaviors. The Head Start study found that parent education led to significant reductions in the number of times that parents took their children to the doctor and emergency room, and to an increase in parents' reliance on books to help them care for mildly ill children.

In Early Head Start (EHS), evaluators saw three statistically significant effects: EHS children were more likely to visit a doctor for treatment of a chronic or acute illness; their immunization rates were slightly higher (although both the treatment and control groups' rates were over 95 percent); and they were much less likely to be hospitalized for an injury or accident than their non-EHS counterparts (.4% vs. 1.6%). Also, children in research sites that fully implemented the key tasks of the health services component (such as health assessments, helping families find a medical home and tracking health service receipt) by Fall 1997 were more likely to have visited a dentist than were children in sites that reached full implementation later or did not fully implement core services (32% vs. 29% and 24%).[7] North Carolina's Smart Start improved the extent to which children had a regular place for health care and increased the proportion of children who received their latest immunization on time, but, importantly, it did not improve children's immunization rates overall.[8]

These impacts on health outcomes should be interpreted cautiously because the evaluations have little information about the content and quality of specific strategies used in the interventions. For example, the EHS programs are required to conduct health assessments of children within 90 days of enrollment, help families find appropriate health care for their children, and follow up with families to ensure that care has been received. How they do so is up to local programs, and the evaluation does not go into great detail on these issues.

In the section that follows, we discuss the potential benefits of strategies to link early childhood education and health care, including five specific strategies and the challenges that might be encountered in implementing them.

## SECTION 2: STRATEGIES TO LINK EARLY CHILD DEVELOPMENT AND CARE PROGRAMS WITH HEALTH SERVICES

> *We have a critical moment here. There are two trends converging: One is the pre-K movement and not a lot of health focus in that; [the second is] a growing number of infants and toddlers in child care because of welfare reform efforts and demographics.*
>
> *—Joan Lombardi*

### Potential Benefits

There are several reasons why linking child care and health services could contribute to better health outcomes for young children.

**First, early childhood development and care centers can provide access to parents and their young children.** In 2001, 56 percent of all children in the U.S. were estimated to be in such programs.[9] Also, since the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) legislation in 1996, many states' welfare programs require that mothers go back to work soon after their children's births, thus expanding the number of poor children in child care. In addition, some states have expanded the number of low-income children they serve through pre-kindergarten programs. Therefore, a large population of children could be reached through early education and care centers.

**Second, parents place high levels of trust in their child care providers.** Parents report high levels of satisfaction with child care centers, and there is some evidence to indicate that the vast majority of parents who use center-based care are satisfied with their arrangements.[10] Interventions that link health services and child care centers could capitalize on that trust. If child care centers act as intermediaries in bringing parents and the health care system together, parents may be more receptive to efforts to link them to health services. This may be particularly useful in centers that serve populations in which there is considerable distrust of medical practice.

**Third, partnerships between the health and child care systems may help improve center-based child care, which studies have shown to be primarily of fair to moderate quality in the U.S.[11]** Only about 10 percent of child care centers overall are estimated to be of poor quality,[12] but child care centers that accept public vouchers may be much more likely to be of poor quality because voucher reimbursements are substantially lower than the actual costs of high-quality child care. As we discuss in greater detail below, the credibility of the medical profession could be leveraged to improve the quality of child care centers by expanding possibilities for funding.

> *There's a lot of resistance to spending money for social services and things that will benefit poor children. On the other hand, if you take the same issues and reframe them as issues of the public's health, you are now talking about something that is medical; you are leaning on the slender reed of scientific legitimacy.*
>
> *—Charles Bosk*

**Fourth, early care and development and the health care fields are complementary systems that share similar goals of improving young children's outcomes.** Research over the past 10 years has established strong links between early environment, health and development, and various long-term outcomes.[13] The distinctions between physical development and cognitive/social development have become blurred as scientists have come to better understand the developing brain and how early environments influence children's development. Consequently, the distinctions between good developmental child care and good health care practices are also less clear, and the aims of child care and health care are converging. In its past work, P/PV has observed that service systems with complementary aims can often collaborate effectively.[14]

## Possible Strategies

Significant population disparities in health outcomes continue to exist. Poor, African American and Latino children have worse access to health care and worse health outcomes than middle-class or non-Hispanic white children. Among other things, the proportion of poor, African American and Latino children who have health insurance coverage is much lower, they have less access to dental care, and they are less likely to have a regular source of health care.

Arguably, however, the bigger gap in policy and practice is not in preventive health care per se, but in ensuring the healthy growth and development of very young children. As a group, babies and very young children are in relatively good health: most are immunized and most have a regular source of health care. However, disparities in young children's health begin to grow over time, and minority, especially Latino, children's growth and development trajectories are far poorer than those of white children. They are more likely to develop diabetes and asthma, be overweight and be unprepared for school than their white counterparts. They are also more likely to be exposed to pollutants that may cause later health problems. Thus, some of the key issues in young children's health outcomes pertain to how to maintain healthy growth and development. Doing so goes far beyond simple preventive health care.

How can links between health care and child care be forged to ensure healthy growth and development? Experts mentioned five strategies for linking child care with children's health services: surveillance and assessment to identify early developmental delays; providing direct services; health and safety training for providers; parent education; and using centers as a point of entry for enrolling young children in public health insurance. Below we briefly discuss each of these strategies.

### 1. Surveillance and Assessment

Although babies and toddlers in the U.S. are basically healthy, some researchers have estimated that as many as one third of all young children are not ready to enter kindergarten—and this seems to be true regardless of the definition of "school readiness" used. Some studies have looked at readiness as having the communication skills, enthusiasm

and ability to sit and pay attention required in a classroom setting.[15] Others have examined the proportion of children who recognize letters, count to 20 or higher, write their names or read or pretend to read.[16] These delays have a number of causes: A few are due to genetic problems (such as Down's syndrome) or variations in children's developmental trajectories, while others are a function of parenting practices and early environment (such as poor feeding practices or severe limitations on developmental activities), family trauma or mental health problems.[17] Therefore, among the health-related services that respondents indicated could be done in partnership with early child care centers were those related to surveillance and assessment.

Centers may be a particularly good place to undertake assessments of cognitive, emotional or physical development because providers are in contact with children on an almost daily basis. According to Dr. Neal Halfon from UCLA, children are typically identified as having developmental delays in early elementary school. Parents begin to recognize that their children might have delays by age three-and-a-half, but medical doctors (and presumably people trained to assess children's development) can begin to see delays by age two. Early intervention can be very successful in helping children with developmental delays, but first children must be identified. And staff members from early childhood development and care centers vary widely in their capacity to assess children's development.

There are at least two major approaches to assessing children in centers. Providers at the centers who work with the children on a daily basis could be trained to conduct preliminary assessments and refer children for further assessment if necessary. Alternatively, developmental specialists or health professionals could perform such assessments through periodic visits to the centers.

### 2. Direct Health Services

Health care services can be provided near or at child care programs, although we found little evidence that doing so is common. One is most likely to find the link between center-based care and health services in family resource centers. Such services can provide immunizations, well-baby care and dental care. It is probably less realistic to think that care for illnesses could be provided in clinics at child care centers because of the potential for the spread of infectious diseases.

### 3. Parent Education

Parenting practices, such as what parents feed their children and how they interact with them (speaking, playing, disciplining and other affective interaction), have an enormous impact on children's health and well-being. Many low-income parents, especially young parents who come from dysfunctional families themselves, have limited knowledge of child nutrition or cognitive, physical or emotional health. Because child care centers are places where parents are often present, if only to drop off or pick up their children, they may be useful venues for educating parents about issues such as healthy growth and development, good nutritional practices and positive disciplinary practices.

### 4. Provider Education

Another approach to linking child care with health services is to offer education to child care providers regarding children's health and well-being. These efforts, including some state, national and local initiatives, often include training in child development, early education, and health and safety. They can be provided through a variety of mechanisms: universities and colleges often have extensive early childhood programs, and community colleges provide courses that lead to child care credentials. Although child health and safety is frequently covered in these efforts, the focus tends to be on safety and avoiding the spread of disease within child care centers (which is very important). Other health components, such as healthy growth and development, are often limited, although the increased use of child care health consultants in some states has begun to address those issues in greater depth.

### 5. Using Early Childhood Education and Care Programs to Reach Uninsured Children

Even though the majority of young children in this country are insured, 18 percent of children living in families with an income less than $20,000 are not.[18] Thus, public education and outreach efforts could play an important role in helping to insure more children. For example, the Robert Wood Johnson Foundation's *Covering Kids* initiative and California's 100% Campaign work to enroll eligible children in health insurance. Healthy Child Care America has also undertaken some of this work, primarily through outreach materials. Its literature recommends that uninsured children in child care programs be linked with health insurance through parent and provider education, an expedited enrollment process for insurance and helping parents fill out insurance forms. The National Association of Child Care Resource and Referral Agencies also encourages similar efforts.

## Discussions of Specific Strategies

On the following pages, we examine the resources necessary to implement activities, the direct benefits of implementing these activities and the hypothesized main outcomes that would result from doing so.

## Surveillance and Assessment

### Figure 1

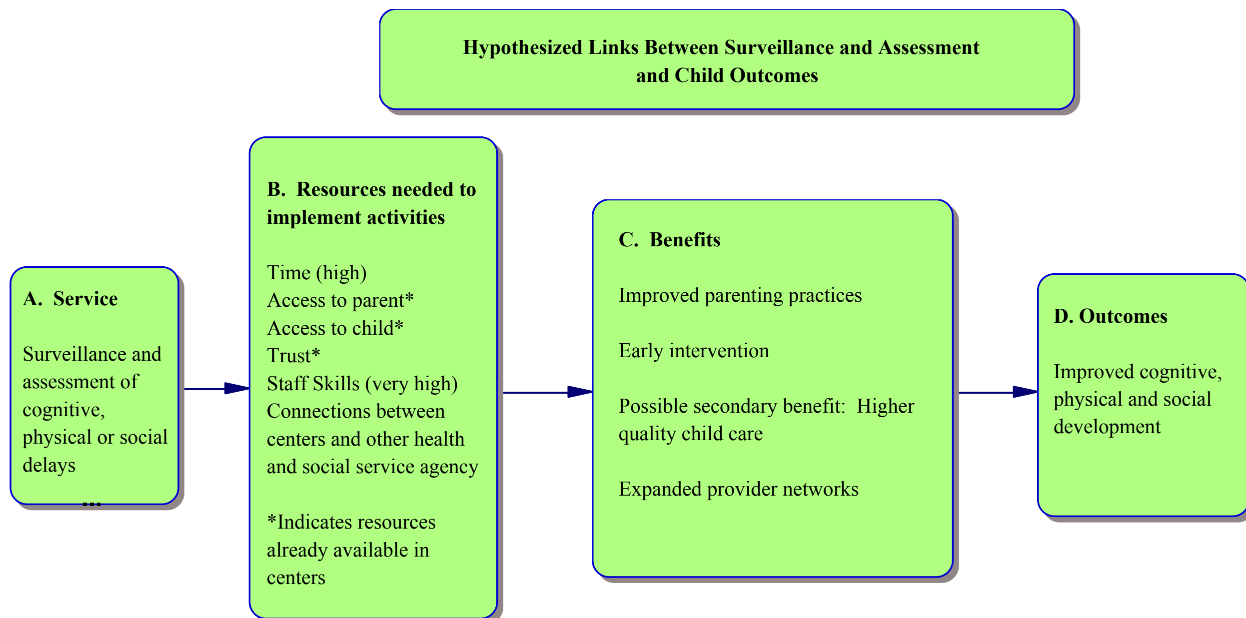


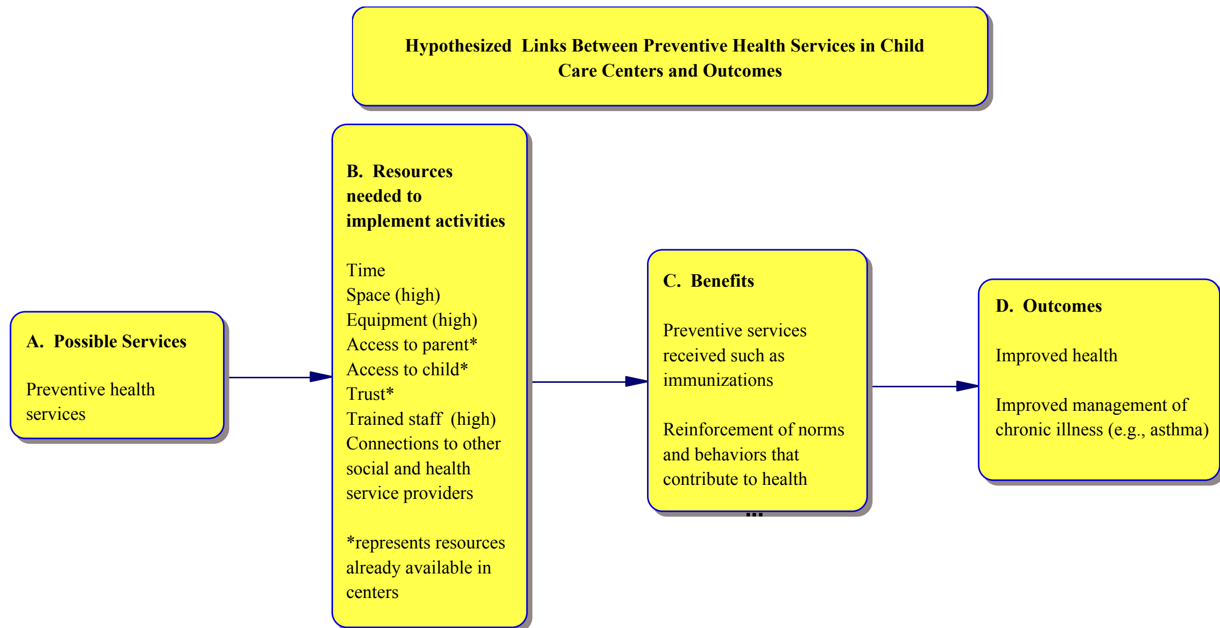

Figure 1 above represents the links between the resources needed to implement strong surveillance and assessment activities in centers, the potential benefits of doing so and the potential outcomes for children. First, as noted in the far right-hand box (D), the benefits of early surveillance and assessment followed by early intervention are substantial. Early intervention with children experiencing developmental delays can be very successful in putting children back on track with respect to cognitive, social and physical development.

One of the major challenges surrounding this strategy is the high level of resources necessary to carry it out. Good surveillance and assessment requires highly trained staff, and staff with high levels of expertise demand fairly high wages. Child care centers, however, have notoriously low wage scales and are unlikely to be able to afford the costs of developmental specialists trained in assessment. Even if they could, the potential disparity in income between those who assess children and those who care for them in child care centers could be problematic for managers, who prefer to keep wages in line.

To overcome this issue, it is possible to link with other agencies that have the expertise to provide surveillance at the centers. In Mercer County, New Jersey, for example, several municipalities contract with Mercer County Special Services to provide developmental assessments to young children, which can lead to early intervention. The cost advantage of this kind of collaboration, however, can be minimal if centers have a relatively high proportion of developmentally delayed children.

**Preventive Health Care Services in Child Care Centers**

**Figure 2**

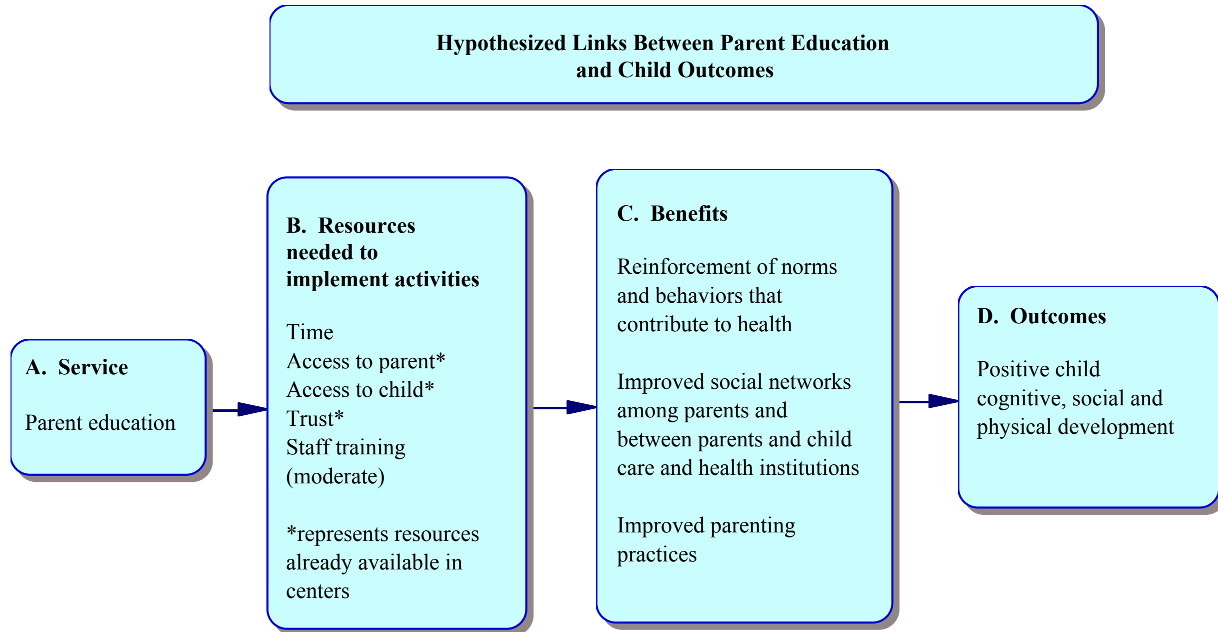



As Figure 2 above indicates, trying to provide preventive health care services in the early childhood development and care center requires substantial resources on a number of dimensions: staff, space, equipment and connections to other social and health service providers that will serve children referred from the centers.

In our discussions with experts, we heard very little about this type of intervention (even in family resource centers that might have a range of services, including early childhood development or child care centers). The resources needed to develop these sorts of services are probably excessive, especially if centers are located in urban areas where parents have access to hospitals and federally qualified health care clinics. A more reasonable use of resources would be to link children in centers with community health providers.

## Parent Education

### Figure 3




In poor, low-income communities where social ties are weak, parents—especially very young, low-income parents—may not have some of the substantive skills or knowledge about parenting that can contribute substantially to children's development. As research on one well-known home visiting program, the Nurse Family Partnership, and other early childhood interventions has shown, providing services to both children and their parents, such as parent education and helping parents learn how to problem-solve effectively, is beneficial for children's long-term cognitive and social development.[19]

Early child care and development centers can provide a useful venue for parent education. Given the age of the children in the centers, parents are very likely to come into the centers and interact with the providers. In addition, parents of young children are often open to suggestions regarding their children's care and development. And finally, parenting practices have such a substantial effect on children's development that the potential gains in providing good parenting education are great.

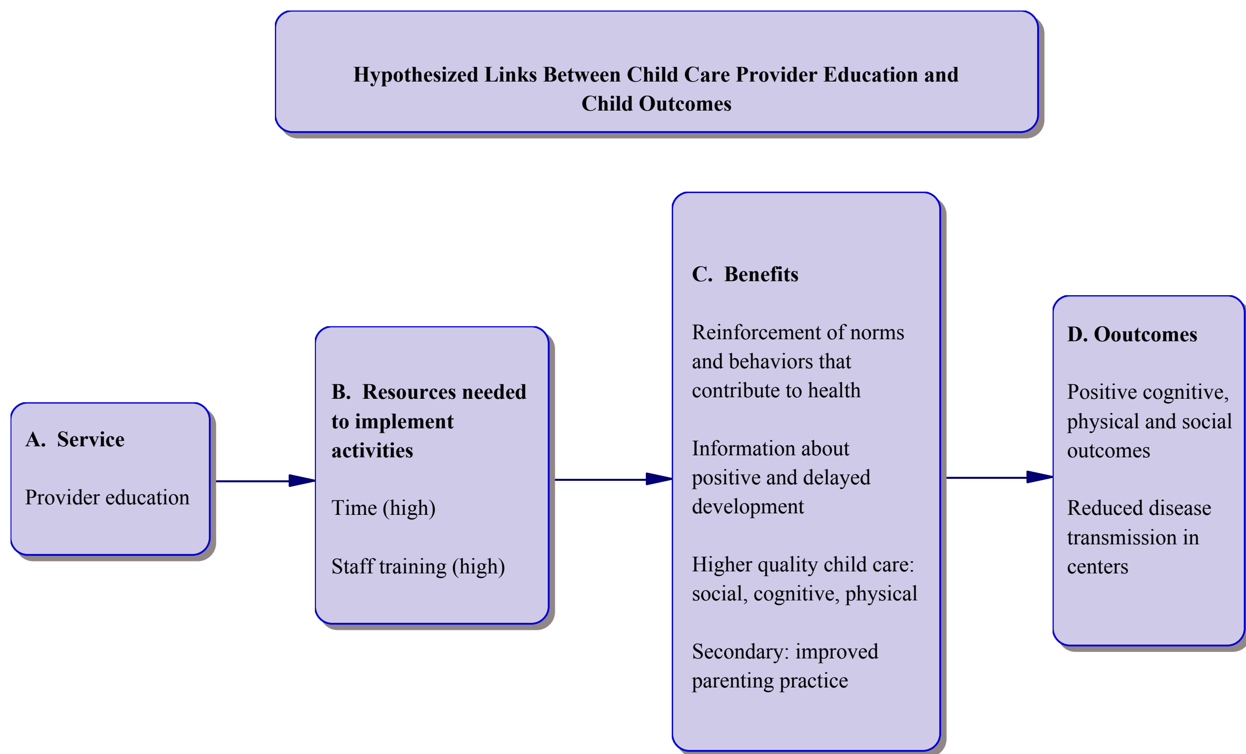
However, a range of issues needs to be considered in undertaking this type of strategy. First, even if parents are open to ideas and information about how to raise their children, recruiting parents to activities can be challenging. Second, such activities, especially among often single, low-income parents, would need to provide child care while parents are in training. In doing so, providers would need to consider how to provide such care both to children who are already in the centers and to other young children that the parent may have. Third, traveling to training sessions can pose a challenge for parents relying on public

transportation. And fourth, activities would need to be scheduled at times when such parents, who may have early-morning or late-evening work schedules, can attend.

In addition to serving the needs of parents, centers would have to provide essential training for staff in child health and development but also in delivering information in interesting and effective ways. A side benefit: if the training is provided to center staff, it may improve their own capacities to work with young children.

## Child Care Provider Education

**Figure 4**




Much research has been published on improving the quality of child care by improving the quality and amount of early childhood education given to providers. In general, the research indicates that the more training received by child care providers, the greater the improvements in the quality of child care. In turn, the greater the improvements in the quality of child care, the more likely child cognitive and social outcomes are to improve[20].

In contrast, there is very little published literature that examines the effectiveness of training providers in practices that can improve children's physical health, with the important exception of how child care providers can minimize the spread of disease among children. In general, there have been relatively few interventions that have attempted this strategy. One

important exception is Healthy Child Care America (HCCA), funded by the Maternal and Child Health Bureau. This intervention attempts to improve health and safety practices in child care and includes the use of health consultants who work with child care providers.

Currently in its last year of funding, HCCA has a program in each of 50 states. Although they vary in content and scope, the state programs' goals are threefold: to improve the infrastructure to provide support around health issues to child care providers (such as building the field of child care health consultants); to improve children's access to health care; and to improve state standards for child care. Laura Aird, the Child Care Initiative Manager at the American Academy of Pediatrics, which runs the national initiative, noted that the initiative's most successful component has been in improving state standards. However, interesting work is being done with respect to child care health consultants—often nurses (sometimes doctors or physician assistants) who visit child care centers and (in some states) family child care homes to consult with providers on issues related to health and safety.

To date, there is no published evaluation literature on these types of programs. Dr. Jonathan Kotch from the University of North Carolina, who runs a national training institute for child care health consultants and has worked extensively with Smart Start in North Carolina, has some preliminary data suggesting that using consultants is effective in increasing health screenings (dental, hearing and vision) among young children in child care.

Ms. Melinda Green, vice president of Children's Futures, a Trenton-based RWJF initiative designed to improve the health and well-being of children zero to three, noted:

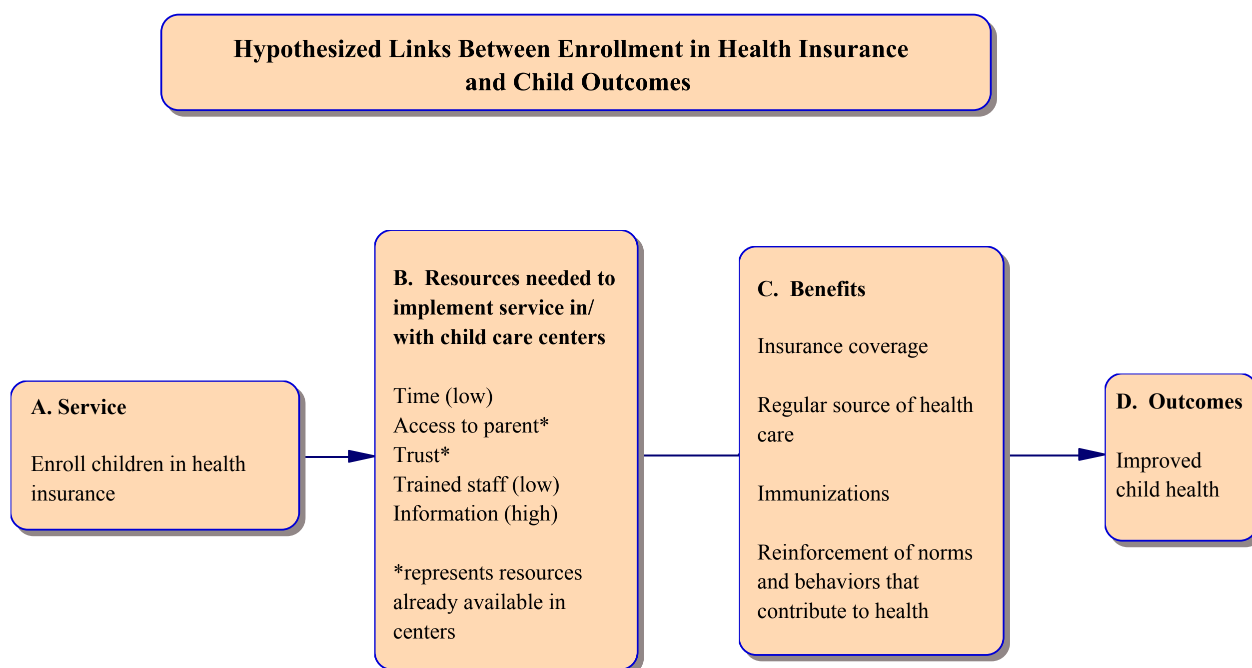
> *I have had discussions on this subject [child care health consultants] with several African American and Latino providers recently. They tell me that, in general, they frequently need help assessing whether a child is healthy or if he/she needs to be removed from the environment because of contagious disease or other unhealthy conditions. Often children in the classroom do not have a medical home [a regular place for medical care] and find themselves in need of medical attention. In instances like these, a child care health consultant could provide valuable service by identifying children who are in need of health-related services.*
>
> *I think that the health consultants have been underutilized in their roles, however. Especially in low-income centers and family child care homes. The issues have often been the lack of sufficient funding to provide increased services, but, since this population of young children often receives very few health care services, the child health consultants can become a very important link to health care. With proper funding, child health consultants can provide some direct health services, parent education and provider education. Provider education, the more traditional focus for child health consultants, can be expanded upon to include important information on healthy growth and development.*

One advantage of this approach is that health consultants can visit both early child development and care centers and family child care providers. Different types of providers

have somewhat different training and credentialing tracks because the environments in which they work and the organizational issues they face differ dramatically. However, education around children's health and development does not need to differ by type of provider, because the content can be very similar.

**Using the Child Care System to Boost Enrollment in Health Insurance and Child Outcomes**

**Figure 5**




There are several reasons why child care is a good point of entry into health insurance enrollment. The RWJF's Covering Kids initiative and the State of California's 100% Campaign are already doing some work in this area, and their literature identifies factors that make this approach a feasible option for increasing health care insurance enrollment. Child care providers are already required to collect information on immunizations and often collect insurance information. Because the eligibility requirements for child care subsidies and health insurance enrollment are very similar, additional paperwork needed to co-enroll children may be minimal. The child care enrollment process can also help identify uninsured children. In addition, parents have relationships with their children's care providers, which may facilitate enrollment in health insurance. Finally, there are successful models of programs that connect elementary and secondary school children with health insurance that can be drawn upon.[21] As part of the Covering Kids initiative, at least two states, Ohio and Florida, have already started using child care centers as a way to identify children who may be eligible for health coverage, including CHIP and Medicaid.

Generally, much of this work goes on in child care resource and referral agencies, which determine eligibility for both federal and state child care subsidies. Typically, the child care resource and referral can go no further than helping parents fill out applications; they cannot help determine eligibility for health insurance, even though state income limits for child care subsidies and state children's health insurance programs are often the same.

According to Donna Cohen Ross from the Center on Budget Priorities, one way to surmount this problem would be to encourage policy efforts to permit presumptive eligibility, which would mean that if parents are eligible for a child care subsidy they are automatically eligible for health insurance. If that is the case, then child care resource and referral agencies could provide greater help to parents. However, few states currently have presumptive eligibility.

In addition, along with a change in state-level policies, a way for health insurance and child care agencies to share information is critical. Many states do not have computer systems that permit easy information sharing.

## Considerations and Challenges

Each of the above-mentioned strategies has potential for improving the health and well-being of young children. Each also poses significant challenges to implementation. In addition to those already discussed, there are two major issues that must be considered in any attempt to improve links between the health care system and early child and development centers.

**The early childhood development and care system is not monolithic.** Several experts noted that the early childhood development and care system is very heterogeneous with respect to its structure. It consists of child care centers, early child development centers (such as Early Head Start and Head Start), preschools, family child care and relative care. Not only are there different types of care, there have traditionally been somewhat different philosophical underpinnings between early childhood development and child care centers.

Traditionally, early childhood development centers, such as Head Start or Early Head Start center-based programs, have operated like school-year programs: open for limited hours during the day and on a typical school-year schedule. The focus in these programs has been on child development, not providing child care for working parents. In contrast, child care centers have tended to operate year-round and focus on providing a service for working parents. Although the distinction between the two types of programs has diminished as educators have recognized the importance of providing child care services for working parents and as child care centers have become more interested in children's development, differences continue to exist.

Even within each type of program there are large differences in centers with respect to size, staffing configurations, population served and quality of services. Mario Luis Small from Princeton University has been conducting a small pilot study of child care centers in New York City and observes that centers have vastly different abilities to collaborate with other social service agencies. However, as P/PV's research on Faith in Action has shown, organizations that have the capacity to collaborate are often those that have other resources,

such as involved boards and experienced directors.[22] Public subsidies for child care tend to be relatively low and insufficient to ensure experienced staff. Thus, it may be difficult for child care centers to develop their ties to other agencies.

The varied nature of the early child development and care system means that strategies to link health and health care and development centers would require multifaceted approaches to collaboration—or targeted approaches that carefully select centers with existing collaborations. Any attempt to implement an intervention to improve children's health or access to health care would need to consider the relative merits of creating partnerships with the various types of care available.

**Rates of Enrollment in Center-Based Programs are Low for Some Populations of Children—Babies, Toddlers and Latino Children.**

Over half of children under two years are in child care, but only 22 percent are in center-based care, and there is little reason to believe that proportion will rise significantly in the next few years. Furthermore, Latino children are particularly underrepresented in center-based programs compared to other types of care; their parents look for care among friends and family. These facts have two important implications for using early child development and care centers as a way to provide young children with health care:

- **Efforts that attempt to improve children's health and well-being through center-based services will reach only a small proportion of all young children.** Eighty percent of all children under two years old will not be reached by collaborations between center-based programs and health care services because they are not enrolled. When children reach three years, their enrollment rates in center-based care rise dramatically (to 43% for three-year-olds, 66% for four-year-olds and 72% for five-year-olds),[23] which dramatically increases the number of children who can be served. However, many children with delays would benefit from earlier assessment and intervention, and some children never enter center-based programs.

- **Given Latino children's low rates of enrollment in center-based programs, initiatives that attempt to use enrollment in child care centers as a way to reach uninsured children are likely to show limited results among Latinos.** This is a significant problem for two reasons. First, their health needs are greater than those of other children. Approximately one quarter of all Latino children do not have health insurance (compared to 10% of African American and 7% of white children). They are also much less likely to have a usual place of health care (13% vs. 5% for African American children) and more likely to have unmet medical and dental needs.[24] Second, the proportion of Latino children is growing quickly in the United States. Although they comprise 16 percent of children under 18 years old, they comprise over 20 percent of children under 2 years. Therefore, the possibility exists that children's health insurance coverage rates and health status may fall overall as the ethnic composition of the population changes. Alternative strategies to reach Latino children will need to be devised.

## SECTION 3: RECOMMENDATIONS

**Focus on one or two major outcomes and use a small number of well-defined strategies to achieve them**. Collaborative or community-based efforts to improve children's outcomes often provide great latitude to the community partners to devise multiple strategies. This is seen as a way to respond to the local community's major concerns and ensure community ownership of the initiative. One concern, already recognized by the RWJF (for example in its work with Children's Futures), is that communities are frequently left reinventing the wheel instead of using strategies that are known to be effective. The time needed for the community to design, implement and troubleshoot its strategies can be considerable; by the time the demonstration was over, the community would have just begun to find its footing.

Experimentation by communities, however, can be very useful in identifying strategies that might be effective, especially when limited evaluation information exists, as in this case. Limiting a demonstration to strategies known to be effective in the case of linking child care and health care is problematic, because there is so little evaluation information available. Neither the Smart Start nor the EHS evaluations include sufficient information to determine which practices work.

Given the risks of community-based efforts that can result in poorly organized, incoherent efforts on the one hand, and the field's lack of extensive information on how to effectively link the child care and health care systems on the other, one option would be to fund a demonstration that identifies one or two major outcomes and uses a small number of strategies to achieve them. Having a menu of specific, well-articulated strategies that draw from other types of community-based and health care initiatives may help the RWJF balance the need for well-organized and -implemented strategies and innovation.

**Given the relatively small proportion of infants and toddlers under two and Latino children who use child care centers, consider placing the locus of activities linking the child care system and health care system in child care resource and referral agencies.** On the one hand, there are advantages to placing activities within child care centers themselves, where they will be visible to parents who come in. Doing so capitalizes on the parents' often positive relationships with the child care centers.

On the other hand, the use of family child care homes is extensive. As we noted earlier, the Latino population in particular does not use center-based child care. Furthermore, according to government vital statistics figures, 22 percent of all babies born in the United States in 2002 were born to Latina mothers.[25] This proportion is significantly higher than the Latino population in the U.S. overall, and has fairly serious implications for any efforts that attempt to improve access to health care through early childhood development and care efforts: Namely, these strategies will not work for a population with high needs that isn't present in the centers.

Given demographic trends and cultural practices, child care resource and referral agencies may provide a good home for efforts to link health-related activities and child care. Almost two thirds already manage child care subsidy programs. In some states, they are involved in

monitoring local child care facilities and ensuring that they meet state standards, and historically they have been very interested in improving the overall quality of child care and in educating parents about the components of high-quality care. Importantly, they train both child care center providers and family child care providers, and it will be necessary to target both groups to reach Latino families.

**Despite the above recommendation, if considering an intervention in which child care centers are the focus of activity, begin with "name brand" early childhood development centers, and supplement with established local child care centers as needed.** We have considered two different types of interventions: those in which staff provide the services within early child development and care centers (e.g., a child care center that hires an early child development specialist to do surveillance and assessment); and those in which staff are located in other community agencies (e.g., locating the early child development specialist within a resource and referral agency).

If locating services within centers, several experts recommended that efforts be undertaken with Early Head Start (EHS) because it is a fairly well-established program that has an explicit mission to improve child outcomes. In a very tight funding environment in which states, in particular, are struggling to close significant gaps between revenues and budgets, federal funds will be required, and it may be easier to find funds in collaborative efforts that rely on existing, well-known infrastructures.

However, any efforts undertaken by the RWJ Foundation to link early childhood development and care centers with health care services will also need to go outside the EHS system. There are two major reasons for this. First, EHS income eligibility guidelines are fairly stringent and it only serves children who meet the federal poverty guidelines. Second, EHS is a relatively small program: Only 61,500 children between birth and three years were served in 2003.[26] Thus, a demonstration should probably investigate the potential of using other types of centers.

One obvious way to select other types of centers would be to choose those that have a high proportion of parents who use child care vouchers to ensure that low-income families are served. The quality of child care centers varies dramatically, however, and it would be useful to select centers that are able to collaborate effectively with other service providers. Mario Luis Small, a sociologist from Princeton University, has done a small pilot study of the extent to which child care centers serve as loci of social capital formation among parents. Although his findings were preliminary and not available on paper when he spoke with P/PV, he indicated that government-funded or private nonprofit centers tended to be more effective in linking parents with other services than for-profit centers.

**Begin with public/private funding partnerships.** Traditionally, foundations have often provided initial funding for social programs in the hopes that, if they succeed, public money would become available. The assumption has been that foundations can be more innovative and creative than public agencies can be. However, initiatives and programs often get to the end of their private funding cycles and have difficulty raising the necessary money to stay in

business. This is especially true in comprehensive initiatives that must pay for staff that can coordinate services across organizations. Cheryl Hayes from the Finance Project noted:

> *As we have become more focused on the value of comprehensive systems of support for families, the foundations have gotten involved as well-- in some ways very productively. But they let the government off the hook [because] they let programs develop the capacity (at least in the short term) to put different funding streams together. When they go away, the programs need core dollars to put things together. We need to think about ways in which programs can create unrelated business income or think about community fund-raising.*

Beginning with public/private partnerships, instead of seeing those partnerships as a goal, could help alleviate this problem because public funds can be more stable than private funds over time. In addition, the act of raising public funds can be a way of generating wider interest within a community in the initiative itself. A number of after-school initiatives, including the San Francisco Beacon Initiative, have successfully managed these public/private partnerships. Although the necessity of raising public funds may delay implementation, ultimately it may also provide greater potential for initiative survival.

Despite the prevalence of categorical funding streams, there are a number of funding sources that could potentially be used for some of the options suggested in this review. In the past 10 years, devolution to the states has provided states with the flexibility of using funds in innovative ways. For example, the Child Care Development Grant has been used in some states to fund child care health consultants. Other states have used funds from local health department budgets.

## Final Thoughts

This brief review of the possibilities of linking the child care and health care systems has indicated that there are a variety of strategies for doing so. Each requires a particular constellation of resources and has the potential to contribute positively to young children's health and well-being. However, as we have shown, each strategy also has drawbacks, which can include high costs or limited reach into needy communities. Although there may be ways of ameliorating those operational challenges, they are likely to persist. Decisions about which strategies to choose, therefore, must balance the availability of funds with needed resources, the potential success of reaching target populations and the potential of achieving positive outcomes.

## APPENDIX A
## REVIEW OF FEDERAL AND STATE POLICIES

### FEDERAL POLICIES

Our review of federal policies includes those affecting the broad population of low-income young children and their families in the following areas: child welfare; health care (maternal and child); child care; early care and education; nutrition; family leave; welfare reform; and community services. However, the consolidation of many federal programs has resulted in policies that extend over several domains.

The federal policies we have chosen for review represent the most expansive publicly funded initiatives targeting low-income young children and their families. For each policy we have identified the target population, policy goal(s), program strengths/weaknesses and the degree of flexibility that states or organizations have to design innovative strategies with the available funds. The family policies include:

- CHILD ABUSE PREVENTION AND TREATMENT ACT
- CHILD CARE AND DEVELOPMENT FUND
- COMMUNITY SERVICES BLOCK GRANT
- EVEN START
- FAMILY AND MEDICAL LEAVE ACT
- FOOD STAMP PROGRAM
- HEAD START/EARLY HEAD START
- HEALTHY START
- MATERNAL AND CHILD HEALTH BLOCK GRANT
- PROMOTING SAFE AND STABLE FAMILIES
- TEMPORARY ASSISTANCE TO NEEDY FAMILIES
- WOMEN, INFANTS AND CHILDREN PROGRAM

Funding and operational issues for these programs are addressed through the reauthorization process—the renewal of any legislation that allows federal funds to be spent for programs of national concern. During reauthorization, Congress must approve a continuation of the program and additional funding for the next specified period. In 2003, a majority of the above programs had either undergone or are pending reauthorization, which will likely have implications for many low-income families.

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A. Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA) is the key federal legislation addressing child abuse and prevention for at-risk families with children. The program provides funding to states in support of prevention, assessment, investigation, prosecution

and treatment activities. It also provides grants to public agencies and nonprofits for demonstration programs and projects.

*Strengths*

Generating public concern and the establishment of a child protective service system are perhaps among CAPTA's major successes. CAPTA has always been considered the centerpiece of federal legislation regarding child abuse and neglect. The definitions of child maltreatment included in CAPTA have served as a template for defining which acts warrant reporting to state child protective service agencies. In addition, statistics show that children in the United States are better off as a result of CAPTA (National Clearinghouse on Child Abuse and Neglect Information, 2001). On any given day, many families are helped by the child welfare system. There have also been successful efforts to improve training for child welfare workers.

*Weaknesses*

In many ways, CAPTA is a rather minor piece of federal legislation. Because of the epidemic proportions in the number of children who are reported as abused and neglected each year, CAPTA has failed to keep pace with the severity of the problem. According to a report conducted by Prevent Child Abuse America, the number of children reported as abused or neglected in the United States from 1990 to 1999 grew by 33 percent to nearly 3.3 million. In 1999, the number of confirmed cases of child maltreatment was just over 1 million. In addition, states report that the child victims or their families receive no treatment or any other type of service following investigation of the report in over one half of confirmed cases of child abuse. Also, CAPTA continues to be funded at amounts well below its authorized levels. As a result, the need is much greater than the resources allocated for many of its programs.

Another shortcoming of CAPTA is that prevention programs remain overlooked and under-funded. Currently, primary prevention programs are funded at $32.8 million, compared to at least $6 billion for intervention, treatment and out-of-home placements. Child abuse prevention advocates argue that there is a tremendous imbalance between what is invested on the front end to prevent abuse and neglect before it happens and what is spent as a consequence after abuse or neglect has occurred and out-of-home placement is needed. Strengthening the prevention focus of and funding for CAPTA would help local communities prevent abuse and neglect from happening in the first place.

*State Flexibility*

In order to receive CAPTA funding, states must adhere to certain reporting requirements in addition to establishing citizen review panels. Statutorily, states can use funds to develop innovative approaches in CPS systems and child abuse prevention programs, and they are given a fairly wide berth in designing their programs. However, lack of adequate funding has

prevented many states from developing a critical mass of programs and services for at-risk families.

In June 2003 CAPTA was reauthorized through 2008 at slightly increased authorized funding levels ($200 million, an increase over the $166 million authorized under the previous law). Provisions under the new CAPTA law include a focus on child welfare workforce issues (training, recruitment and retention) and an emphasis on collaboration among child protective services and other human service agencies (health, mental health and juvenile justice). These provisions are expected to significantly strengthen the program.

### B. Child Care Development Fund

The Child Care Development Fund (CCDF) is the primary source of support for families who cannot afford child care, and is the major federal funding source for state child care programs. Assistance is in the form of a subsidy available to families with children under age 13 or with children up to age 19 who have special needs or are receiving protective services. The federal income-eligibility limit is 85 percent of State Median Income (SMI).

*Strengths*

Increased federal funding since 1996 (in which states were able to redirect TANF block grant funds to benefits and services other than cash assistance) made it possible for many states to increase numbers of children served, raise eligibility levels, reduce parental copayment requirements, raise provider rates and expand initiatives to improve the quality of care. Additionally, the program has enhanced collaboration and coordination with other early care and education initiatives and increased employment options for welfare recipients through broadened child care availability.

*Weaknesses*

While the above developments are notable, states still must make difficult trade-offs, mostly due to limited resources. A recent report by the U.S. General Accounting Office (GAO) found that since January 2001, 23 states have adopted policies that reduce the overall availability of child care assistance for low-income working families. These policies include: changing income eligibility thresholds to narrow coverage; restricting access by starting waiting lists; and increasing copayments. In addition, states continue to grapple with issues of quality of care and a dearth of well-trained child care workers. As a result, many low-income families are faced with limited child care options.

Perhaps the most urgent issue facing CCDF is funding. After federal and state spending on child care more than doubled between FY 1997-2000 due to the availability of surplus TANF funds, state use of TANF for child care declined in FY 2001 (Center for Law and Social Policy, 2003). TANF remains an important source of funding for state child care programs; however, it is no longer an *increasing* source of funding in many states**.** The Bush administration's recently proposed TANF reauthorization plan would substantially increase

work requirements but provides no additional TANF or CCDF funding for the inevitable surge in child care needs among low-income families.

*State Flexibility*

States use their CCDF funds to provide child care services for low-income families and for quality initiatives that may benefit all families. The federal income-eligibility limit is 85 percent of State Median Income (SMI), but states are free to set lower eligibility limits. States must spend at least 4 percent of their CCDF funds for quality initiatives, but have broad discretion in determining how to use those funds. The federal government requires that states establish minimum health and safety standards for use of CCDF funds. It also demands that CCDF programs ensure that families receiving subsidies have "equal access" to care comparable to that available to families with incomes above eligibility levels. Otherwise, however, states have broad discretion in determining payment rates to eligible providers, copayment requirements for families, licensing and regulatory standards, consumer education requirements and other dimensions of state systems. Many states are finding creative ways to use federal funds, state revenues and public-private partnerships to support quality initiatives.

**COMMUNITY SERVICES BLOCK GRANT**

The Community Services Block Grant (CSBG) is a federal antipoverty program that funds the operations of a state-administered network of local agencies that deliver programs and services to low-income families. The federal agency that oversees the block grant is the Office of Community Services within the Administration for Children and Families at the U.S. Department of Health and Human Services. The CSBG is charged with "mobilizing the resources of the community to eradicate causes of poverty and move low-income persons to self-sufficiency" through activities driven by eight statutory goals:

- Securing and maintaining employment;
- Securing adequate education;
- Better income management;
- Securing adequate housing;
- Providing emergency services;
- Improving nutrition;
- Creating linkages among antipoverty programs; and
- Achieving self-sufficiency

While the network serves a heterogeneous group of low-income Americans, the typical CSBG client lives in a family with children, is white, non-Hispanic and very poor. In addition, nearly three fifths of the client families include children less than 18 years of age. Single mothers head more than half of these families.

*Strengths*

The CSBG network is made up of more than 1,100 local, private, nonprofit and public entities called Community Action Agencies (CAAs). CAAs both represent and are accountable to their local community for the manner in which they pursue their poverty-fighting mission. CAAs are governed by a board of directors consisting of elected local public officials, representatives of the low-income communities and appointed leaders from the private sector. This structure helps low-income people to participate directly in the development of antipoverty programs. At the same time, private and public representatives gain a clearer knowledge of the issues confronting low-income people in their community.

To meet their goals, CAAs offer a variety of programs for low-income families. They coordinate emergency assistance; provide weatherization services; sponsor youth programs; operate senior centers; provide transportation to rural areas; and provide linkages to job training opportunities and GED preparation courses. They also offer a range of services addressing poverty-related problems: income management and credit counseling; domestic violence crisis assistance; parenting class; food pantries and emergency shelters; and low-income housing development and community revitalization projects.

In addition to service delivery, CAAs identify the specific needs of their clients and their communities, and design opportunities and programs to meet those needs. Local CAAs begin with an environmental assessment to ascertain unmet needs of low-income persons, identification of resources to address those needs, and a survey of the effects of public policy and legislation on low-income persons. This assessment helps to identify the most critical areas of need within a local community.

*Weaknesses*

In very rare occurrences, states have designated CAAs as deficient and terminated funding to them. The current law does not provide a consistent means to require minimum standards of performance by CAAs in order to receive funding. As a result, the authority for some CAAs to provide services and continue to receive funding in impoverished communities has essentially been unchallenged and subject to very little monitoring and evaluation.

The 1998 reauthorization of CSBG provided requirements aimed at strengthening accountability, including the development of a performance measures system for CAAs. However, states allowed their CAAs participating in performance evaluation to identify, collect and report outcome information related to goals their local programs identified. This lack of consistency in management has not allowed for much insight into the performance by individual CAAs, nor has it provided a means to ensure a minimum standard of performance for all CAAs.

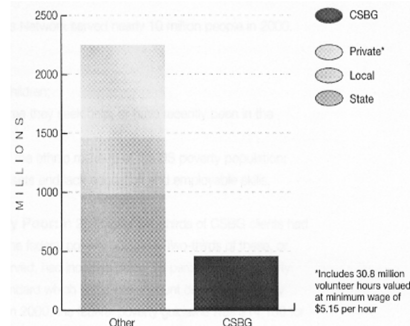
In the FY 2004 reauthorization for the CSBG, the Bush administration has proposed increasing accountability by streamlining performance outcomes tools for CAAs within a uniform, results-focused system. In addition, it plans to expand the pool of applicants by extending eligible CAA entities to faith-based and community-based organizations.

*State Flexibility*

CSBG funds are directed to state human service agencies, which, in turn, are required to allocate 90 percent of the funds to local CAAs. The CSBG statute also mandates that no more than 5 percent of the federal funds may be used by the states for administrative costs. States may use 5 percent as discretionary funds to support innovations and fill service gaps.

The CAA network is unique in large part because of the flexible nature of CSBG funding, which permits the shaping of national and state programs to meet local needs. Programmatically, the only federal requirement is that services must fall within the eight poverty-fighting goals as outlined in the statute. The federal appropriation leverages substantial investments from other sectors. In 2000, CAAs nationwide leveraged $5 from state, local and private sources for each federal CSBG dollar expended (see Table 1).

**Table 1.**
**Nonfederal Funds Leveraged by CSBG**
**FY 2000**




Source: Office of Community Services, U.S. Dept. of Health and Human Services

## EVEN START

Even Start is a family literacy program administered by the Department of Education that provides grants to states for the planning and implementation of statewide family literacy initiatives. The program is intended to help break the cycle of poverty and illiteracy and improve the educational opportunities of low-income parents and children (from birth to age seven). Services are provided to participants (on a voluntary basis) that are of sufficient intensity in terms of hours and of sufficient duration to make sustainable changes in a family, and that integrate all of the following:

- Interactive literacy activities between parents and their children;
- Training for parents regarding how to be the primary teacher for their children and full partners in the education of their children;
- Parent literacy training that leads to economic self-sufficiency; and
- An age-appropriate education to prepare children for success in school and life.

The program's underlying premise is that eligible families need each of these four core instructional components, and that these services will be more effective when integrated in a unified program.

*Strengths*

Even Start is intended to benefit families in several ways. Potential outcomes for parents are improved literacy behaviors (e.g., shared literacy events with children and increased reading and writing activities in the home), parenting behavior and skills (e.g., positive parent-child relationships), and educational and employment skills that lead to economic self-sufficiency (e.g., improved reading and English language ability and higher education attainment). Goals for parents also may include growth in personal skills and community involvement. The potential effects of Even Start on children include improved school readiness (e.g., language development and early literacy). Once in school, outcomes might include reading on grade level, satisfactory attendance, and a lower incidence of special education and retention in grade.

Even Start projects are required to identify, recruit and serve the neediest families in their communities. Evaluations have shown that projects take their mandate seriously, as Even Start families are poor, undereducated and underemployed by any standards. In 2000-2001, almost half of the parents who joined Even Start had less than a 9th grade education and 85 percent lacked a high school diploma or GED (see Table 2). During 2000-2001, 39 percent of new Even Start families reported annual household income of less than $9,000 and 84 percent lived below the federal poverty line (see Table 3).

**Table 2.**
**Percent of New Even Start Parents,**
**By Educational Background at Enrollment, 2000-2001**

| Year | Educational Background at Enrollment | | | | | |
|---|---|---|---|---|---|---|
| | HS, GED or Higher | Special Ed Diploma | Grades 10-12 | Grades 7-9 | Grades 1-6 | No School |
| 2000-2001 | 15% | **1%** | 39% | 30% | **13%** | 1% |

**Table 3.**
**Percent of New Even Start Families,**
**By Annual Household Income, 2000-2001**

| Year | Income Category | | | | | | | | Percent Under Fed Pov Level |
|---|---|---|---|---|---|---|---|---|---|
| | <$3,000 | $3,000-$5,999 | $6,000-$8,999 | $9,000-$11,999 | $12,000-$14,999 | $15,000-$19,999 | $20,000-$24,999 | >$25,000 | |
| 2000-2001 | 14% | 14% | 11% | 13% | 14% | **14%** | **11%** | **9%** | 84% |

Source: Mathematic Policy Research, Inc.

*Weaknesses*

A large research literature links levels of parental education to levels of child achievement (National Research Council, 2001). However, no experimental evidence has been found to support the hypothesis that family literacy programs (or adult education programs more generally) can make large enhancements in parent literacy and parenting skills. Even

assuming that it is possible to significantly alter parent literacy and parenting skills, research has not shown that these changes will translate into improved literacy performance among children in a timely manner.

In a national evaluation of Even Start, it was found that the program did not change the literacy skills or parenting skills of parents, nor did it change the literacy skills of children, over and above the changes that were seen in parents and children who did not participate in the program. Specifically, the evaluation found that:

- Children and parents in the 18 Even Start programs that participated in the study did not gain more than children and parents in the control group;
- Even Start children and parents made small gains on literacy measures and scored low compared to national norms when they left the program;
- Families do not take full advantage of the services offered by Even Start projects, participating in a small amount of instruction relative to their needs and program goals; and
- There was not sufficient emphasis on language acquisition and reasoning in Even Start projects to produce measurable impacts and hence to achieve legislative outcomes.

The problem appears to be twofold: 1) families did not participate long enough and did not get enough instruction to make the kinds of changes that are needed, and 2) the quality and content of instruction on language acquisition is insufficient to meet Even Start's legislative goals and hence needs to be improved. Given Even Start's intuitive appeal as an approach for enhancing parent and child literacy, researchers interpreted the lack of effectiveness as an indication that the Even Start approach needs to be strengthened.

*State Flexibility*

Even Start grants are awarded to local education agencies by states (usually state departments of education) for periods up to four years, after which a project may reapply. The Even Start law includes the following program elements that projects must implement:

- Build on and coordinate with existing community resources;
- Identify, recruit and serve families most in need of services;
- Screen and prepare families to participate;
- Provide support services and flexible scheduling;
- Provide high-quality, intensive adult education, parenting education and early childhood education;
- Provide integrated, home-based instructional services;
- Conduct an independent local evaluation;
- Serve children in at least a three-year age range;
- Provide an increasing local funding match.

The Even Start legislation is more specific than that of many similar federal programs, though it does not define curricula. Decisions on how to implement each program element

are left to individual projects. For example, the legislation requires high-quality, intensive instructional programs, services for parents and children together, and instructional services in the home. But projects decide on the frequency and duration of program activities, whether activities are primarily center-based or home-based, and whether to invent educational curricula from scratch or use a hybrid of existing approaches. Based on the availability of local services, projects decide which activities will be supported by Even Start funds and which will be provided by collaborating agencies.

### C. Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) guarantees that people who work for companies with 50 or more employees can take up to 12 weeks of unpaid leave a year to care for a newborn or newly adopted child or for a seriously ill child, spouse or parent, or to recover from their own serious health conditions. The bill, signed into law by President Clinton, became effective August 5, 1993.

*Strengths*

The FMLA is of great benefit to a large number of working Americans while imposing minimal burdens on employers. Fewer workers will have to choose between their jobs and their loved ones if a child or parent should need care. In addition, employers must continue to pay health insurance premiums at the same rate while an employee is on leave. For their part, most employers find that FMLA is easy to administer and costs are small. The majority of leaves are short in duration and most workers return to their jobs. Some businesses have reported reduced employee turnover, enhanced employee productivity and improved morale, which they attribute to the FMLA.

*Weaknesses*

FMLA guarantees only *un*paid leave. Many women and men are unable to take essential time off because they cannot afford to take unpaid leave. The promise of family and medical leave remains unfulfilled for many because going for weeks without a paycheck isn't a viable option. Low-income workers are still forced to choose between taking care of a sick family member and maintaining their family's economic security.

In addition, employees cannot use FMLA (or paid sick leave) to care for the kind of routine or non-emergency illnesses from which children all too often suffer. A recent study found that family issues, such as caring for a sick child, account for approximately 46 percent of employee absences in any given year (CCH, Inc., 1996).

Lastly, the FMLA currently covers only 57.5 percent of the country’s private workforce (National Partnership for Women and Families, 2000). This is largely a result of two factors: 1) employers with fewer than 50 employees are not covered by the FMLA, and 2) the FMLA does not cover most people who work one or more part-time jobs. This leaves a large portion of the workforce without access to FMLA protection.

**Table 4.**
**State Expansions Under the Federal Family and Medical Leave Act**

| Businesses with < 50 Employees | Participation in Children's Activities | Routine and Non-Emergency Medical Care | Expanded Definition of "Family Member" | Extension of Leave Beyond 12 Weeks |
|---|---|---|---|---|
| District of Columbia | California | Maine | District of Columbia | California |
| Oregon | District of Columbia | Massachusetts | Hawaii | Connecticut |
| Vermont | Illinois | Vermont | Oregon | District of Columbia |
| | Louisiana | | Rhode Island | Louisiana |
| | Massachusetts | | Vermont | Oregon |
| | Minnesota | | | Puerto Rico |
| | Nevada | | | Rhode Island |
| | North Carolina | | | Tennessee |
| | Rhode Island | | | |
| | Vermont | | | |

Source: National Partnership for Women and Families

*State Flexibility*

The FMLA allows states to set standards that are more expansive than the federal law. However, no state can provide fewer family leave options. State expansions of FMLA include: extending medical leave laws to employers of fewer than 50 people; allowing leave for participation in children's activities; providing longer periods of family and medical leave; allowing leave for medical and dental care; and using a more expansive definition of "family member" for whose illness an employee may take leave (i.e., grandparents, in-laws) (see Table 4).

D. Food Stamp Program

The Food Stamp Program (FSP) was established for the twin purposes of improving the health and nutrition of low-income families and strengthening the agricultural economy. Generally, those who are eligible for food stamps are working poor families, persons with disabilities and seniors. Individuals who pass both the gross income and asset test for eligibility can receive benefits. Approximately 89 percent of food stamp households have gross incomes below the poverty line.

*Strengths*

The FSP is the nation's most important food assistance program, especially for children. It provides more substantial nutritional assistance to low-income children than all of the nation's child nutrition programs combined. Studies have shown that receiving food stamps increases the nutritional value of low-income households' food supplies by 20 to 40 percent (Center on Budget and Policy Priorities, 2002). Furthermore, many low-income working families, in particular, do not earn enough to pay for rent, utilities, clothes, health care, child

care *and* food. Food stamps help these families make ends meet. As families move from welfare to work, food stamps can provide important transitional assistance.

*Weaknesses*

FSP participation among eligible households has declined significantly over the last 10 fiscal years (see Table 5). Despite improvements, policy experts agree that some administrative aspects of the FSP still remain barriers to participation. Many households have dropped out of the FSP, finding it too burdensome to keep up with the program's demands for detailed information on a monthly basis. The FSP has historically demanded that states be aware of changes in a household's income on a monthly basis—a requirement that poses particular difficulty for working families, whose financial circumstances are more likely to fluctuate.

In addition, states are likely to make errors in benefit levels for households with fluctuating incomes (like most low-income working households). As a result, states have felt pressure to target the growing number of working food stamp households for extra verification of their circumstances and more frequent face-to-face eligibility reviews. These changes appear to have driven many working households from the program.

**Table 5. Food Stamp Program Participation, FY 1992-2002**

| Fiscal Year | Average Participation (in thousands) |
|---|---|
| 1992 | 25,406 |
| 1993 | 26,982 |
| 1994 | 27,468 |
| 1995 | 26,619 |
| 1996 | 25,542 |
| 1997 | 22,858 |
| 1998 | 19,788 |
| 1999 | 18,183 |
| 2000 | 17,139 |
| 2001 | 17,313 |
| 2002 | 19,094 |

Source: Food and Nutrition Service, U.S. Dept. of Agriculture

Lastly, most low-income families that leave TANF cash assistance programs remain eligible for food stamps when they go to work. Many of these eligible families, however, do not stay connected to the FSP when they leave TANF. Frequently these families are asked to complete paperwork detailing their circumstances once they leave TANF. Many, failing to understand that they continue to qualify for significant food stamp benefits, never respond to the welfare offices' queries.

*State Flexibility*

The FSP grants states broad flexibility. The Department of Agriculture and Congress have acted in the last few years to accord states numerous options in how food stamp benefits are determined and delivered. These options allow states greater flexibility in program administration and better enable them to align food stamps with other programs such as

TANF and Medicaid. In addition, in the area of work and training programs and sanctions for noncompliance, the FSP provides states with flexibility to design their own programs and to coordinate with other programs.

### HEAD START/ EARLY HEAD START

Head Start is a comprehensive child development program that serves children from birth to age 5, pregnant women and their families. It is a child-focused program with the overall goal of increasing the school readiness of young children in low-income families. Head Start and Early Head Start (EHS) provide a range of individualized services in the areas of education and early childhood development; medical, dental and mental health; nutrition; and parent involvement.

While Head Start primarily serves low-income preschool children ages 3 to 5, the Early Head Start program (created in 1995 as part of the Head Start reauthorization) serves low-income infants and toddlers (birth to age 3) and pregnant women. At least 90 percent of EHS enrollment must be made up of low-income families, defined as those families with incomes at or below the federal poverty level, families receiving public assistance or families with children in foster care.

Early Head Start providers may deliver services through several different program options, including center-based care, a home-based option in which families are supported through weekly home visits and group socialization experiences, locally designed program models, and a combination option with a mix of center-based and home-based care. The program services include:

- Parenting education;
- Health education;
- Adult education, ESL and job training;
- Emergency/crisis intervention;
- Transportation assistance;
- Housing assistance;
- Mental health services; and
- Child care (in child development centers or through partnerships with child care providers).

Over the course of the 2002 program year, 60,663 young children and 7,669 pregnant women were served through Early Head Start, making up 7 percent of the total Head Start population. The age breakdown of children served was split about evenly between infants, one-year-olds and two-year-olds. A small portion of children served were preschoolers aged three and up. A majority of these children (60 percent) were from single-parent/caregiver families (Irish, et al., 2003).

*Strengths*

In 1996, the Administration for Children and Families selected 17 EHS programs (involving 3,000 children) from across the country to participate in a rigorous, large-scale, random-assignment evaluation. The evaluation, conducted by Mathematica Policy Research, Inc., was designed to carry out the recommendations by policy-makers for a strong research and evaluation component to support continuous improvement with EHS. It found that EHS programs had:

- Statistically significant, positive impacts on children's cognitive, language and social-emotional development up to age 3;
- Significantly favorable impacts on a wide range of parenting outcomes (i.e., discipline, home environment, self-sufficiency, subsequent births);
- Positive impacts on fathering and father-child interactions;
- Particular effectiveness in improving child development and parenting outcomes among African American and Hispanic families; and
- Benefited two difficult-to-serve subgroups—parents at risk for depression and teenage parents, although the findings for teen parents were not significant.

*Weaknesses*

The overall results from the evaluation of the Early Head Start program are promising and provide lessons for program improvement and further development. Specifically, the study suggests that:

- Implementing key services in accordance with the Head Start Program Performance Standards early and fully is important for maximizing impacts on children and families;
- Programs that combine the features of home-based and center-based programs have the strongest impacts;
- Programs need to better serve families who have large numbers of demographic risk factors;
- Greater access to services that address mental health needs of parents is needed;
- Programs should be more vigilant about parental safety practices; and
- Programs that enroll families during pregnancy, or very early in the child's life, have the greatest chance to effect change.

*State Flexibility*

The Head Start Bureau and the 10 regional offices of the Administration administer EHS local programs for Children and Families. Regional office responsibilities include grants administration, monitoring evaluations, site visits and ongoing support to programs. Federal program specialists evaluate local programs every three years, and more frequently as needed. EHS grantees may be either public or private, for-profit or nonprofit organizations or public school systems.

EHS programs must adhere to the Head Start Performance Standards, which define the scope of services that must be offered to children and families, and cover the provision of services for pregnant women and children from birth to five years of age in the areas of: Early Childhood Development and Health Services; Family and Community Partnerships; and Program Design and Management. While the Performance Standards define the scope of

services that programs must offer to children and families served through Early Head Start and Head Start programs, they do not prescribe how these services must be carried out. Hence, programs are able to design services to meet the needs of those being served in their local communities. In addition, Early Head Start programs must make at least 10 percent of their enrollment opportunities available to children with disabilities.

### HEALTHY START

In response to concern over high infant death rates, the Healthy Start program was launched in 1991 by the Health Resources and Services Administration (HRSA) of the U.S. Public Health Service to reduce infant mortality by 50 percent and to improve maternal and infant health in communities with high infant death rates. Healthy Start is a community-based initiative in which local programs design and implement interventions targeting low-income women, infants, their families and the communities where they live. These interventions include outreach and case management for pregnant women and infants; broad-based public information campaigns; support services; individual and classroom-based health education; co-location of prenatal care services; and enhanced clinical services for women and infants.

Since its inception, the Healthy Start Program has been located in HRSA. Healthy Start is a component of the Maternal and Child Health Bureau and resides in the Division of Perinatal Systems and Women's Health. Presently, there are 96 federally funded Healthy Start projects in 37 states.

#### *Strengths*

Healthy Start programs are located in the poorest neighborhoods in the United States. Since its initiation in 1991, Healthy Start has served hundreds of thousands of families. More than 90 percent of all Healthy Start families are African American, Hispanic or Native American, as these population groups have disparate rates of infant mortality and low birth weight. Healthy Start specializes in outreach and home visiting—a proven method to reach the most at-risk women. In addition, Healthy Start has a strong emphasis on community involvement in planning and implementing the program.

A 2000 national evaluation of Healthy Start found that the program affected a broad range of outcomes, including prenatal care utilization, pre-term birth rate, low and very-low birth weight rates, and infant mortality rates. In addition, Healthy Start was successful at enrolling women with high risk of adverse pregnancy outcomes and establishing case management programs. The study also found that Healthy Start program filled important service gaps—outreach, case management and support services—that are generally not provided in traditional clinic settings.

#### *Weaknesses*

One of the guiding principles of the Healthy Start programs is to include the community in the planning process. In general, community involvement in Healthy Start is accomplished through two main strategies—a consortium and community empowerment. Healthy Start

grantees are required to establish consortia of community leaders, community residents, medical and social service providers, and community organizations to plan and implement the program services. Community empowerment efforts include neighborhood-based consortia, employment, contracts and economic development efforts. However, the study found that it was difficult to involve community residents in grassroots efforts. Healthy Start implementation took longer than expected because community involvement was a time-consuming and labor-intensive process.

Additionally, Healthy Start was found to be less successful in implementing, or less successful in documenting, the case management component of ongoing contact and tracking of clients. In particular, while the case management programs identified resources available to clients within the community, they were not able to monitor a client's receipt of services and ongoing needs. A review of case management records in each Healthy Start program revealed numerous referrals for an array of services but a lack of information on whether the services actually were received. This lack of follow-up information left case managers unable to track whether their clients received needed services; it also prevented programs from fully assessing the impact of their case management programs. Tracking referrals is a problem common to many case management or home visiting programs.

*State Flexibility*

To be eligible for a Healthy Start grant, a project area must have a higher than average annual infant mortality rate. Most Healthy Start grantees are city, county or state health departments. To give communities the flexibility to build on local resources and address local issues, HRSA set broad goals and criteria for the Healthy Start grantees while allowing them the flexibility to design their own approach. All Healthy Start grantees are required to develop a Comprehensive Healthy Start Plan that accomplishes the following objectives:

- *Focus on Reducing Infant Mortality.* The overarching goal of Healthy Start is to reduce infant mortality by 50 percent over five years.
- *Include the Community in Planning.* All Healthy Start grantees are required to establish consortia of community leaders, community residents, medical and social service providers, and community organizations to plan and implement program services.
- *Assess Local Needs.* Grantees are to conduct a needs assessment to identify a core set of community problems and the resources available to address them.
- *Develop a Package of Health and Social Services for Pregnant Women and Infants.* Based on the needs assessment, each grantee determines the spectrum of services to be offered.
- *Develop a Service System Plan.* Grantees are required to develop and implement a service system plan that would identify those systemic issues that contribute to high rates of infant mortality and develop strategies to address these issues.
- *Increase Public Awareness.* Grantees are required to develop a public information and education component that would focus on (1) providing community residents with information on the goals of Healthy Start and the availability and location of

services, and (2) sensitizing the larger community to issues relating to infant mortality.
- *Evaluate the Initiative.* Grantees are to monitor their progress toward their goals and cooperate with a national evaluation. Additional local evaluation activities could complement the national evaluation, at the grantee's option.

## MATERNAL AND CHILD HEALTH BLOCK GRANT

The Maternal and Child Health (MCH) Block Grant provides funding for prenatal and primary health care with the goal of improving the health of all mothers and children. The MCH Services Block Grant program was authorized under Title V of the 1935 Social Security Act and is administered through the Maternal and Child Health Bureau within the U.S. Department of Health and Human Services. In 1981, Title V's categorical programs were consolidated with five other federal programs under block grant legislation, allowing states increased discretion in the use of program funds. Federal law requires the program to coordinate with other related federal health, education and social services programs, including Medicaid, to enhance program effectiveness and reduce duplication. Title V also provides uncovered or "wrap-around" services and access to care in underserved areas for uninsured, underinsured and publicly insured families.

Among the Title V block grant programs is the "State Maternal and Child Health Early Childhood Comprehensive Systems Development" (SECCS) grant program. Its purpose is to enable state Title V maternal and child health programs to "provide leadership in developing comprehensive systems for universal access to early screening and follow-up treatment services for young children with deficiencies in social and emotional development.[1]" Currently, 51 states and jurisdictions have one- or two-year grants to plan statewide activities to foster greater integration across service systems (such as the early childhood care and health care systems). Funding is available only to states or jurisdictions that currently have a Title V block grant.

### *Strengths*

Title V remains the only federal program that focuses solely on improving the health of all mothers and children. The conceptual framework for the services of Title V is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services for mothers and children. The pyramid also displays the uniqueness of the MCH Block Grant, which is the only federal program that consistently provides services at all levels of the pyramid (see Figure 2).

The program makes a special effort to build community capacity to deliver such enabling services as care coordination, transportation, home visiting and nutrition counseling, which complement and help ensure the success of state Medicaid and SCHIP medical assistance programs. Title V-supported programs also provide gap-filling prenatal health services to two

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[1] State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program (SECCS), New Announcement, Announcement Number HRSA-04-094. Downloaded May 6, 2004, from ftp://ftp.hrsa.gov/hrsa/04guidancemchb/hrsa04094.doc.

million women and primary and preventive health care to more than 17 million children, including almost one million children with special health needs (Maternal and Child Health Bureau, U.S. Department of Health and Human Services, 2000).

Additionally, special Title V projects target underserved urban and rural areas with efforts at the community level that promote collaboration between public and private sector professionals, leaders and health care providers. Today many historical legacies of Title V survive as key components of local and state systems of care.

**Figure 2. MCH Pyramid of Health Services**

Source: Maternal and Child Health Bureau, U.S. Department of Health and Human Services

*Weaknesses*

The MCH program has been widely hailed as a program that provides a critical health care safety net for low-income mothers and children. Our research found no significant shortcomings across programs.

*State Flexibility*

MCH programs are located within the state departments of health and directly operate health programs as well as contracting with other public or private providers. Services offered under MCH programs must be free of charge to people with incomes below federal poverty guidelines. Three fourths of state MCH programs have integrated other health or social services providers such as Medicaid and the WIC food program into single-site locations to improve access. All Title V programs support some home visiting services.

States receive MCH Services Block Grant funds through a formula based on each state's share of the programs that were consolidated into the block grant in 1981, with some consideration of the state's percentage of children in poverty. States must match the federal appropriation with $3 for every $4 received from the grant. States must:

- Use at least 30 percent of their appropriation on preventive and primary care services for children, such as immunizations, lead poisoning prevention, sudden infant death syndrome (SIDS) counseling, injury prevention and newborn screening;
- Earmark at least another 30 percent of their appropriation for family-centered, community-based coordinated care systems for children with special health care needs, including such services as outreach, case management, health education, home visiting and nutrition counseling; and
- Spend no more than 10 percent on administrative costs and maintain the state contribution at or above fiscal 1989 levels.

The MCH Bureau provides leadership and technical assistance to state programs and offers funding for additional demonstrations, research and training, and services projects, with emphasis on those targeted to children with special health care needs.

**PROMOTING SAFE AND STABLE FAMILIES**

The Promoting Safe and Stable Families (PSSF) program provides grants to states to prevent the unnecessary separation of children from their families. The program is one of the few federally supported programs designed to help families to stay together, avoid removal of children from their homes, and support timely and safe reunification where temporary removal has been necessary. The program is targeted toward families and children who need services to assist them to stabilize their lives, strengthen family functioning, prevent out-of-home placement of children, enhance child development, improve parenting skills, facilitate child reunification and promote appropriate adoptions.

*Strengths*

PSSF is an important source of federal funding for vulnerable families. The program represents the most significant effort by the federal government to support services that may prevent child abuse and neglect from occurring, and that help children move quickly from foster care to permanent homes. Currently, there are more than half a million children in

foster care, and nearly one million cases of child abuse or neglect substantiated every year. PSSF provides vital services for needy families (Cardin, 2003).

*Weaknesses*

PSSF is a program that stresses services and outcomes. Little incentive is provided to states in developing services to families and children based on need. To the extent that family preservation/support services should be structured differently for children under the age of five compared to those in adolescence, the failure to adjust strategies based on need has led to undifferentiated service designs that are inherently less effective. Currently, there is little in PSSF that encourages more needs-based services on the part of states.

In addition, PSSF funding is disproportionately directed toward funding foster care—the very part of the system that state agencies are seeking to minimize to achieve greater permanence for children. As a result, states have found difficulty in meeting the increased demand for services other than foster care, such as front-end services, reunification or post-permanency services for children who come to the attention of the child welfare system. Advocates have urged Congress to give states the option to redirect federal funds from foster care into other child welfare services that promote safety and permanency whenever foster care caseloads are reduced.

PSSF has also given scant attention to the connection between substance abuse and child welfare. Substance abuse is estimated to be a factor in more than half of child abuse and neglect cases (Rosenbaum, 2001). Enhanced federal resources are needed to ensure safety and permanence for children in the child welfare system and appropriate alcohol and drug treatment and prevention services for their families. PSSF should also emphasize cross-agency partnerships, since child welfare and alcohol and drug prevention and treatment agencies must work together at federal, state and local levels and with other service providers, the courts, communities and families.

*State Flexibility*

Most PSSF funds go directly to state child welfare agencies. The U.S. Department of Health and Human Services requires that 20 percent of the funds given to states be spent on each of the four service categories under PSSF (see above). States believe that this interpretation does not provide sufficient flexibility, as states may need to spend more than 20 percent of this limited pot in more than one category to adequately respond to the spectrum of needs of children and families in their particular jurisdiction and to fill the gaps in service delivery systems.

Under current law, HHS has authority to approve up to 10 child welfare demonstration waivers per year to encourage innovation among states. Specific types of demonstrations that have been approved and are being considered include projects designed to identify and address reasons for delay in adoptive placements for foster children; address parental substance abuse problems that endanger children and result in placement of a child in foster care; and address kinship care.

## E. Temporary Assistance to Needy Families

Temporary Assistance for Needy Families (TANF) is a block grant created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 as part of a federal effort to "end welfare as we know it." The TANF block grant replaced the Aid to Families with Dependent Children (AFDC) program, which had provided cash welfare to poor families with children since 1935.

Under the TANF structure, the federal government provides a block grant to the states, which use these funds to operate their own programs. States can use TANF dollars to meet any of the four purposes set out in federal law, which are to: "(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families."

*Strengths*

There is a widespread consensus that the implementation of TANF has led to some important and positive outcomes. Caseloads have dropped significantly, especially among single mothers, in large part because welfare recipients left the rolls to go to work. Furthermore, states report that nearly two thirds of all adults are working or participating in activities intended to lead to work.

One of the most surprising positive outcomes of the 1996 law, moreover, has been the ability of states to use the flexibility in the law to "make work pay." The combination of caseload decline, the promise made and kept by Congress to retain level funding of the TANF block grant for five years and the flexibility provided in the TANF regulations has made it possible for states to invest more than half of the block grants in child care, transportation and other services. Research increasingly shows the importance of these supports for families that stay in the workforce. Given this record of achievement, considerable consensus about the success of the law has emerged.

*Weaknesses*

Unfortunately, many TANF recipients who leave welfare for work generally earn low wages and often remain poor. In a review of studies of families who left welfare and are working, the Center for Law and Social Policy found that working former recipients tended to earn between $6 and $8.50 per hour. In addition, many families who left welfare do not receive two key income supports—Medicaid and food stamps—despite remaining eligible for these benefits. This happened in some cases because states did not have procedures in place to ensure that former TANF recipients continued to receive these important benefits, which help low-income working families make ends meet.

Many families also left welfare not because they found a job but because they were terminated from the program for failing to comply with requirements, such as the work requirements. Research has shown that many of these families experience barriers to employment that likely impeded their ability to meet the state's expectations. These barriers include mental and physical impairments; substance abuse; domestic violence; low literacy or skill levels; learning disabilities; having a child with a disability; and problems with housing, child care or transportation. Many low-income families with barriers to employment remain on TANF, and one of the challenges in the years ahead will be to help them overcome these barriers so they can succeed in the workforce.

As cash assistance caseloads fell sharply in the early years of TANF, states redirected the freed-up resources that previously went to pay cash benefits into programs that provide supports to low-income working families (particularly child care), as well as into welfare-to-work programs. These freed-up reserves are now dwindling. The net result is that many states no longer have enough TANF resources to maintain the same level of investment in child care and other supports for working families while continuing to provide basic cash aid and welfare-to-work services for needy families. In fact, many states are already making cuts in their TANF programs.

Finally, national TANF caseloads have declined each year since March 1997; however, the rate of decline has slowed over time. Drawing from the U.S. Dept. of Health and Human Resources official data and state data, it was found that national TANF caseloads declined by 20.1 percent between March 1997 and March 1998, but declined by a little more than 2 percent between March 2001 and March 2002, and by a little less than 2 percent over the last year (see Table 6).

Table 6. TANF Annual Caseload Decline, 1997-2003

| | Change in National TANF Caseload | Number of States with Annual Caseload Declines Greater Than 15 Percent |
|---|---|---|
| March 1997 - March 1998 | -20.1% | 39 |
| March 1998 - March 1999 | -16.9% | 28 |
| March 1999 - March 2000 | -14.6% | 17 |
| March 2000 - March 2001 | -6.9% | 5 |
| March 2001 - March 2002 | -2.2% | 3 |
| March 2002 - March 2003 | -1.9% | 2 |

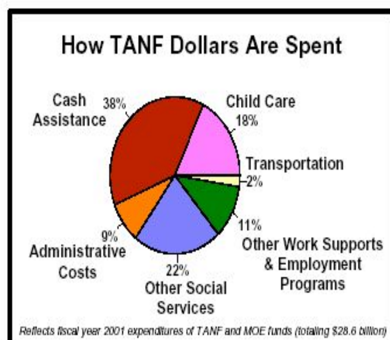
**Source: Center for Budget and Policy Priorities**

The law that created the TANF block grant authorized funding through the end of federal fiscal year 2002. This year Congress considered legislation to reauthorize the block grant and make some modifications to the rules and funding levels. However, a final agreement has yet to be reached.

*State Flexibility*

States have broad discretion to determine who will be eligible for various TANF-funded benefits and services. The main federal requirement is that states use the funds to serve families with children. States have used their TANF funds in a variety of ways, including

cash assistance; child care; education and job training; transportation; and a variety of other services to help families make the transition to work (see Figure 1). In addition, in order to receive TANF funds, states must spend some of their own dollars on programs for needy families. This is what is known as the "maintenance of effort" (MOE) requirement.




There are three exceptions to the flexibility that states generally have to establish TANF eligibility rules: 1) states are barred from using federal TANF dollars to assist most legal immigrants until they have been in the U.S. for at least five years; 2) half of the families receiving assistance under TANF in a state must be engaged in some kind of work-related activity for at least 30 hours a week;[1] and 3) no family may receive federally funded assistance for longer than five years.[2]

[1]States get credits for reduced caseloads, however, and are currently effectively required to have much less than half of families engaged in federally defined work activities. Nonetheless, states have generally exceeded the minimum federal requirements for the number of families participating in work activities.

[2]States are allowed to use federal TANF dollars to extend time limits, but only so long as no more than 20 percent of the caseload has exhausted the five-year limit. Families receiving assistance funded entirely with state MOE are not subject to the federal time limit. While about 20 states have established time limits shorter than five years, states often provide exceptions and exemptions for some groups of families meeting specified criteria.

Not every state currently is required to comply with all of the federal TANF rules. Several states are exempt or partly exempt from TANF requirements because they are operating under a “waiver" already in effect when the 1996 welfare law was enacted.

**Women, Infants and Children Program**

The Women, Infants and Children Program, better known as WIC, serves to safeguard the health of low-income women, infants and children who are at nutritional risk. WIC provides federal grants to states for supplemental foods, health care referrals, nutrition education and counseling for low-income pregnant, breastfeeding and nonbreastfeeding postpartum women, and to infants and children (up to age five). WIC is not an entitlement program. The number of women and children served in a given year is established by the amount Congress appropriates, with states having the option to add funding.

Under federal rules, eligibility for WIC is based on income and "nutritional risk." Income eligibility is set at family incomes up to 185 percent of the poverty line. (Recipients of welfare, food stamps and Medicaid automatically meet the program's income criteria.) Nutritional risk is a broad concept including medical conditions such as anemia and low weight; a mother's age, history of pregnancy complications or poor pregnancy outcomes; and inadequate diets. It is estimated that nearly half of all infants, one quarter of children aged one to five and the same proportion of pregnant women throughout the country are being served by WIC (Besharov and Germanis, 1999).

*Strengths*

The WIC program achieves its success as a nutrition program because it rests more completely on a base of solid scientific knowledge than do other federal nutrition programs. This base clearly identifies a target population and provides benefits closely related to identified nutritional problems. Studies have shown that WIC has a positive effect on pregnancy outcomes. In particular, participation of pregnant women in the program appears to increase birth weights and to reduce infant mortality and premature births. By providing services during times of critical growth and development, WIC leads to improved birth and diet-related outcomes and boosts cognitive development.

The food package designed for infants does guarantee that they receive sufficient nutrients. As a result, WIC also appears to have been successful in reducing iron-deficiency anemia among poor children. Evidence shows that participating children consume greater amounts of such critical nutritional ingredients as iron and zinc.

WIC has also been shown to be a cost-effective program. Medicaid savings for newborns and their mothers in the first 60 days after birth average between $1.77 and $3.13 for every dollar spent on WIC (Food and Nutrition Service, U.S. Department of Agriculture, 2003).

*Weaknesses*

While WIC provides critical nutrition services for low-income families, the program faces several criticisms. First, the WIC program does not adequately address the problems of obesity and healthy diets, which is a major health concern in low-income communities. The food packages for 1- to 4-year olds are heavily tilted toward high-calorie, high-cholesterol foodstuffs rather than fruits and vegetables. And while some WIC programs do provide more intensive counseling about preparing more healthful food and for actual cooking instruction, these services are almost always provided with non-WIC funds.

Additionally, one in 10 of those eligible for WIC services does not receive them due to funding constraints, confusion about program eligibility and infrastructure limitations. Funding needs to be expanded, and, ideally, WIC should be an entitlement program.

*State Flexibility*

As part of its administration of the WIC program, the Food and Nutrition Service (within the U.S. Department of Agriculture) makes grants to 88 state health and/or human service agencies that, in turn, provide program benefits to participants through more than 1,800 local WIC agencies. The state agencies develop guidelines intended to ensure that local agencies effectively deliver WIC benefits to eligible participants, and monitor local agencies' compliance with these guidelines. Local agencies approve applicants for participation, provide food benefits (typically in the form of vouchers that can be exchanged for WIC-approved foods at specified merchants), provide nutrition education, and make health referrals to eligible individuals.

Local WIC agencies must spend at least one sixth of their administrative funds on nutrition education. WIC recipients must also be offered at least two nutrition education sessions each

time they are certified. These may be either one-on-one counseling sessions or group classes designed to teach about the importance of good nutrition and its relationship to good health. Participants are also instructed on how to deal with their own particular nutritional risks and those of their children.

## STATE POLICIES

We have also identified innovative state policies that draw on federal policies' funding streams or expand upon federal policies within the same domains.

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**Policy Area:** Family Leave
**State:** California
**Program:** Family Temporary Disability Insurance Program
**Target Group:** All
**Year Enacted:** 2002
**Purpose:** Assist families in balancing the demands between family and work, and to reduce worker turnover.
**Strategy:** Enhancing family support

Last year, Governor Davis signed a bill establishing paid family leave in California. Beginning July 1, 2004, California will become the first state in the nation to provide six weeks of paid leave to workers who take time off to care for a new child or seriously ill child, spouse, parent or domestic partner. Key provisions of the bill include:

- The program will be funded through employee contributions. A minimum-wage earner will pay an additional $11.23 a year into SDI, while the estimated average cost is $27 per worker per year;

- Payments are capped at six weeks over a 12-month period and at 55 percent of wages, up to an annually adjusted maximum of $728 a week;

- Employees began paying into the fund January 1, 2004, and can begin taking leave July 1, 2004.

The federal Family and Medical Leave Act and the California Family Rights Act entitle covered workers to only unpaid leave, a right many workers cannot afford to exercise. A 2000 survey by the U.S. Department of Labor reported that 78 percent of eligible employees who needed family or medical leave but did not take it cited being unable to afford unpaid leave. This new bill enables California workers not to have to choose between caring for an ill family member and going without pay.

**Research/Evaluation:** None. The program will begin in July 2004.

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**Policy Area:** Maternal and Child Health
**State:** Illinois
**Program:** Coordination Rewards Illinois Babies (CRIB)
**Target Group:** Low-income pregnant women and infants
**Year Enacted:** 1998
**Purpose:** Reducing low birth weight and infant mortality
**Strategy:** Using federal programs as a platform to expanded services

CRIB fully integrates the federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program with the state's Family Case Management program (a service coordination program targeting pregnant women and infants) in an effort to reduce the incidence of low and very low birth weight and infant mortality in the state. Services provided by these two previously separate programs can now be accessed through a single agency contact. The initiative grew out of an evaluation showing that families served by both programs had better outcomes. CRIB's objectives are to:

- Effectively reach underserved populations;
- Address the fragmentation of services across the state;
- Enhance service delivery and client satisfaction; and
- Eliminate consumer confusion about how best to access needed services, especially for clients with multiple needs.

CRIB's approach is client-centered: the coordinated service delivery system was built around the perspective of a client with multiple needs and not the bureaucratic needs of an agency trying to adhere to funding regulations. For example, pregnant and postpartum women of low income require not only nutritional assistance but also prenatal care, family planning assistance, income support, health insurance and a host of other services dictated by their individual circumstances. CRIB makes these multiple services more accessible and allows seamless service enrollment. Implementation of CRIB involved a statewide training effort of agency staff that focused on improving service delivery and is supported by a sophisticated data management system that also facilitates coordination with a wide range of health and welfare-related programming. The program is budget neutral.

**Research/Evaluation:** The initiative has been successful in increasing enrollment rates for the two programs in down-state Illinois (excluding Chicago) from 87 percent of those eligible before CRIB was instituted to 96 percent participation after CRIB. Since the initiative's inception, breastfeeding rates have increased, and rates of low and very low birth weight and infant mortality have fallen by more than two thirds among Medicaid-eligible women participating in both WIC and FCM, compared with rates among nonparticipating women. Rates among participating Medicaid-eligible women are now comparable to those among women in the general population. In addition, health care expenditures during the first year of life were 50 percent lower among children born to program participants than among children of eligible women who did not participate.

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**Policy Area:** Maternal and Child Health
**State:** South Carolina
**Program:** South Carolina Partnerships for Children
**Target Group:** Medicaid-eligible pregnant women and children (up to three years)
**Year Enacted:** 1991
**Purpose:** Creating collaborations between family support staff and pediatric practices to help low-income families overcome barriers to care
**Strategy:** Enhancing family support

Partnerships for Children brings public health and family support staff from the state's Department of Health and Environmental Control together with physicians in private practice to help overcome barriers to serving low-income families. By creating collaborations between family support staff and pediatric practices, the initiative helps alleviate doctors' concerns about being able to address adequately the complex needs of Medicaid-eligible and other low-income families, thereby making them more willing to serve these families and provide them with medical homes. Well-child visits become an opportunity for families to receive a wide range of medical, educational and support services. Partnerships are tailored to the unique needs of individual practices and the communities they serve. Medicaid reimburses for the family support services provided.

**Research/Evaluation:** Partnerships for Children negotiated with the state Medicaid agency and the state Office of Research and Statistics to gain access to Medicaid claims data, which allows the initiative to compare health care utilization among families in partnership practices with those who obtain well-child care in other settings.

Evidence from the evaluation of Medicaid records indicates that partnership efforts are making an impact; children seen in partnership practices are less likely than others to rely on the emergency room for acute care and are more likely than others to utilize regular preventive health care.

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**Policy Area:** Child Care
**State:** Rhode Island
**Program:** Starting Right
**Target Group:** Low-income families with children
**Year Enacted:** 1998
**Purpose:** Improving access, affordability and quality of child care
**Strategy:** Enhance family support

Starting Right was implemented as part of the state’s Starting Points Initiative to bring attention to, and capture support for, young children and families, particularly in the area of quality early care and education. The Starting Points initiative focused on five major site-specific goals—the first being improved access to quality child care programs.

The state enacted Starting Right legislation in 1998 that included a provision to increase the child care entitlement to cover children in families with incomes up to 225 percent above the poverty threshold. In addition, it provides health coverage for family and center-based child care providers who serve children receiving state subsidies (applies to centers in which 50 percent or more of children receive state subsidies). Starting Right also addresses school-age care by extending subsidies to include after-school care for teens between the ages of 13 and 16. What makes this program unique is that the state has established a legal entitlement to child care subsidies for all families who meet the income guidelines, not just for those receiving cash assistance or transitioning to employment. Participants were once primarily the poor receiving cash assistance; now 60 percent are low-income working families.

**Research/Evaluation:** Rhode Island's Department of Human Services (DHS) recently received a federal grant from HHS to evaluate Starting Right and to better inform future decision-making about the program. The department will receive $250,000 a year for three years. With the grant, the state will set up a Child Care Policy Research Group that will analyze and communicate data about child care and early education, particularly looking for factors that lead to success in early literacy and school readiness, strong families and positive youth development. The state will also contract with the Wellesley College Child Care Research Partnership to provide technical assistance.

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**Policy Area:** Maternal and Child Health, Early Care and Education
**State:** Kentucky
**Program:** Kentucky Invests in Developing Success Now (KIDS NOW)
**Target Group:** Pregnant women and children through age eight
**Year Enacted:** 2000
**Purpose:** Assuring maternal and child health, supporting families, enhancing early care and education, and establishing a support structure
**Strategy:** Building infrastructure to support coordinated and comprehensive services; enhancing family support services

This statewide initiative, funded through legislative mandate and administered through the governor's Office of Early Childhood Development, aims to promote healthy child development by building on existing resources and encouraging collaborative planning and program implementation to streamline service delivery. The initiative's three core program components—assuring maternal and child health, supporting families, and enhancing early care and education—offer a range of services and supports that target pregnant women and families with children from birth to age eight. Several key programs primarily target infants and toddlers. A fourth initiative component—establishing a support structure—addresses the administration and planning necessary to incorporate input from a wide range of local stakeholders and participating agencies, and to coordinate funding, services and policies. Key components of the programs are outlined below:

- *Assuring Maternal and Child Health:* Providing information and services to pregnant women and on anticipating the needs of families with newborns with the goal of improving birth outcomes;

- *Supporting Families:* The HANDS program (Health Access Nurturing Development Services) is a voluntary home visiting service offered to all first-time parents in the state;
- *Enhancing Early Care and Education:* Aims to increase quality and availability of child care workers throughout the states; offers staff training and education for child care workers;
- *Establishing a Support Structure:* Providing coordination for the initiatives programs and services and realization of the program's goals.

**Research/Evaluation:** KIDS NOW relies on existing data from agencies administering individual programs as well as centrally pooled data from across the state to track the initiative's success. In the last budget, $1.2 million was appropriated to fund a data systems integration effort that will link tracking systems across state agencies. A research team of faculty and doctoral students from the University of Kentucky and the University of Louisville is conducting an evaluation of the initiative. The team will select a range of communities and use a case-study approach, collecting both quantitative information from state databases as well as in-depth qualitative data to examine child, family and community outcomes of KIDS NOW programs.

Individual programs that are part of KIDS NOW are regularly documenting formative progress, but the initiative has yet to document outcomes among its target population because programs have been operating under the KIDS NOW umbrella for only a little more than one year. Even before outcomes for young children and families have been documented, KIDS NOW can point to several indicators of the initiative's success. Because staff training had begun even before money was dispersed to programs, the start-up time from receipt of funds to program implementation was short, and families could begin receiving services immediately. In addition, administrative costs have been minimized and the bulk of initiative funding is spent directly on children and families.

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| **Policy Area:** | Child Health/Parent Education |
| **State:** | Maryland |
| **Program:** | Family Support Centers Network |
| **Target Group:** | Any parent with a child under four years of age (majority of participants are low-income) |
| **Year Enacted:** | 1986 |
| **Purpose:** | Help families with infants and toddlers live healthy lives by focusing on the parent/child relationship |
| **Strategy:** | Enhance family support |

This statewide initiative consists of 31 community-based Family Support Centers that offer a comprehensive roster of services for families with children from birth to age four. The initiative's objectives reflect its holistic approach to child and family well-being: child health, early identification of and referral for developmental delays, improved parenting skills, increased use of family planning, and family self-sufficiency and advocacy. Centers have flexibility to develop and offer these services on site or through contractual

arrangements with existing community-based providers. All centers also provide developmentally appropriate child care for parents enrolled in center programs to use when they are on site receiving services or when in need of respite.

The network has found that making available a wide array of adult programming is an important initiative strategy. This programming serves as a "carrot" to attract low-income parents with infants and toddlers into the centers, where they can then be offered comprehensive assessment and intervention services for their babies as needed.

**Research/Evaluation:** A quality assurance monitor visits each site twice yearly to obtain a total view of how the center is functioning. The monitor speaks with both participants and staff, examines records and activity programming, and submits a report that rates the site's functioning on a five-point scale, considering program integration, level of additional programming (beyond mandated activities) and the degree to which the center meets or exceeds expected levels of participant involvement. The Infant-Toddler Environmental Rating Scale is administered annually at each site. The role of the monitor complements the work of program consultants, who work with each center to ensure ongoing quality enhancement. Program consultants each work with approximately nine sites, providing training, troubleshooting and consultation as needed. Program consultants work together to enhance communication within and among centers, and produce an annual narrative summary for each site they are assigned.

The initiative examines a set of outcomes based on data gathered from the individual sites and documented in an annual report: immunization rates, child development assessments, number of children identified with developmental disabilities and referred for services, GED and high school graduation rates, and number of adult participants who obtained jobs.

Surveys of 200 parents indicated that clients feel "overwhelmingly good" about the centers' services. Positive changes are evident in parents' expectations about appropriate child development and in their parenting practices (such as a decrease in the belief that physical punishment is effective, and an increase in home safety practices). Parents also demonstrated better problem-solving skills and were better able to seek care for their children after participating in programs at the Family Support Centers.

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| **Policy Area:** | Child Welfare |
| **State:** | Rhode Island |
| **Program:** | Families Together for Therapeutic Visitation |
| **Target Group:** | Court-separated families |
| **Year Enacted:** | 1991 |
| **Purpose:** | Drawing parents and children together in a nonthreatening, participatory environment |
| **Strategy:** | Developing new approaches to training and technical assistance for service providers |

Families Together is a family visitation partnership between the Providence Children's Museum and Rhode Island's Department of Children, Youth and Families, and provides biweekly therapeutic visitation at the Children's Museum for children under 12 and parents. This program has pioneered a fresh approach to therapeutic visitation for families separated by court order due to abuse and neglect. Through shared learning and play, Families Together helps participants rebuild relationships and strengthen parenting skills. Caseworkers observe each family and get a more complete picture of them, which leads to more accurate and valid recommendations to family court judges.

An average of 75 families take part in therapeutic visitation each year. Beyond providing clinicians to guide and observe family interaction at the museum, Families Together staff work with social workers all over the state, training them to better assist parents in meeting the needs of their children. In 2001, Families Together trained 387 social workers and supervisors. The program also helps social workers creatively resolve challenges they encounter with families during visitation.

**Research/Findings:** Preliminary results from a survey indicate that the program is changing how social workers deal with and use visitation.

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| **Policy Area:** | Child Care |
| **State:** | Minnesota |
| **Program:** | At-Home Infant Child Care Program |
| **Target Group:** | Low-income parents with infants |
| **Year Enacted:** | 1998 |
| **Purpose:** | Helping families with children under one year of age cover some of the costs of staying home and caring for their infants |
| **Strategy:** | Using subsidized child care funds to allow low-income parents to stay at home with their infants |

The At-Home Infant Child Care Program (AHIC) allows families who have a child under age one, are eligible for or currently receiving basic sliding fee child care assistance, and provide full-time care for their infant child, to receive a subsidy in lieu of child care assistance. The program was designed as a complement to Minnesota's general child care assistance program for low-income families, the Basic Sliding Fee Program (BSF). To be eligible for the program, families must: 1) meet the eligibility criteria used for the BSF, which includes both income eligibility criteria and parental participation in employment, education or job search, and 2) provide full-time care for their infants (children under one year of age).

Eligible families are:

- limited to a lifetime total of 12 months of assistance from AHIC;
- able to split the 12 months between children or use for one child;
- not allowed to obtain child care subsidies for nonparental care for any other children in their family;
- permitted to pursue employment or education while receiving AHIC assistance; and

- eligible for the sliding scale program once they complete their participation in AHIC if they request additional child care help and meet all eligibility criteria for the BSF program.

When first enacted, AHIC was available only to families already receiving, or at the top of the waiting list to receive, the BSF child care (families in those counties without waiting lists were also eligible). However, in July 1999 the Minnesota legislature revised the participation regulation to allow families on waiting lists for BSF to move directly into AHIC, even if they were not at the top of the BSF waiting lists.

**Research/Evaluation:** Minnesota released data on the limited number of families (63) that completed their participation by December 1999. Due to the even smaller number of families (19) who completed the parent evaluations for the program, the data that Minnesota has compiled can only offer a preliminary evaluation of the program. However, using the participant data from 51 of 63 possible evaluations on the families who've completed the program provided by Minnesota's counties, which administer the program, the February 2000 legislative report on AHIC describes the following trends:

- All families were involved in an authorized work activity prior to the birth of their infants. Ninety-four percent of these families were undertaking employment and 8 percent were participating in education prior to the birth of their children. (Two families were involved in both education and employment);

- Families who were able to receive the benefits of the at-home infant care program were more likely to be two-parent families, and in that sense, were unlike the Basic Sliding Fee population overall;

- Among the families that have completed their AHIC participation, the average number of children is 2.3, and the number of children ranges from 1 to 5. Overall, the families that participated in AHIC were slightly larger than BSF families;

- Prior to AHIC, the average income for participants was $21,891 or 40 percent of the State Median Income. This income fell to $19,379 (35% of the State Median Income) during AHIC, and then increased to $23,671 (43% of State Median Income) after participation. Minnesota attributes this eventual increase in earnings to the relatively high proportion of two-parent families who participate in AHIC;

- The average subsidy per month to families in AHIC was $277, and the average total subsidy was $1,469. The aggregate data from completed participants indicates that a significant portion of participants received $200 to $299 a month, and almost all participants were provided between $100 and $399 a month;

- Due to the 1999 changes in participation procedure, Minnesota was unable to determine cost savings for the AHIC at the overall program level. However, cost savings at the family level were determined; and

- The anecdotal information gathered from the 19 parental responses to the AHIC evaluation indicate that 17 of the families felt that there were benefits, either developmental or financial or both, to AHIC. Only two parents found it difficult or somewhat difficult to participate.

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**Policy Area:** Child Welfare
**State:** Illinois
**Program:** One Church One Child Minority Adoption Campaign
**Target Group:** Court-separated families
**Year Enacted:** 1980
**Purpose:** To promote the development of foster and adoptive parents for the abundant number of minority children in the child welfare system
**Strategy:** Establish formal ties with a network of churches to facilitate the adoption process

The One Church One Child (OC/OC)minority adoption program is a unique church/state partnership that challenges primarily African American churches to recruit at least one family from each congregation to adopt a child. Founded in Chicago in 1980, the program was initiated by the state's Department of Children and Family Services in concert with the state's black churches. Although most states have developed special techniques to encourage black families to adopt black children, Illinois was the first to establish formal ties with a network of ministers and churches to facilitate the process. Through OC/OC, black ministers and congregations are helping find permanent homes for black children needing adoption. In addition, black clergy affiliated with the program have advised ministers in 14 states on how to launch similar programs. OC/OC has become a model for similar partnerships in more than 1,000 churches in 32 states.

**Research/Evaluation:** Approximately 100,000 children have been adopted through this program.

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**Policy Area:** Child Welfare
**State:** North Carolina
**Program:** Smart Start
**Target Group:** All children in the state age birth to five
**Year Enacted:** 1993
**Purpose:** Improve the health and school readiness of children ages birth to five
**Strategy:** Supporting locally responsive efforts to support children and families

Smart Start began as the result of a task force created under Governor James B. Hunt. The task force saw that solutions for children needed to come from the local communities where they and their families lived. In 1993, legislation established a structure at the state and county levels and allocated funds for providing services to young children and families. The state-level partnership would provide funding and technical assistance, and county-level partnerships would design and implement quality services and programs for children based on community needs. County partnerships were given flexibility to make decisions about the

services they would provide. Beginning with 12 partnerships in 1993, Smart Start has now expanded to all 100 North Carolina counties.

All children from birth to age five and their families are eligible for Smart Start services, regardless of income. In each county partnership, planning teams make decisions about the kinds of programs to develop using Smart Start funds. County partnerships spend anywhere from 30 to 76 percent of their Smart Start funding on child care subsidies. Currently, 42 percent of all Smart Start funds across the state are being used for this purpose. Smart Start funding spent on child-care-related activities other than subsidies, such as teacher education and support, is 30 percent. The remaining funds are spent on health services and family support programs and services, such as parenting and education.

**Research/Evaluation:** There are a number of studies and evaluations of the Smart Start initiative, and they have found that:

- Children who attend child care centers that are very involved in Smart Start quality improvement activities have better cognitive and language skills and fewer behavioral problems than children in centers not participating;
- Family child care programs participating in Smart Start provide higher-quality child care;
- The percentage of high-quality child care centers has increased from 20 percent in 1993 to 66 percent in 2001. The percentage of poor-quality child care centers has decreased from 80 percent in 1993 to 34 percent in 2001;
- The quality of center-based care in NC has improved significantly over time because of Smart Start. Child care centers participating in more Smart Start quality-improvement activities provide higher-quality care;
- Children with special needs are more likely to be in higher-quality child care because of Smart Start;
- From 1994 to 1999, the number of child care facilities enrolling children with special needs increased by 50 percent due to Smart Start training and resources;
- Smart Start children are more likely to be immunized on time and have a regular source of health care;
- The number of children who received Smart Start health and developmental screenings has tripled since 1996, increasing from 40,000 in 1996 to 120,000 in 2001;
- More than 90 percent of families participating in Smart Start activities read to their child at least once a week; and
- In FY 2000-2001, more than 28,700 parents participated in Smart Start parenting classes, support groups and home visiting programs, compared to 14,651 in 1996.

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**Policy Area:** Child Welfare
**State:** Arizona
**Program:** Family Builders
**Target Group:** Families at risk of child abuse and/or neglect
**Year Enacted:** 1997

**Purpose:** Enhance parents' ability to create safe, stable and nurturing home environments that promote the safety of all family members and healthy child development
**Strategy:** Provide risk-level-appropriate responses to child abuse and/or neglect

Family Builders is a community-based program administered by the state Dept. of Economic Security. It was established to address a backlog of uninvestigated child abuse and neglect reports and to fill a need for early-intervention services. Based on the premise that families with different risk levels for child abuse require different responses, potential- and low-risk child abuse and neglect reports are referred to Family Builders for treatment and immediate services rather than for an investigation by Child Protective Services (CPS).

Family Builders currently operates in 10 of Arizona's 15 counties. When CPS receives a report of potential- or low-risk abuse/neglect in an area served by Family Builders, the case is referred to a Family Builders contractor, and CPS closes its case. In the five counties without the program, CPS investigates all of the child abuse and neglect reports. When Family Builders receives a referral, a caseworker visits the family's home and offers a variety of voluntary services through community-based organizations. Services include parent counseling, child care, transportation and emergency services such as food, clothing and rent assistance. Family Builders cases typically follow one of three paths:

- If the family cannot be contacted or declines services, the case is closed;
- If the family accepts services, an assessment is completed. Depending on the results, a service plan is developed and the services chosen by the family are provided; or
- If there are signs of abuse or neglect, the case is referred back to CPS.

From August 1, 1999, through April 30, 2001, Family Builders received more than 14,000 referrals. Just under one third of those referrals (4,397) accepted and received services.

**Research/Evaluation:** the state auditor general conducted a performance audit of Family Builders in November 1991. Evaluators found that although the services provided by Family Builders and CPS differ, the two groups of families had comparable proportions of subsequent CPS reports. However, families who completed Family Builders had fewer subsequent reports than families who did not. In addition, Family Builders program participants experienced a reduction in their risk for child abuse or neglect, as measured by the Family Risk Scale. The report also describes the Department of Economic Security's limited progress in addressing previously identified monitoring and oversight problems. Although the Department has made an effort to resolve problems, it still lacks reliable cost data, needs to improve its other program data and could provide greater guidance to local advisory boards.

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**Policy Area:** Child Care
**State:** Kansas
**Program:** Early Head Start Expansion Initiative

**Target Group:** Low-income pregnant women and families with infants and toddlers
**Year Enacted:** 1998
**Purpose:** Maximize the availability and improve the quality of community-based child care; improve professional development opportunities for child care professionals
**Strategy:** Using federal programs as a platform for expanded services

In 1998 Kansas became the first state to expand the federally funded Early Head Start program with state funds, with the goal of maximizing the availability and improving the quality of community-based child care for infants and toddlers in addition to improving professional development opportunities for early child care professionals. Also, the state expansion targets a gap in services for three-year-olds by enabling grantees to offer continuous EHS services until children become eligible for Head Start at the age of four.

Through the Kansas EHS expansion (KEHS), state-funded programs offer the same comprehensive services as federal EHS programs—early, continuous and intensive child development and family support services for low-income pregnant women and families with infants and toddlers. Whereas federal EHS programs may either provide child care services themselves or partner with existing child care providers, the Kansas expansion requires that its EHS sites partner with child care providers in their communities. Because these community-based providers must meet federal Head Start Performance Standards that are more stringent than current state child care regulations, the initiative increases the overall quality of community-based child care. The initiative also partners with the federal EHS infrastructure, and additional federal funds are used to provide training and technical assistance and to increase professional development opportunities for child care providers, including workshops, stipends, substitutes and college credits leading to the Child Development Associate credential.

**Research/Evaluation:** Each of the 13 local EHS programs throughout the state must adhere to performance standards as laid out by the National Head Start program and monitored every three years through on-site visits. Since 1998, 11 sites have received site visits; all have met the federal performance standards. Selected KEHS programs were also included in a national evaluation conducted by Mathematica Policy Research. The evaluation found that Kansas EHS grantees often had fewer areas of noncompliance with the Performance Standards than traditionally funded federal EHS programs.

In 2001, KEHS served 825 children in 32 counties statewide. By mid-2002, the expansion initiative had enabled 2,875 extra children in the state to receive high-quality child care services. An additional 2,000 children who are not part of the program but receive care at participating child care sites also indirectly benefit from the enhanced quality of care.

Currently, the initiative is in its sixth year of providing services to children and families in Kansas. KEHS programs continue to meet bimonthly to plan, discuss and network about current and future topics for their programs. As a result, statewide outcomes have been developed using data from Connect Kansas, a statewide project to help communities identify and solve children's health problems. The outcomes are: 1) pregnant women and newborns

thrive, 2) infants and children thrive, 3) children live in stable and supported families, 4) children enter school ready to learn. A partnership with KU and KSU has been formed to use a new language measurement tool and language intervention guide as part of the outcomes.

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| **Policy Area:** | Early care and education |
| **State:** | West Virginia |
| **Program:** | Starting Points Family Resource Centers |
| **Target Group:** | Low-income families |
| **Year Enacted:** | 1996 |
| **Purpose:** | Make early care, education and family support services available and accessible to families with children (up to age eight) |
| **Strategy:** | A multisite, comprehensive approach to family self-sufficiency and child well-being |

The Starting Points initiative creates Family Resource Centers across the state to bring together early care, education and family support services to increase service coordination and accessibility for families with young children. The Starting Points Centers (18 statewide) serve as community "hubs" that make early care, education and family support services available and accessible to West Virginia families with children up to age eight. The centers focus on: 1) bringing resources together in one place, 2) coordinating services, 3) educating and supporting families and 4) integrating early care and education. Center programming targets families with children from birth to age eight, but infant and toddler services make up a large proportion of center offerings. Starting Points Centers are open to all, but typically serve poor and low-income families. Centers are typically set up in underserved areas and at community-based sites such as schools, child care centers and housing projects that are easily accessible for low-income families.

Key features of the initiative include:

- *Coordination across agencies and programs*—When the Family Resource Networks become Starting Points centers, they expand their membership to include an array of early childhood providers and consumers. The networks subcontract with other agencies (schools, child care centers or local housing projects) to serve as the physical site for service delivery. Each center has a full-time coordinator.
- *An array of services*—The centers provide family intake and assessment, case management and resource coordination, health and nutrition services, developmental screening and referrals, parent and preschool education, home-based services and outreach, medical referrals and follow-up, and child care or playgroups. Some also provide GED classes, adult literacy programs and links to computer and job centers.
- *Training and technical assistance*—Center staff receive training in evaluation, procedures and practices, strategic planning, database management, and media and public relations.

**Research/Evaluation:** Starting Points centers submit quarterly and annual progress reports to the West Virginia Governor's Cabinet on Children and Families. The quarterly reports

give the cabinet critical information about the degree to which the centers are achieving the initiative's goals as well as the broader state goal of coordinated early childhood infrastructure and service delivery system. They contain a narrative describing the impact of the center's work on the surrounding community, barriers faced, successes achieved and obstacles overcome. The report also documents service utilization patterns, including the types of scheduling of activities, so that service delivery schedules that do not coincide with identified needs or patterns of utilization can be altered. The West Virginia Prevention Resource Center collates the quarterly reports from all Starting Points centers to create an initiative-wide report that is disseminated across the state.

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| **Policy Area:** | Early care and education |
| **State:** | Washington |
| **Program:** | Early Childhood Education and Assistance Program |
| **Target Group:** | Four-year-old children whose family income is at or below 110 percent of the FPL |
| **Year Enacted:** | 1985 |
| **Purpose:** | Provide community-based education and assistance to low-income families and children who are at risk of school failure |
| **Strategy:** | A multisite, comprehensive approach to family self-sufficiency and child well-being |

In 1985, the State of Washington began developing statewide comprehensive early childhood education and assistance services to support the healthy development and success of children in low-income families or children who are otherwise at risk of school failure. The Washington State Office of Community Development (OCD) administers Washington's Early Childhood Education and Assistance Program (ECEAP).

ECEAP is composed of four interactive components: education, health and nutrition, parent involvement, and family support. Key features of the program include:

- *Education*—For at least 32 weeks of the year, ECEAP offers programs for pre-kindergarten children that foster their intellectual, social, physical and emotional growth. Staff identify and intervene with problems that might interfere with learning when the children enter the public school system.
- *Health and nutrition*—ECEAP screens children for medical, dental, mental health and nutritional needs within the first 90 days of their participation. Staff bring children's immunizations up to date and arrange for fluoride treatments where the water is not fluoridated. Children receive at least one complete meal each day in the classroom. The curriculum includes education about healthy eating habits for children and parents. Staff refer families to appropriate community providers when they need health services.
- *Parent involvement*—ECEAP encourages parents to volunteer in the classroom and to serve on local policy councils, where they make programmatic decisions. ECEAP also provides training and support groups that help parents become better parents.
- *Family support*—ECEAP staff help families assess their needs and locate resources.

ECEAP operates 260 program sites locally through 35 contractors, including school districts, educational services districts, local governments, nonprofits, child care providers and tribal organizations. Throughout the past 16 years, ECEAP has significantly increased the number of children it has served, from 1,000 in 1986 to 7,879 served during the 2000-2001 program year. The program has served more than 90,000 children and families since its inception.

**Research/Evaluation:** The Washington State Early Childhood Assistance Act of 1985 mandated an external evaluation of ECEAP. The Northwest Regional Educational Laboratory (NREL) conducted a longitudinal study from 1988 to 2000 to measure outcomes of enrolled children and families. The study examined ECEAP's effectiveness in preparing these children to achieve educational success, and later, to measure family well-being, changes in social status and family resources, and dependence on public assistance. The longitudinal study completed 12 years of data collection and evaluation, in which it followed 1,358 children drawn from groups selected over three consecutive years beginning in 1988. A comparison group of 322 children who were eligible but not served by the program was also established. The comparison sample was not a random sample, but was composed of children in the same schools as ECEAP children who matched the ECEAP children on age, gender, ethnicity, primary language and level of poverty. However, a much larger percentage of the ECEAP group was at or below the poverty level at the start of the study than was in the comparison group (95 percent versus 53 percent). In addition, the follow-up rate among the comparison group had been about 65 percent while the follow-up rate among the ECEAP participants had only been about 55 percent.

The Year 8 Longitudinal Study found that:

- ECEAP children showed a steady increase in academic progress ratings starting in third grade relative to the comparison group;
- ECEAP children had consistently higher scores on positive behaviors displayed at school, such as adjustment to school and parental or teacher reports of academic progress, than those in the comparison group;
- ECEAP parents had a higher rating of participation in their children's activities outside of school than parents in the comparison group;
- Forty-two percent fewer ECEAP children and families were at or below the poverty level in Year 8 compared with the number at the time of enrollment, whereas the same was true of only 16 percent of the comparison group.

The Years 9 and 10 Study showed that:

- Fifty-seven percent fewer ECEAP children and families were at or below the poverty level in Year 10 compared with the number at the time of enrollment; among the comparison group participants, only 20 percent fewer children and families were at or below the poverty level.

By 2000, evaluators felt that the longitudinal study was no longer providing significant information, and it was ended in favor of developing a yearly outcomes evaluation for

enrolled children and families. The new study design is currently being developed, and possible outcomes have been identified but not finalized.

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## APPENDIX B

The following people were very generous in providing information, insights and referrals as P/PV researched and wrote this review.

**Lawrence Aber,** professor at the Steinhardt School of Education, New York University, and formerly the director of the National Center for Children in Poverty as well as Associate Professor at Columbia University's School of Public Health.
Dr. Aber's research interests include the relationship between neighborhood environments and developmental outcomes, program implications of developmental research with high-risk children, and developmental approaches to the design of preventive intervention. Dr. Aber is working on delineating key elements of a child care policy research agenda that takes into account the shift for decision-making authority for child care and policies from federal government to state and local governments. Among his publications are *The Impact of Poverty on the Mental Health and Development of Very Young Children* and *The Effects of Poverty on Child Health and Development.*

**Laura Aird**, manager, Child Care Initiatives, the American Academy of Pediatrics. Ms. Aird has a background as a child care center director and has spent a number of years at the American Academy of Pediatrics, where she has been involved in the implementation of Healthy Child Care America and other projects that attempt to link health services with community-based services. She is very knowledgeable about state efforts to improve links between health services and child care.

**Charles Bosk**, professor of sociology, University of Pennsylvania. Dr. Bosk is the author of *Forgive and Remember: Managing Medical Failure* and is a leading bioethicist. A past member of the Institute of Advanced Study, he is a fellow of the Hastings Center for Bioethics.

**Donna Cohen Ross,** director of outreach, Center on Budget Priorities. Ms. Cohen Ross oversees the Center's highly acclaimed Earned Income Tax Credit outreach campaign. She also developed and directs Start Healthy, Stay Healthy, a national effort to enlist government agencies, health and human services providers, community-based organizations and institutions and others to help families get their children enrolled in free and low-cost health insurance programs. The project also provides technical assistance to state child health officials, nonprofit groups and others on policies and procedures to simplify children's health coverage enrollment and renewal processes. Ms. Cohen Ross joined the Center's staff after 12 years as a child advocate in New Jersey. A seasoned state EITC campaign organizer, her outreach efforts in New Jersey were recognized as among the best in the country. As director of Invest in Children, a coalition of New Jersey's business leaders and child advocates working to improve health and education programs for young children, Ms. Cohen Ross spearheaded a statewide WIC Quality Enhancement project and cofounded the Early Childhood Facilities Fund. Her early work in New Jersey resulted in the initiation of a successful state School Breakfast Start-Up Fund.

**Yvonne Chan,** the Principal of the Vaughn Next Century Learning Center in Los Angeles, which serves students living in poverty. Her degrees include an M.A. in special education from California State University and a doctorate in education from UCLA. The Vaughn Next Century Learning Center was named the 1995 California Distinguished School and the 1996 National Blue Ribbon School by the U.S. Department of Education. Time magazine, Prime Time Life, Good Morning America, National PBS, Education Week and many others, profiled Dr. Chan. She received numerous awards including the National Educator Award by the California State Department of Education.

**Frank F. Furstenberg, Jr.**, Zellerbach Family Professor of Sociology and Research Associate in the Population Studies Center at the University of Pennsylvania. His interest in the American family began at Columbia University where he received his Ph.D. in 1967. His most recent book is *Managing to Make It: Urban Families in High-Risk Neighborhoods* with Thomas Cook, Jacquelynne Eccles, Glen Elder, and Arnold Sameroff (1999). His previous books and articles center on children, youth, families and the public. His current research projects focus on the family in the context of disadvantaged urban neighborhoods, adolescent sexual behavior, cross national research on children's well-being, and urban education. He is a member of the American Academy of Arts and Sciences and the Institute of Medicine.

**Melinda Green,** vice president of Children's Futures, a major initiative funded by the Robert Wood Johnson Foundation to improve child health and development outcomes for children in Trenton, New Jersey. Children's Futures works with local stakeholders in the design of intervention strategies, providing funds for implementation, and linking community organizations with research and best practice. In her role as vice president, Ms. Green oversees the development and management of grants to community organizations. She also heads the leadership and capacity-building initiative.

Before coming to Children's Futures, Ms. Green served as National Director of the Early Childhood Leadership Resource Center at the National Black Child Development Institute in Washington, D.C. While there, she developed several key programs that were designed to promote the development of diverse leadership in the early care and education field.

Ms. Green also spent 10 years as the executive director of Child Care Connection, a major child care resource and referral agency in New Jersey. The agency is recognized for high-quality services in the areas of parent education, child care resource development and education of child care providers. Ms. Green is a past president of the board of directors of the National Association of Child Care Resource and Referral Agencies.

Throughout her professional career she has held a variety of positions in the early care and education field including many years as a therapeutic teacher of preschool neurologically impaired children.

**Neal Halfon,** MD, MPH is the Director of the UCLA Center for Healthier Children, Families and Communities, and also directs the Child and Family Health Program in the UCLA School of Public Health, and the federally funded Maternal and Child Health Bureau's

National Center for Infancy and Early Childhood Health Policy Research. Dr. Halfon is a Professor of Pediatrics in the UCLA School of Medicine and Professor of Community Health Sciences in the UCLA School of Public Health, and is Professor of Policy Studies in the School of Public Policy and Social Research and is a also consultant in the Health Program at RAND.

Dr Halfon was appointed to the Board on Children, Youth, and Families of the National Research Council and Institute of Medicine in 2001. He has also served on numerous expert panels and advisory committees including the 1999 Institute of Medicine committee commissioned by Surgeon General Satcher to propose the leading health indicators to measure the countries progress on our National Healthy Peoples agenda. He currently serves on a congressionally mandated Committee of the Institute of Medicine to evaluate how children's health should be measured in the US.

**Cheryl Hayes** serves as executive director for the Finance Project. She has approximately 20 years of experience in public policy research on issues affecting the well-being of children and families. Before joining the Finance Project, Ms. Hayes served as executive director of the National Commission on Children, a bipartisan Presidential-Congressional Commission charged with assessing the status of America's children and families and presenting a national policy agenda for improving health, education, income security and social supports. Prior to her Commission appointment, Ms. Hayes directed the National Academy of Science/National Research Council policy research program on children and families. She is the author/editor of numerous books and articles on public policies for children and families. Ms. Hayes is also a recognized expert on financing issues and strategies. As executive director of the Finance Project, she manages an array of policy research, development and technical assistance activities to improve financing for education, other children's services, and community building and development.

**Jody Heymann,** M.D, Ph.D., is founder and director of the Project on Global Working Families. An Associate Professor at the Harvard School of Public Health and Harvard Medical School, Heymann is founding chair of the Initiative on Work, Family, and Democracy. She is the Director of Policy at the Harvard Center for Society and Health

**Ellen Kisker** (Ph.D., Applied Economics, Stanford University) is a senior researcher at Mathematica Policy Research. During her 17 years at Mathematica, Dr. Kisker has worked extensively on issues of public policy and program evaluations related to child care and early education.

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**Joan Lombardi** (Ph.D., Human Development Education, University of Maryland Institute for Child Study) is senior policy fellow with the National Institute for Early Education Research (NIEER). She is a child and family policy specialist, serving as an advisor to a number of national organizations and foundations across the country on early care and education issues. Her recent book, *Time to Care: Redesigning Child Care to Promote Education, Support Families and Build Communities*, argues that our current child care system is not meeting the needs of America's families, and proposes ways to redesign the system to promote healthy child and youth development. Prior to her current appointment, she served as the first associate commissioner of the Child Care Bureau and as the staff director of the Secretary's Advisory Committee on Head Start Quality and Expansion.

**Sara McLanahan** is a professor of Sociology and Public Affairs at Princeton University. She directs the Bendheim-Thoman Center for Research on Child Well-Being and is an associate of the Office of Population Research. Her research interests include family demography, poverty and inequality, and social policy. She teaches courses on poverty and family policy. She is co-author of *Fathers Under Fire* (1998), *Social Policies for Children* (1996); *Growing Up with a Single Parent* (1994); *Child Support and Child Well-being* (1994); and *Single Mothers and Their Children: A New American Dilemma* (1986). Dr. McLanahan has served on the boards of the American Sociological Association and the Population Association of America, and is currently a member of the board on Families, Youth, and Children of the National Academy of Sciences.

**Jean Mitchell,** program director, Friends of the Family, Inc., Baltimore, Maryland. An intermediary organization, Friends of the Family provides funding, training, technical assistance, monitoring, evaluation and other quality assurance services to the statewide network of 26 Family Support Centers in Maryland. These Centers serve pregnant women and young parents with children from birth through age three and provide comprehensive, preventive services related to child and parent health, early identification of and referral for developmental delays, improved parenting skills, increased use of family planning, and skill-building in family social and economic self-sufficiency and self-advocacy. In addition to its coordination of Family Support Centers, all of which are supported through the intermediary with State funds provided by Maryland's Department of Human Resources and/or federal Early Head Start, Friends of the Family trains hundreds of participants from numerous education and social service agencies and child care programs statewide in all aspects of family and child development.

**Patricia O'Campo** (Ph.D., Johns Hopkins School of Hygiene and Public Health) is professor with the Department of Population and Family Health Sciences at Johns Hopkins. Her current research interests lie in applying epidemiological methods to a range of maternal health and child health issues, examples of which are early childhood health, health policy impacts on child development, and the evaluation of maternal and child health community-based and clinic-based interventions. She has developed innovative methods for accurately

measuring effects of neighborhood characteristics on perinatal outcomes, for which she has been recognized with the Loretta P. Lacey Award for Academic Leadership.

To date, Dr. O'Campo has been the principal investigator or co-investigator on 11 research projects supported by institutions concerned with child well-being, including the National Institute of Child Health and Human Development, the Maternal & Child Health Bureau and the Heinz Endowment.

**Mario Luis Small** (Ph.D., Sociology, Harvard University) is assistant professor in Sociology at Princeton University. Dr. Small's ongoing research concerns include the impact of neighborhood organization on family structure and the resulting impacts on child well-being. He is currently heading a study of social capital generation among parents in child care centers in New York City. Dr. Small is completing a book on the functioning of social capital and community participation in a low-income Latino neighborhood.

In addition to his position as assistant professor, Dr. Small is a faculty associate with the Office of Population Research.

**Ralph R. Smith** is the senior vice president of the Annie E. Casey Foundation, a private philanthropy dedicated to help build better futures for disadvantaged children in the United States. The primary mission of the foundation is to foster public policies, human-service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. In pursuit of this goal, the foundation uses its resources to help states, cities, and communities fashion more innovative and effective responses to these needs. Smith was a member of the law faculty at the University of Pennsylvania from 1975 to 1997 and is founding director of the National Center on Fathers and Families and the Philadelphia Children's Network. He joined the foundation in 1994, and has spent the last decade working with foundations, civic organizations, public agencies, and school boards across the country on issues relating to education reform, child and family policy, and public sector systems change across the nation.

**Jane Waldfogel** (Ph.D., Public Policy, M.P.A., M.Ed., Harvard University) is professor of Social Work and Public Affairs at Columbia University. Her current research focuses on the effects of parental leave policies on child care and consequent impacts on child well-being. She has been the principal investigator or co-investigator on research projects regarding child well-being with the support of the National Institute of Child Health and Development. Dr. Waldfogel has authored numerous articles analyzing the effects of the Federal Family and Medical Leave Act on child care. Forthcoming publications include "Child Care, Women's Employment and Child Outcomes" and "Family-Friendly Policies for Families with Young Children."

Prior to teaching, Dr. Waldfogel was a policy analyst for the Massachusetts Department of Social Services and a research associate for the Suntory-Toyota International Center for Economics and Related Disciplines at the London School of Economics. She has been a member of the MacArthur Network on Poverty and Inequality in Broader Perspective since 1997, and serves on the editorial board of *Children and Youth Services Review*.

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