Connecticut's Zero to Three State Policy Action Team Meeting Application
November 2011

Vision: In Connecticut we envision a home visitation system that has common standards, a coordinated referral system, universal assessment, and provides a continuum of services that families can access in their communities, based on priorities, culture, and needs. A true system is inclusive and comprehensive, with fathers engaged, state poverty reduction strategies embedded, EPSDT and Medicaid opportunities integrated. It is our vision to develop a system in which strategies are utilized to systematically narrow both health inequities and the achievement gap.

The desired outcome is greater collaboration among home visiting programs and mutual recognition and community awareness of each program's unique expertise that enables Connecticut (CT) to build a continuum of care for all our children and families. It is this vision that drives CT's goal to reach every child, every year, in every setting.

1. Current status of quality early childhood services for infants and toddlers in CT
Connecticut has approximately 120,000 children from birth to three years old. Among these 79,000 are from low-income families; 14,000 face disabilities or developmental delays. As these two populations overlap somewhat, we estimate 80,000 of these children to be high need.

Quality & Access: Connecticut is a national leader in the number of accredited programs, in our Accreditation Facilitation Project, and in the rigor of our child day care licensing standards. Connecticut mandates publicly funded child care settings to have an educator with an associate's or bachelor's in early childhood development or child development by 2015. We lead in facilities development, with a low interest loan fund for cities/towns to build early care facilities or adapt buildings to meet quality standards for children.

The Child Development Infoline (CDI), a specialized unit of United Way/211. CT families can access information and services through the state's leading resource and referral agency. The CDI provides telephone referrals for care coordination for families, child health and service providers regarding child's development, behavior, health and special needs. The service includes access to CT Part C at the Department of Social Services (DSS), *Help Me Grow* at the Department of Developmental Disabilities (DDS), Children and Youth with Special Health Care Needs at the Department of Public Health (DPH), and Pre-School Special Education at the State Department of Education (SDE).

ECCP (Early Childhood Consultation Partnership) is a mental health consultation program designed to meet the social/emotional needs of children birth to five. It offers support, education, and consultation to those who care for them. Funding is provided by DCF and SDE.

Connecticut's Birth to Three System, (IDEA, Part C Administrator): (1) strengthens the capacity of families to meet the developmental and health-related needs of their infants and toddlers, with five straight years of meeting all IDEA compliance measures; (2) provides 90% of its services in natural environments, most frequently the home, some in child care settings; (3) serves 3.7% of children under three, the highest compared to states with similar eligibility criteria and 10th in the nation; (4) produces service guidelines and family materials that are widely copied by other states; (5) created comprehensive autism-specific early intervention programs to give families access to providers with specific expertise and capacity to provide autism services; and (6) received 8,063 referrals in FY11. Data indicates that of

all children enrolled in Kindergarten in 2010-11 who had received early intervention services, 51% did not require special education services.

Reaching the most vulnerable: Early Head Start partners with the Department of Children and Families (DCF) to support all children in foster care enrolled in quality early care and education. Since 2001 the two have worked together to maximize enrollment and attendance of infants and young children into comprehensive quality early care and education and mental health programs. Professionals are trained in protective factors, trauma informed interventions, infant mental health and resiliency. This strategy supports both foster families and relative caregivers.

Linkages between Health and Early Care: 103,800 CT children are EPSDT eligible, birth to five. Of these, 79% are on track for well-child visits. One-fifth to one half experience developmental or behavioral issues. A philanthropic partnership supports local collaboratives to look at both early care and health needs. Over 200 independent health consultants support early care programs. We have created extensive supports for professional mental health consultation. This facilitates health and safety, screening referrals and well-child visits.

Family as Asset: Connecticut's focus on family engagement is very strong in most communities. Dr. Ed Zigler created family resource centers, seeking cohesive systems of service for the family. These 61 centers are scattered throughout the state in neighborhoods and in schools. We have strong birth to eight plans for young children on the neighborhood level financed in a public-private partnership, through the Graustein Discovery Initiative.

Connecticut models parent leadership and family civics through a sustainable Parent Trust Act, with public-private funding of $1 million, for family engagement at the community level. This family civics, with parents as assets, is coupled with proven parent leadership programs (PLTI, PEP, and Parents SEE) now being replicated in other states.

Public-Private Partnerships: A strong coalition of agencies work together for young children (CT Early Childhood Alliance) and a coalition of funders help pilot and innovate best practices in early care (Early Childhood Funders Collaborative). A 2011 CT Council for Philanthropy survey found that 38 private and philanthropic funders in CT invested $72 million in early childhood efforts from 2007 to 2011.

Informal Care: A high proportion of CT infants and toddlers are in informal care settings. Parents choose this for proximity to home and a neighborhood 'family feel', for cultural or racial preferences, and/or because it is less costly and more accessible. A recent report shows that working with informal care providers can benefit the providers as well as the families they serve. We envision expanding this effort. All Our Kin helps unlicensed family, friend and neighbor caregivers meet health and safety standards, fulfill state licensing requirements, and become part of a professional community of child care providers. They serve an annual average of 1,200 infants and toddlers and 300 family child care providers.

The Gap: Connecticut's infant care appears to be fragmented and is characterized by marked variation in quality. The burden of poor quality and limited choice rests most heavily on low-income, working families whose financial resources are too great to qualify for state support, yet too low to afford quality care. Program quality is unknown for thousands of high-need children in unlicensed settings. There is not yet integration of early care and home visitation.

2. Current status of Connecticut's home visiting system

Connecticut has unique strengths in our array of home visiting programs. We have four evidence-based models in the state, which are partially or completely funded through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. These models address varying levels of need from a "universal" program model, open to any family, to a prevention/treatment model for the most vulnerable. The Parents as Teachers (PAT) curriculum is widely utilized. Several Early Head Start programs throughout the state have home-based programs, serving high risk children in poverty. In most instances, they use the PAT curriculum as well. The consistency of this curriculum leads to a common language and approach, which has the potential to promote a well-integrated early childhood system.

Nurturing Families Network (NFN) Home Visiting program is in every CT birth hospital. First time mothers are identified during pregnancy or in the first three months post-partum and have the potential for home visitation services for up to five years. NFN requires the use of the PAT model and curriculum, and targets families at risk for child abuse and neglect. The home visitor is a paraprofessional, but the training is extensive and there is close supervision. Annual data show NFN screened 5,868 new families and provided home visiting for 1897 high-risk families and "connections" services (a low intensity intervention) for 1508 low-risk families.

Child Family Interagency Resource, Support, and Training (Child FIRST) is the third home visiting program, and was recently added to the list of national, evidence-based models. It uniquely fills a major gap in home-based services as it concentrates on the highest need and most vulnerable families, with the goal of decreasing emotional and behavioral problems, developmental and learning problems, and abuse and neglect. Families with serious challenges (protective services involvement, maternal depression, substance abuse, domestic violence, homelessness) or with children with emotional or developmental problems may enter services at any time from pregnancy to age six years. A master's level mental health clinician teams with a care coordinator for each family. Medicaid reimbursement for diagnosed children is accessed. Connecticut is the only state that currently has this model, which is being replicated in partnership with DCF throughout the state.

Finally, the Nurse-Family Partnership (NFP) program provides nurse home visits to pregnant women with no previous live births, most of whom are (i) low-income, (ii) unmarried, and (iii) teenagers. The nurses visit the women approximately once per month during their pregnancy and the first two years of their children's lives. The nurses teach (i) positive health related behaviors, (ii) competent care of children, and (iii) maternal personal development (family planning, educational achievement, and participation in the workforce).

Connecticut's home visiting models recognize the importance of concentrating on three critical areas: maternal depression, fatherhood, and cultural diversity with specific treatment modalities, programmatic adaptations, and multicultural, multi-ethnic staff. We have parent educator certification through Charter Oak State College. Parent civic engagement is very strong in CT, and provides a critical foundation to complement home visiting education.

Most of CT's moderate to high need communities have early childhood collaboratives with birth-5 plans. There is tremendous will to develop an integrated early childhood home visiting system embedded within an early childhood system of care to meet the diverse needs of young children and families. Connecticut's State Advisory Committee (SAC) prioritizes home visitation and family engagement as one of four of its work agendas.

The Gap: We recognize we need to integrate our strong parent models and our work with fathers into our home-based work. "Non-evidence-based models" need to be closely evaluated for effectiveness and replication where they can fill existing gaps.

The DPH home visiting needs assessment – required by the MIECHV initiative – documented striking racial and ethnic disparities. A disproportionate burden of poor maternal, infant and early childhood outcomes and risk factors exists among Black and Hispanic families. This indicates that minority communities have a high need for home visiting services.

3. Connecticut's current political, regulatory, funding or other challenges to integrating quality home visiting services in our early childhood system

Leadership: Governor Dannel Malloy led the signing of Public Act (P.A.) 11-181, which creates an early care and education system with coordinated data, standards, professional development and training as well as a family-focused model. The goals of the P.A. focus on school readiness, integration of special needs children, and closing the achievement gap. Programs in social services and education are streamlined through agency consolidation or cross-agency compacts.

The state SAC created workgroups in workforce, data, standards and home visitation and family engagement to reach its goals.

In addition, the key leader in the legislature for young children is now the Senate Chair of Higher Education, a support for professional training and educational standards for home visitation.

Model Policies: CT leads in poverty reduction strategy and prevention planning. State law requires a 50% reduction of child poverty within a decade. Statute requires a shift in spending for children from crisis to prevention.

Leveraging funding: Child FIRST received a grant of 5.5 million from Robert Wood Johnson as a best practice and was approved as evidence-based model by the federal government. Because of its use of professionals and mental health focus, it receives Medicaid and can offer this in partnership with other home visitation sites if programs are better integrated. DCF has committed to sustain replication of Child FIRST throughout the state. We will examine further maximization of federal funding, including possible EPSDT for home visitation.

Funding Challenges: Connecticut's regulatory and political climates generally have been favorable for home visiting programs and for integrating systems overall. However, recent economic constraints have severely limited our capacity to expand efforts with state resources. New federal dollars and national technical assistance activities are valuable to make progress.

4. Who is on our team?

Lead Contact: *Rosa M. Biaggi*, MPH, MPA, Chief, Family Health Section, CT Department of Public Health, is the State Title V Director, Principal Investigator for the MIECHV Program, oversees the department's Medical Home Initiative, is responsible for numerous initiatives that address maternal and child health care, and is a member of several state advisory and council groups.

Karen Foley-Schain, Executive Director, the Children's Trust Fund which has developed a large statewide home visiting program, the Nurturing Families Network. Services are provided through all 29 birthing hospitals. The Trust Fund has built a statewide infrastructure of community agencies to provide home visits and work with organizations to support families.

Darcy Lowell, MD, Executive Director and founder of Child FIRST, brings a pediatric view with attention to the most vulnerable young children and families, including those suffering from addiction, mental health problems, and violence. The Child FIRST model has been approved by HHS as an evidence-based home visitation model which will soon be available for replication in other states in need of an early childhood mental health model.

Grace Whitney, CT Head Start State Collaboration Office, brings years of expertise in Head Start and early care and education both on the state and national level. She has created an exciting model of statewide program and policy integration between Head Start and child welfare, and collaborates with state and national partners.

Elaine Zimmerman, Commission on Children, links the legislature and home visitation and home visitation and the achievement gap. She Co-Chairs the Home Visitation & Family Engagement workgroup. She is the Speaker's designee on the CGA Achievement Gap Task Force and an appointee for the National Conference of State Legislature's, NCSL), Advisory Committee on Home Visitation. She is a national leader in parent leadership.

5. What CT hopes to accomplish through participation in the state policy action team meeting
We hope to learn:

High Quality Programs: (1) How to embed culturally and linguistically competent models into home visitation to address racial and ethnic disparities in program services; (2) How to use Medicaid viably in home visiting models with nurses and mental health practitioners; (3) What existing data can be combined and mined effectively with interagency data sharing agreements; and (4) How to create a professional development system that is shared across home visitation and which of this might be shared across early care and education models.

Strong Linkages & Comprehensive Services: (1) How to intentionally link home visitation and the achievement gap strategies to bolster political will and action; and (2) How to link family literacy, early language acquisition and early reading success across home visitation, early care and education and k-3 policy initiatives.

Supportive Governance & Policy (1) How a universal set of practice guidelines and standards of performance can be created and implemented without limiting the unique aspects of individual programs; and (2) How we can integrate our state advisories into one that address federal and state statutes on components of home visitation, birth to three and/or developmental disabilities.

Additionally, the Zero to Three Policy Action Team will be an important opportunity for us to share systems development challenges with other state teams and to gain insights from national colleagues as we continue our expansion efforts. It will motivate us to conduct a thorough self-assessment of and to design a realistic system building plan.