Rising to the Challenge: Building Effective Systems for Young Children and Families, a BUILD E-Book
Race to the Top—Early Learning Challenge (ELC) is the major federal funding initiative seeking to support states in developing high quality early childhood systems, especially targeted to children with high needs. Launched in 2011 as a joint initiative of the U.S. Departments of Education and Health and Human Services, there have been three rounds of major grants under the ELC, with 20 states now participating and funding that totals just over $1 billion.

This federal initiative had particular meaning to the BUILD Initiative and its founders, members of the Early Childhood Funders Collaborative. For more than a decade, BUILD has served as a catalyst for change and a national support system for state policy leaders and early childhood systems development. Not only did BUILD’s work help shape the federal initiative, but it was also the fulfillment of the founders’ most fervent hopes—that states could create detailed blueprints for an early childhood system, with budgets to support significant infrastructure development. BUILD staff, consultants, and many colleagues in the field rose to the challenge and provided extensive support to states as they applied for, and now implement, the federal opportunity.

The Early Learning Challenge supports states in their efforts to align, coordinate, and improve the quality of existing early learning and development programs across the multiple funding streams that support children from their birth through age five. Through the ELC, states focus on foundational elements of a state system: creating high quality, accountable early learning programs through Quality Rating and Improvement Systems; supporting improved child development outcomes through health, family engagement and vigorous use of early learning state standards and assessments; strengthening the early childhood workforce; and measuring progress.

Thirty-five states plus the District of Columbia and Puerto Rico applied for the 2011 round of the Early Learning Challenge grants with nine states initially and then five more selected from this pool for funding. Sixteen states plus the District of Columbia responded to a new 2013 third round of grants; six were selected.

Round 1: California, Delaware, Maryland, Massachusetts, Minnesota, North Carolina, Ohio, Rhode Island, and Washington

Round 2: Colorado, Illinois, New Mexico, Oregon, and Wisconsin

Round 3: Georgia, Kentucky, Michigan, New Jersey, Pennsylvania, and Vermont

Since the launch of the ELC, grantee states have rapidly moved from concept to implementation. Through this E-Book, we share learnings from the initial implementation of the efforts, highlighting experience, trends, and reflections stemming from the significant federal investment in this strategic work. The chapters are authored by experts who have worked in tandem with state leaders to gather information. By documenting the experience of the states, captured through interviews with state leaders, Rising to the Challenge provides a source of learning for all fifty states and territories and puts into practice our leadership commitment to continuous learning in the best interests of the children and families to whom we are all dedicated.

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Introduction

The relationship between child health and early learning feels like common sense. Yet when goals are created to optimize child health or educational attainment, the conversations are rarely held in tandem. And at the systems level, the reality of separate silos in everything—from funding, to agency leadership, to provider education and training, to what children and families experience on the ‘front lines’—feels far more common than opportunities for alignment and collaboration across health and early learning.

Despite the barriers, there is a growing level of interest and activity at the intersection of health and early learning. This is due, in part, to high level attention and new funding in both areas. Expansion of Medicaid and the Affordable Care Act has focused the nation, states, and the public on health insurance and access to care at unprecedented levels. Simultaneously, visible federal investments in early childhood are occurring, including the Race to the Top–Early Learning Challenge (ELC); Maternal Infant and Early Childhood Home Visiting; and, Preschool Development Grants.

Behind all of this are longer standing state-level, cross-systems efforts, including the Early Childhood Comprehensive Systems state grants (a federal initiative) and the BUILD Initiative, which was created over a decade ago by the Early Childhood Funders Collaborative, a consortium of private foundations. There also is momentum around national public-private partnerships with statewide counterparts, including developmental screening, surveillance, and linkage to services through Help Me Grow, and early literacy promotion in the medical home through Reach Out and Read. When momentum in child health and early learning are combined with comprehensive systems efforts, there is great potential for progress in states across the nation.

This chapter focuses on the health projects that states are implementing with their federal ELC grants. Nine of the 20 state grantees opted to address the offered priority of health promotion. The states are: California, Delaware, Maryland and North Carolina, which received funding in 2012; New Mexico and Oregon, which received funding in 2013; and Michigan, New Jersey and Vermont, which received funding in 2014. In order to understand the ELC health experiences to date, interviews were conducted with individuals identified by each of these nine states in late 2014.

Why Include Health in the Early Learning Challenge?

States were asked why they thought health was included in their Early Learning Challenge grant strategies. Each state felt that having a previous health focus in the state influenced its inclusion in the ELC. Several states emphasized a fundamental belief in the central importance of child health in early learning. California noted that health issues are of major concern, with both the State Superintendent of Public Instruction and many of California’s First 5 County Commissions prioritizing health in early childhood. Delaware recognized that national surveys showed that they were doing poorly in the use of standardized developmental screening tools. Maryland described a whole child approach to kindergarten readiness, with its school readiness assessment including both social-emotional and physical health. New Mexico is striving to take a holistic approach that includes all essential elements, including health, across its early childhood systems, particularly embedding it within its Tiered Quality Rating and Improvement System (TQRIS).

Other states noted their experience in cross-systems work as the impetus for the inclusion of health. Michigan described a strong history of cross-systems work in early childhood, with health, education, and human services working together collaboratively. Michigan takes a life course approach, and considers both physical and social-emotional health as the foundation for children’s growth and learning. The ELC provided an opportunity for investment in
physical and social-emotional health, building on previous grants and the state’s early learning and development plan. New Jersey noted that between its first (unfunded) ELC application and its successful later application, the state increased relationships across agencies, so it was easier to include health in this grant. North Carolina recognized that kindergarten readiness requires strong systems that cross education, physical health, and social emotional health, calling this “three legs of a stool.” North Carolina’s ELC grant was written by the Governor’s Early Childhood Advisory Council, which has a broad membership including health representation. North Carolina also had systems in place to build from that connect to health, including a Child Care Health Consultant network and historic participation in the Assuring Better Child Health and Development (ABCD) initiative focusing on developmental screening through primary care providers.

Finally, two states had significant leadership from pediatricians in public health leadership whose efforts were greatly responsible for the inclusion of health in their ELC grants. Oregon’s child health director is a pediatrician intentionally working at the intersection of health and early learning. The state is currently transforming both systems while trying to connect them together. This enabled the director to assure that cross-connections with health were embedded in the ELC grant. Vermont’s director of maternal and child health is a pediatrician who has made a concerted effort to make early learning part of the Health Department. The Department of Health shares home visiting responsibility with the Department for Children and Families. Vermont’s ELC grant was written by the Governor’s office and having the state Maternal and Child Health Director involved in grant development enabled the inclusion of a health focus.

### Notes on Terminology

Within early childhood there are multiple terms used to describe early learning settings and experiences, such as child care, early care and education, preschool, early childhood education, and early learning. Because the definitions of these terms vary, this paper uses the terms used by each state, providing clarifying information, as needed, to help the reader understand the scope and context of a particular state strategy. In addition, several terms that are used repeatedly are noted below.

**AAP** American Academy of Pediatrics. The national professional organization for pediatricians.

**ABCD** Assuring Better Child Health and Development. A program administered by the National Academy for State Health Policy (NASHP), designed to assist states in improving the delivery of early child development services for low-income children ages 0-3 and their families.

**ASQ/ASQ-SE** Ages and Stages Questionnaire and ASQ-Social Emotional. Standardized development and social-emotional developmental screening tool.

**Birth to 5: Watch Me Thrive!** A coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them.

**CCHC** Child Care Health Consultant. A professional who provides health expertise to child care providers, often connected to a public state system.

**ECCS** Early Childhood Comprehensive Systems. A grant program of the federal Maternal and Child Health Bureau within the Health Resources and Services Administration (HRSA) to strengthen state systems.

**ECMH** Early Childhood Mental Health.

**ELC** Early Learning Challenge, used to describe Race to the Top-Early Learning Challenge federal grants.

**HMG** Help Me Grow. A comprehensive system to identify children at-risk for developmental delays and connect them to needed services. A public-private initiative with a national center and state affiliates.

**IDEA** Individuals with Disabilities Education Act, federal law to support the identification of and services to children with developmental delays and disabilities.
Notes on Terminology, cont.

**MIECHV** Maternal Infant and Early Childhood Home Visiting. A grant program of the federal Maternal and Child Health Bureau to support improvements in health and development outcomes for at-risk children through evidence-based home visiting programs.

**Project LAUNCH** A grant program of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to states, promoting the wellness of young children birth to age eight.

**QRIS or TQRIS** (Tiered) Quality Rating and Improvement System. A state system to assess and support quality improvement in child care and early learning programs that is required for all states participating in the ELC.

**Reach Out and Read** A parenting support and early literacy program embedded in pediatric preventive care visits for children birth through 5. A national non-profit organization with public-private partnerships, a national center, and state affiliates.

**SEFEL** Social-Emotional Foundations for Early Learning. A framework for teaching social and emotional skills to children that is also known as the Pyramid Model. The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is a national resource center supported by the Administration for Children and Families for disseminating research and evidence-based practices to early childhood programs.

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**Engaging Leadership**

The states involved with advancing an early learning-health agenda to support the “whole child” recognized the need for leadership by both state agencies and primary care providers. They made a point of engaging people at different levels of public and private leadership. They understood that success would require collaboration across sectors and beyond traditional partnerships, and that strategies would need to impact both professionals and families. Moving forth a health agenda effectively within a state early childhood system requires engagement of agencies and people with both knowledge and influence in relevant areas. The ELC Health Projects commonly involved staff from a myriad of state agencies, such as children and families; education; health/public health; human services; as well as governor’s offices. Within state agencies, these states brought in representatives from child care licensing; child welfare and prevention; children with special health care needs; early learning; Head Start; IDEA Part C Birth–3 Early Intervention; IDEA Part B Preschool Special Education; maternal and child health; and, mental/behavioral health.

In addition to involving multiple players within state agencies, states made a concerted effort to partner with pediatric primary care providers. They recognized that advocacy, input, and leadership from pediatricians and other medical providers could inform and enhance state systems. They saw opportunities to leverage changes in the health care system simultaneously with the development of a strong early childhood system. They understood that near-universal access to health care means that the medical home is an untapped resource, and a place to reach children and families. These states understood the central role of medical providers in supporting both child health and development in their care for families. Recognizing this as an opportunity both within the health projects of the ELC, as well as in overall grant leadership, a number of strategies were implemented by states to effectively facilitate engagement of and partnerships with primary care providers.

In addition to engaging agency leadership and primary care providers, states used leadership groups to help guide or implement their Early Learning Challenge health projects. These were mostly cross-discipline (health and early learning) and usually involved both public and private partners. States provided the following examples of these groups: developmental screening initiatives leadership; early childhood
advisory council; Early Childhood Comprehensive Systems (ECCS) advisory group; health policy board; Help Me Grow advisory group; State Interagency Coordinating Committee (Early Intervention, Birth-3); home visiting advisory group; and/or, Project LAUNCH advisory group.

Finally, states used a variety of ways to coordinate the work. States described intentional cross-sector engagement involving complex coordination. Often, states’ Early Childhood Advisory Councils included primary care-related members, such as a representative from a state’s American Academy of Pediatrics chapter. Some councils created committees that engaged representatives of health-related fields to assure the inclusion of child and family health and wellness. At the executive level, heads of state agencies were meeting or planning regularly across agencies. And agency leaders more directly involved in implementation might meet to coordinate more regularly. These structures together provided opportunities for leadership and oversight for the ELC health project, the ELC in general, and the overall state systems approach.1

Investments in Child Health
States identified their top Early Learning Challenge health initiatives. The two biggest areas of investment of ELC funds were in Developmental Screening (8 of 9 states) and Child Care Consultation Systems (7 of 9 states). Because of the robust experience in these areas, the interest of states nationally in these topics, and the potential benefit from understanding the work in depth, this section focuses on these two areas. A variety of other health topics were described by states; short summaries of these projects are provided at the end of this section.

Overall, the amount of ELC funding invested in the health strategies is relatively small, ranging from 2% (California) to 12% (Michigan). Some states were unable to precisely define the amount invested because health was combined with family support in the budget (14%, New Jersey) or not fully called out as a separate project, so no estimate was given (Maryland, New Mexico). Overall, it seems conservative to estimate that the total national investment of ELC funding in health is substantively less than 10% of the grant funding provided to these states, and 5% of the overall funding. States are leveraging the ELC money by building on previous federal initiatives such as ECCS, MIECHV, and Project LAUNCH, along with ongoing funding from the Maternal and Child Health Block Grant. States are typically building on what they have, adding capacity, and providing both infrastructure and consistency of approach in their health-related work.

Developmental Screening
Developmental screening is the most commonly identified health project within the ELC, and is defined as the systematic implementation of standardized developmental screening processes for children under five years of age. The goal is for children to receive standardized developmental screenings followed by appropriate referrals and linkages to services.

States started from different places and used different strategies to approach developmental screening. There are both commonalities and differences in the approaches, challenges, and successes states have experienced to date. An overview of each state’s developmental screening project is followed by additional discussion that synthesizes information across the states around key learning and challenges. Overall, the increase in screening rates is impressive. Oregon nearly tripled the number of children screened in its first project year, and California, Delaware and North Carolina report gains of 48%, 23%, and 9% over two years. Collectively, these four states screened 116,300 more children with high needs in the past year compared to project baseline.

Developmental Screening Projects by State:
The ELC is funding the California Statewide Screening Collaborative, which brings together state and local, public and private entities that focus on California’s capacity to promote and deliver effective and well-coordinated health, developmental and behavioral screenings for young children, birth to age five, through medical providers and early childhood educators. The goals are to: 1) improve coordination among state agencies and programs involved in early identification, recognition and response activities

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to support the development of young children; 2) promote the use of standardized screening tools, effective screening protocols, and increased communication among agencies and services; and, 3) identify screening resources, funding and follow-up supports that promote healthy early childhood development, school readiness, positive parent-child relationships, and access to services. Through this work, stronger connections are being made between state and local efforts, and between the early education and medical fields.

In 2013, Ages and Stages Questionnaire (ASQ) Developmental Screening kits, and its social-emotional screening counterpart (ASQ-SE), were purchased with ELC funds. They were provided throughout the state with trainings, and resulted in 186,429 children with high needs being screened. During 2014, based on the work of the federal Birth to Five: Watch Me Thrive! screening initiative, an ECE Provider Screening Toolkit was developed for use in 2015. The accompanying technical assistance focuses on the creation of local screening pathways and referrals through use of the Toolkit. In addition, the Help Me Grow (HMG) model is being implemented or explored in 22 counties.

**Help Me Grow** is a comprehensive system that identifies children at-risk for developmental delays and connects them to needed services. Many of these states are replicating the HMG model as a way to assure their developmental screening system is fully connected to a system of services to meet child and family needs. There are four core components of a comprehensive HMG system: child health care provider outreach, community outreach, centralized telephone access point, and data collection, all of which work to help assure that families’ needs are fully assessed and that they are able to access needed resources. It helps families find community-based programs and services through comprehensive physician and community outreach and centralized information and referral. The HMG National Center provides support to states replicating the HMG model originally started in Connecticut.

**Delaware** set an ELC goal to increase the number of young children screened and linked to services, noting that national surveys showed that it was doing relatively poorly in the use of standardized developmental screens. This project is focused on engaging two audiences in developmental screenings: health care providers and early childhood providers. Improving screening by primary care health providers is taking place via the PEDS (Parents’ Evaluation of Developmental Status) developmental screening tool. Delaware’s Division of Public Health offers free developmental-behavioral screening via PEDS Online for children residing in Delaware. Efforts to improve screening through early learning providers include use of the ASQ and the ASQ-SE. This initiative is integrated into the state’s QRIS, Delaware Stars. Programs can achieve higher QRIS ratings when they implement screenings. Over time, the developmental screening aspect of the QRIS is becoming mandatory. Through the ELC, free access to the ASQ/ASQ-SE is available, along with training. Work is underway to offer access to an online database, supports, and materials, along with additional funding incentives to influence practice change.

The state also recognizes that care coordination is essential to ensure that families actually receive recommended services. Help Me Grow Delaware has established
significant outreach activities along with a central telephone line that families and providers can call to get help with referrals and connections related to developmental concerns. This system is tracking calls and referrals to services. There is also an online toolkit just for health care providers that explains how the Delaware developmental screening initiative works, and provides information about the screening and referral process.

**Maryland** set a goal to increase the use of validated developmental screening instruments statewide among its early learning providers and began to implement a plan to do so as part of the ELC. Relatively quickly, leaders realized they had “jumped in too fast” without assessing baseline information about what types of screening were already happening, and where they were being done. They decided to pull back and regroup. The project then engaged experts at Johns Hopkins University and created a workgroup of 40 members representing diversity in both geography and professions.

Through that process, Maryland ultimately chose four reliable developmental screening instruments for the statewide effort and tested, and later incorporated, a fifth instrument. Maryland is now creating both online and in-person trainings to support implementation through a partnership with Maryland Public Television. The initial plan is that by July 2016, all licensed child care providers will be required to be trained and then implement developmental screening with the families they serve.

**Michigan** is using its ELC-supported Child Care Health and Social-Emotional Consultants to train child care providers in the importance of developmental screening, and encouraging them to talk with families about this. While Michigan is not otherwise directly funding health care-related developmental screening work through the ELC, it has a history of encouraging developmental screening in physicians’ offices. The state has had an ABCD project and a Project LAUNCH grant, and various other efforts to implement screenings for development, autism, and maternal depression. There is also action to encourage state Medicaid policy and funding to support screening efforts within primary care. The ELC strives to connect these efforts with that of the grant so that developmental screening is linked into Michigan’s early learning system.

**New Mexico** is working on developmental screening at the intersection of health and early learning although it did not define its developmental screening work as a separate ELC health project. The state is aligning early childhood systems through broad participation in the Tiered Quality Rating and Improvement System (TQRIS), which includes child care, Head Start, Pre-K, Home Visiting, as well as Part B and Part C early intervention services. The goal is to include all essential elements of quality, including health, across early childhood systems. ELC funding is embedded in the TQRIS effort to train early learning providers around health and connections to primary care. The project is working with the Health Department to train early learning providers to implement developmental screening with the ASQ.

**New Jersey** is working to expand developmental screening statewide through both health care and early childhood providers. As with New Mexico, this work is not directly funded, but developmental screening is included in the state’s tiered QRIS as its strategy to reach early childhood providers. On the health care side, New Jersey is leveraging the state’s Early Childhood Comprehensive Systems (ECCS) grant, its Project LAUNCH grant, and its Help Me Grow initiative. Project LAUNCH is piloting physician outreach in partnership with the New Jersey Chapter of the American Academy of Pediatrics, and is currently assessing data on physician participation in developmental screening. Five medical practices have been recruited for a LAUNCH-funded quality improvement effort to implement developmental screening.

New Jersey is focusing on assuring children have a medical home, making appropriate referrals to early intervention for children screened, and sharing developmental screening results with primary care providers. New Jersey will also use existing child- and family-serving systems, including Head Start and Early Head Start providers and home visitors, to connect screening to referral processes and back to the medical home.

**North Carolina** is focusing its developmental screening efforts on supporting primary care health providers. This builds from a long history of implementation of the Assuring Better Child Health and Development (ABCD) Program, which strengthens primary health care services...
and systems that support the healthy development of young children. North Carolina’s state level ABCD Advisory Group realized that there remained a need to improve developmental screening in primary care. It also recognized the need to improve the system of referrals for families after screening, including a feedback loop to the medical home.

To address this, North Carolina established a new ABCD partnership with Community Care of North Carolina, a public-private partnership sponsored by the North Carolina Department of Health and Human Services and the North Carolina Division of Medical Assistance. Community Care is comprised of 14 regional health networks across the state that support the “medical home” model that matches each patient with a primary care provider. In each of these regions, there is now a dedicated ABCD program coordinator to focus on quality and to provide ongoing support to incorporate developmental screening and autism screening into well-child visits. North Carolina is starting first with screening goals for children receiving Medicaid services, with the intent of extending a successful system to all children statewide.

Oregon is striving to increase the rates and number of children who receive standardized developmental screening across the state, with coordination between primary care and early childhood providers, and a goal of universal screening. The ELC grant is leveraging Oregon’s Early Childhood Comprehensive Systems (ECCS) grant, which built on foundational work from Oregon’s ABCD grant and from success implementing developmental screening in primary care through the Oregon Pediatric Society’s Screening Tools and Referral Training (START).

Oregon plans to use developmental screening as an accountability metric in both health and early learning. To operationalize this successfully requires partners to have a cohesive approach to data collection and a strong and broad work force to do the screening. The ELC grant is helping to develop a training curriculum to help child care, Head Start, and home visiting providers learn, implement, and participate in continuous quality improvement processes for developmental screening. Because Oregon already has a strong training system in place for primary care providers via START, the new curriculum is focusing on early learning providers. There is a two-pronged approach to professional development through regional trainings of providers, and a “train the trainers” system. Both have had high levels of participant interest.

Vermont’s goal is to implement a developmental screening system that assures all children under two years of age are screened and linked to services by blending the silos of education, early intervention, and medical providers into one system that works for families. The state is building from the part of its 2009-2013 Project LAUNCH grant that focused on developmental assessments. This brought together 35 cross-discipline stakeholders including early childhood, Early Head Start, home visiting, primary care medicine, and education. They spent two years conceptualizing what Universal Developmental Screening would look like and began to implement it in one county.

Vermont is starting with primary care. This builds on longstanding relationships with the Vermont Chapter of the American Academy of Pediatrics and the Vermont Child Health Improvement Program (VCHIP), which recently collected developmental screening data from the majority of primary care practices in the state. Developmental screening is now an accountable care outcome measure for Vermont which providers can choose to use. The state plans to train
early childhood providers to use the ASQ screening tool, put screening scores into a shared database that primary care providers can see, and link families to primary care preventive services and well-child visits. The project is built around a central Child Health Profile database, and leverages the Help Me Grow initiative to connect the screenings to a system of referrals and linkages for families into early intervention and other services, as indicated.

**Linkages to Services:**
While there is increasing attention to the need for “universal developmental screening,” it is often the case that no mention is made of what to do after the screening occurs. It is exciting to see that all of the ELC health states are attuned to this need, and developing systems that include linkages to needed services. Many states note that their developmental screening project is working closely with their Part C early intervention program. In some cases, new referral forms and feedback processes are being implemented.

The most common approach to enable providers to better support linkages is for states to embed information about how to refer and link families to services as a core part of the training about implementation of developmental screening. When this happens, providers understand that screening is part of a process, not an end in itself, and they are provided with referral information allowing them to put the concept directly into practice with the families they serve. This is occurring in various ways, including as part of a developmental screening toolkit, an in-person or online training, or as part of specific “modules” on linkage and referral. Families are most likely to be well-connected when they receive very specific information about local resources.

The most robust state efforts around linkage to services are connected with Help Me Grow (HMG), a system that connects at-risk children and their families to services to support child health and development. Six of the nine states profiled in this chapter are Help Me Grow Affiliate States.

**What Has Worked Well:**
States identified what has worked well so far in their developmental screening projects. California emphasized that integrating developmental screening training into TQRIS was met with enthusiasm by child care providers. Documenting the performance of more than 28,000 developmental screens was Delaware’s highlight. Maryland said that its decision to “step back” and engage a large and diverse working group was helpful. New Jersey was able to expand its central intake to support the developmental screening process and strengthen linkages between early care providers and the medical home. Oregon noted that tying developmental screening trainings to the child care registry so it “counts” for provider requirements was important, and that two statewide needs assessments built understanding around the issues and the workforce development needs for child care and Head Start providers and for home visitors. Vermont was excited to report the addition of a developmental screening “tab” to the existing child health profile database, which will facilitate communication about children’s developmental screening status and associated needs among health and early childhood providers.

**What Has Been Challenging:**
Two clear themes emerge as challenges: first, cross-system collaboration, and second, data systems. Many states noted the time and intentionality that it takes to effectively work cross-agency, cross-discipline, and across a state. Engaging in thoughtful, goal-oriented processes with the “right” people at the table is critical, and when that doesn’t happen, things don’t go well. Maryland demonstrated that even when a state realized it started off without broad enough engagement, it is possible to pause, strategize, engage more stakeholders, and move forward effectively.
There was consistent, considerable frustration about a lack of data systems to support this work. Most states have no real access to baseline screening data either for individual children, or the population as a whole. Where data exists, it is usually not “un-duplicated” and it is often inaccessible. States did not see easy paths to get to such data systematically; at the same time, they want to set specific goals around increasing screening rates. In addition, states share a goal around referral and linkages to services after screening, but, typically, they also lack systems to track this.

Developmental screening is happening in medical settings, child care, preschool, and home visiting programs at variable rates across states and communities. Even within each of these categories, there typically is not a single data repository. For example, in states that reimburse doctors for developmental screening, Medicaid billing records might have some data and private insurers other data, but they are not pooled together or released publicly. Head Start programs do screening, but that data is rarely combined or accessible at the state or community level. Home visiting programs track screening results but they tend to have their own model-driven databases that are stand-alone systems within each model’s data system. For states to effectively implement universal developmental screening initiatives, there must be better population-level data systems that will allow screenings from all settings to be included. And if the primary goal is to assure each child gets what s/he needs to promote optimal health and development, there must also be ways to store and review screening and services data for individual children in “real time.”

At the population level, there is a need to have unduplicated data about all the children who are screened in order to assess how “universal” the screening is. The data needs to be able to be disaggregated by race/ethnicity, language, family income, gender, age, geography, and potentially other factors so that equity issues can be identified and addressed. This data should be accessible at the state and local levels. Such data could identify where screening is occurring, and where more outreach and training is needed to increase implementation rates. If data were tied to providers or provider type (such as health care provider or child care provider), it could help inform professional development systems, as well as local outreach strategies. This data could be used to monitor trends over time regarding both prevalence and outcomes of screening. States could look at population trends related to developmental screening and other child health and education data over time, such as the relationship between developmental screening data and use of early intervention or preschool services, or to kindergarten entry assessment data.

At the individual child level, a privacy-protected database, like an immunization registry, could monitor whether a child is up-to-date on recommended screenings. This system could also hold information about screening results, referrals, and linkages to services. This could help assure that the child and family receive what they need. It could also facilitate communications and connections among families, medical providers, early intervention, early learning and other providers. This type of data needs to be accessible and used in “real time,” not available in annual reports. If this data were connected with a longitudinal data system that carries forward developmental screening results along with preschool and K-12 assessments, the family and teachers could have a view of trends over time that could help inform individualized instructional goals and practices for the child.

The ELC states reviewed in this chapter are acknowledging and trying to address the data challenges. Most are at the stage of defining the extent of the challenge, and beginning to have discussions across agencies about what data is available, and what is needed. Some are exploring or creating new data systems. Ideas include building the data into an existing health data system, such as an immunization registry, which may or may not be accessible to non-health care providers. Others are exploring embedding screening done by child care providers into a state child care database, or those by home visitors into a state home visiting data system, but neither of these would be accessible more broadly, or easily cross-walked with data from the health care system. Several states are exploring whether an evolving or hoped-for state longitudinal data system could encompass this data. Across all of these is a common need to implement data sharing agreements across systems with attention to privacy laws and family desires, and this is a huge challenge.

Vermont is the only state interviewed that currently has an actionable statewide developmental
screening data storage and sharing plan that addresses many of these issues. Vermont has a repository for individual child health data, called Child Health Profile. The system currently has four results “tabs,” for immunizations, lead screening, newborn hearing screening, and newborn screening. Currently health and early learning providers and schools with signed agreements can ‘view’ this information, and doctors can enter data into it. The state is adding a fifth tab to include developmental screening results. When this is fully integrated, all those who currently have access will be able to review the results, and those who are trained to do developmental screening will be able to input the results. Thus, a doctor could see a screen implemented by a child care provider, and vice versa. The initial implementation will start with the medical home, as almost all medical providers are already using the Child Health Profile system and have access to data entry. Eventually the goal is to include data from home visiting, Head Start, and early care and education providers, as well as from Children’s Integrated Services, a community-based system that is a central point of access for families.

**Advice for Other States:**

State leaders had several suggestions for other states pursuing developmental screening, including:

- Build from what you have.
- Develop a structure for collaboration and coordination.
- Spend enough time on the planning phase; it is foundational for success.
- Take the time to build consensus and a constituency and make sure the expertise is right.
- Take a systems/universal approach.
- Embed a cultural and equity lens from the start of planning.
- Embrace the vantage of disability, so that the systems and strategies work for families of children with special needs.
- Identify an existing state structure that can facilitate a state healthcare network.
- Connect early learning and health together in the system, not as separate silos:
  - Target health providers as the primary source for screening.
  - Work with child care providers to provide additional resources and child development information to parents.

**Child Care Consultation Systems**

Child care-related consultation services were the second most common investment within the health projects of the ELC. Multiple types of health consultation were provided across the states and are described. All states include some focus on social-emotional/mental health consultation, and four use the Social-Emotional Foundations for Early Learning (SEFEL) framework or the Pyramid Model.

**Child Care Consultation Initiatives by State:**

**Delaware** used the ELC to expand its Early Childhood Mental Health Consultation (ECMHC) system, with services provided through the Children's Department Division of Prevention and Behavioral Health for early childhood providers, prioritizing those participating in the state’s QRIS. Growing from 3 to 10 consultants, these ECMHCs are licensed behavior health clinicians who screen young children and make referrals to a statewide mental health system of care with evidence-based, trauma-specific treatments for young children. Consultants provide child-specific staff consultation as well as classroom and program level consultations. Two professional development options are also offered to the early childhood workforce, a 6-hour, quality assured Child-Adult Relationship Enhancement course and a site-based, intensive 8-10 week Teacher-Child Interaction Training course. ELC resources are also invested in continuing education for clinicians implementing Parent-Child Interaction Therapy. This system has resulted in a 97% success rate in preventing expulsions of young children from early childhood settings. In addition, Delaware also has consultation for nutrition and health embedded in its ELC. This builds on earlier work by Nemours Health and Prevention Services that had trained 70% of the early childhood workforce in these issues. The ELC added free online professional development modules for ECE providers.

**Maryland’s** work is focused on Early Childhood Mental Health (ECMH) Consultation to child care and Head Start providers around the state. ELC funding has leveraged existing state-funded work into the system’s approach. This project enables a consultant with ECMH experience to evaluate both programs and child
behavior problems, then engage with the provider and the parents, referring to mental health clinicians, as needed. Usually the consultant can facilitate positive change by working with the program on policy and instructional practices, and/or on relationships with families. The goal of the program is to keep children with behavioral problems enrolled, and to give educators tools to work well with children and families. The ongoing coaching relationships with teachers using the Social-Emotional Foundations of Early Learning (SEFEL) framework has created resources and strategies that work, enabled consultants to share best practices across providers, and reduced the rate of expulsion of young children from care.

**Michigan** is deploying a variety of consultants as part of its ELC work. Within the QRIS system, consultants who specialize in social-emotional health, general health, and family engagement are available to child care providers in the highest needs areas. General child care consultants can help with quality, and can do some health and social-emotional consultation themselves, referring to specialists as needed. They also assist with linkages into the system. Michigan has never had general health consultants for child care, so this is a completely new resource for providers. The social-emotional consultants themselves, however, are not new, as they were piloted through a Project LAUNCH grant. The ELC is supporting expansion of services using the Social-Emotional Foundations for Early Learning (SEFEL) model in child care.

**New Jersey**’s emphasis is on a statewide training academy to ensure provider access to education and consultation for child health, including social-emotional health, safety, and inclusion for children with special needs. The goal by the end of three years is to be doing cross-sector trainings that support center-based and family child care providers, Head Start/Early Head Start, and state-funded preschools, as well as other infant/early childhood partners, such as home visiting providers and family resource centers. There will be three regions in the state for trainings, plus a limited amount of consultation. Historically, New Jersey had a statewide system of 21 health consultants, but it wasn’t sustainable and the system was eliminated several years ago. The ELC is testing this new model to try to demonstrate success in workforce training that will be sustainable. In addition, New Jersey is intentional about including infant and early childhood mental health in trainings, with plans to expand use of the Pyramid Model framework and promote the Infant Mental Health Endorsement.

This builds from previous state work, and embeds social-emotional consultation into a statewide system.

**New Mexico** emphasizes mental health consultation in child care, and is blending ELC and state general funds to do so. Mental health is a scored component of the state’s TQRIS system, and New Mexico is using a variety of strategies to strengthen this work. The state is promoting the social-emotional development and school readiness of young children birth to age 5 through the use of the Social-Emotional Foundations for Early Learning (SEFEL) model. Infant and Early Childhood Mental Health (ECMH) competencies are being infused into training and consultation. Mental health consultation is designed to help support providers and families, and facilitate referrals as needed. The state is also trying to support the behavioral health systems so they can increase infant and ECMH competencies.

**North Carolina** is implementing a statewide Child Care Health Consultation project with the goal of strengthening capacity and improving quality and consistency across the Child Care Health Consultation system. The project works with UNC Chapel Hill Child Care Resource Center. North Carolina is adding a standard model of coaching to support the CCHCs who, in turn, use coaching to support the child care providers. At the same time, the project is also directly increasing the number of CCHCs in the four counties that are part of the transformation zone (a large project within North Carolina’s ELC grant). The project created a new “app” for CCHCs to report information and data electronically. Bringing Child Care Health Consultants (CCHCs) together to learn with each other is a strategy that is professionalizing the workforce and helping it feel empowered to do high quality work.
Vermont is working to enhance health and safety consultation in child care. Prior to the ELC, there was a community-based system of 18 nurses on contract via grants across the state who have been trained, but had no real central organizing process to support them in an ongoing manner. The ELC funded a new position in Maternal and Child Health to coordinate the team across the state and provide broader training in child development, nutrition and physical activity. The nurses are mostly part-time school nurses who would like to work full-time, and thus are a professional workforce the system can tap. Vermont is also providing social-emotional- and mental health-related training, with a focus on making child care environments as conducive to learning as possible, with attention to social-emotional health and comprehensive health services. This project will create opportunities for training in these areas that will benefit early childhood settings, while building from earlier work in the state, including the use of the Pyramid Model, and Project LAUNCH’s work to include community mental health centers.

Other Investments in Health
A number of states highlighted other areas of investment in ELC health initiatives as their next top strategies, briefly described here.

California is incorporating child health into its Quality Rating and Improvement System (QRIS) as an element of a high quality early learning program. This includes health (regular check-ups and/or vision and hearing screening) and developmental screening (including social-emotional) as rated elements in TQRIS. The goal is to increase awareness of the importance of screening for both child care providers and parents, and ultimately increase the number of children screened for health and developmental issues.

Delaware is investing in connecting families to services using Health Ambassadors. The ELC provided funding to build from earlier experience with this model. Health Ambassadors work within communities to implement outreach strategies, such as inviting families to a communitywide baby shower to connect with one another and learn about available family supports. The ELC is also supporting expansion of Delaware’s Help Me Grow efforts, which supports the connection of families to needed services. Developmental screening is also a rated element in the Delaware QRIS.
Maryland is working with the state chapter of the American Academy of Pediatrics to expand the Reach Out and Read program, an evidence-based parenting and early literacy program implemented within the medical home. Fifteen of Maryland’s 25 local Early Childhood Councils, which determine which ELC priorities to emphasize, chose to focus on Reach Out and Read using ELC funds. This support is increasing training and providing books to expand services so that doctors incorporate more child development and school readiness support into their practice. The state has already reached 97,000 children through this strategy. Maryland is also partnering with the University of Maryland Department of Psychiatry to strengthen primary care provider’s ability to support Early Childhood Mental Health in the medical home through telephone consultation and training opportunities.

Michigan is using the ELC as an opportunity to update its child care licensing standards related to health, social-emotional health, and family engagement. Michigan’s whole ELC grant focuses on family home child care providers and informal settings, with a major goal of engaging these providers in improving quality by participating in the quality rating system. As those providers connect, there will be an opportunity to increase attention to health within these settings.

New Jersey highlighted the use of ELC funds to support a Department of Health (DOH) expansion of “central intake” hubs that serve as a single point of entry to link families with infants and young children to local services and supports. The project builds from a system that exists in 15 counties (seven funded by the Department of Children and Families, and eight by DOH). The ELC is adding the opportunity for the remaining six counties to apply for funding via DOH, creating a statewide system. This project provides a central access phone line that providers and families can call. It supports families from pregnancy through a child’s 8th birthday, helping identify needs and link families to services to improve health and well-being.

New Mexico is embedding health promotion strategies across the systems, particularly using ELC funds to embed training through TQRIS. For physical health, providers are encouraged to ask families about well-child checkups and dental visits, and to refer families as needed. They are trained to help families understand the role of primary care providers and the medical home, and why they are important for their children, as well as how to implement health promotion activities. New Mexico also has a significant focus on mental and behavioral health systems as it works to increase infant and early childhood mental health competencies and look at gaps in services when trying to refer families.

North Carolina is investing in several projects involving parent support and health. Family Connects is an early childhood nurse home visiting program supporting families from birth through three months of age, which is being implemented within the four-county Transformation Zone project (a separate project in the ELC Grant). The goal is to assess families’ needs and connect them to community resources. The state is also expanding the evidence-based Triple P parenting program to 17 counties, using coordinators in the Transformation Zone, and a state learning collaborative. Using a public health approach, North Carolina is training all providers “who work with kids and/or parents countywide,” including physicians and child care providers. North Carolina is also partnering with Reach Out and Read to expand this parenting and early literacy program delivered by primary care providers throughout the Transformation Zone.

Oregon has a strong focus on cross-coordinating the transformation efforts of both health and early learning at the state and local levels. The ELC is providing some support for a staff position to work across the early learning division in the Department of Education to help coordinate collaboration within Education, and with Health. Oregon is working to coordinate and deliver technical assistance across both systems to align the work.
Factors Supporting Success
Leadership within key agencies combined with primary care engagement and cross-sector coordination appear to be key factors for making progress at the intersection of health and early learning. State leaders also emphasize the importance of cultural context, supports for families, supports for providers, and supports for states as critical parts of the work.

Cross-Sector Engagement
The collective experience shared by these states can help states strengthen early learning and health connections within state systems. The states are using a variety of cross-sector engagement strategies, such as:

- Creating joint advisory groups for state level initiatives to enable broader participation of health disciplines.
- Creating a health subcommittee for the state Early Childhood Advisory Council and/or other initiatives.
- Building from public-private partnerships or previous early childhood initiatives that involve primary care providers.
- Actively supporting public health partnerships with primary care in ongoing ways, such as through workgroups or regular meetings.
- Inviting State Chapter, American Academy of Pediatrics (AAP) Executive Director and/or pediatrician to serve on the state Early Childhood Advisory Council.
- Inviting pediatricians/primary care providers to serve on local Early Childhood Advisory councils.
- Engaging AAP or state medical society to do primary care outreach or training.
- Partnering with hospitals or health systems to implement project strategies.
- Providing training and support to medical providers to implement developmental screening.
- Engaging and supporting primary care providers through Help Me Grow.
- Implementing Reach Out and Read as a parent engagement and child development strategy within primary care.
- Involving pediatricians in child care and QRIS standards review/development.

Many of these strategies work together within a state. For example, New Jersey has simultaneously increased

For example, as both health and early learning providers participate in a statewide system of developmental screening and linkages to services for young children and families, they will look for opportunities to coordinate technical assistance services, which might involve common messages and training elements.

**Vermont** has a strong emphasis on partnering with primary care providers, based on a long history of Maternal Child Health-primary care partnerships. Vermont is using the Help Me Grow (HMG) program to augment and expand current systems, offering developmental surveillance, screening, and care coordination with linkages to community-based programs and services up to age 8 as a preventative approach to school readiness. The program serves as an umbrella for coordinating early childhood health, social, and educational services into an integrated approach that meets the needs of children and their families.
attention to child health and development and streamlined advisory groups for several large early childhood initiatives. The state’s Infant and Child Health Committee is a core committee of the state Early Childhood Advisory Council. Described as “an amazing group that shows up and contributes,” it includes primary care providers, maternal child health constituents, early intervention, child care resource and referral agencies, Head Start, family advocates, special education, and health services for children with special needs. This cross-sector group is now serving as a single advisory group to three large grants/initiatives: Early Childhood Comprehensive Systems (ECCS), Help Me Grow (HMG) and Project LAUNCH.

The desire and the need to collaborate across state agencies and through public-private partnerships were evident across all states. Various strategies were employed or arose which helped facilitate progress in these states. As Vermont worked to bridge disciplines, it discovered the extent of both language and trust challenges across sectors. The work to get to a common language is ongoing, and building partnerships will take time. In Oregon, developmental screening emerged as a key focus for both the health and early learning systems, creating momentum toward achieving common goals. California’s Statewide Screening Collaborative brought together state agencies and community partners to focus on screening-related issues and, in the process, helped break down historical silos, such as those existing between the medical and early education fields. Maryland brought together physicians, including the American Academy of Pediatrics (AAP) president and the AAP child care liaison, to brainstorm innovative approaches to communication between early childhood providers and pediatricians, which connects back to parents.

Cultural Context
States recognize the challenge and importance of supporting diverse populations and viewpoints as they develop their systems. Maryland emphasized that for all things, but especially developmental screening, states have to take the time to build consensus and make sure the right expertise is at the table. Through Family Connects, North Carolina learned how to staff programs to be accepted locally, and about challenges of working across (not just within) counties. Lessons were also learned about the challenges implementing multiple strategies in rural and under-resourced areas, and how important it is for “state players” to go out and sit at local tables. As Oregon contemplated the state’s role in the creation of a developmental screening training curriculum, multicultural input was sought from the start. Oregon noted the importance of building this perspective in from the ground up, instead of developing something from a majority/English perspective, and then seeking to translate it.

Supports for Families
As states implemented developmental screening initiatives in particular, they were simultaneously focused on assuring effective systems of information and referral supports for families. Delaware noted its biggest challenge was a lack of data systems; there was no way to track screenings and referrals systematically. Diverse strategies evolved to address these needs. New Jersey noted the opportunity to partner providers with parents/families through county-level early childhood councils, while North Carolina increased attention to the importance of the referral and feedback loop after screening. Maryland began to involve the medical community and families in the whole-child approach, based on a vision of parents, caregivers, and pediatricians in a “circle of communication.”

Many of the states addressed this need through implementation of a Help Me Grow System. New Jersey benefited from the strong collaborations and strategic priorities that were established during the planning phase of its work to become a Help Me Grow affiliate state. It then created a statewide network of central intake hubs that know the local resources and can help connect families to an array of needed services and supports. Vermont noted that having health at the table and convincing stakeholders that Help Me Grow was the basis for all of their collective work were key strategies by which they achieved a population-based approach to finding and serving all kids at-risk.

Supports for Providers
In order to enhance health outcomes for young children, states recognized the need for professional development and other supports for providers, and a number of successful strategies were employed. Oregon
conducted two statewide developmental screening needs assessments to understand the issues and the workforce development needs. In California, the creation of an Early Childhood Screening Toolkit with information and training materials has been an effective cross-sector strategy, and is becoming a valuable resource that can be customized by counties and regions. New Mexico learned that it needed to add rating criteria for Social-Emotional Development and Mental Health to its TQRIS, in addition to providing training. California discovered both the importance and the challenge of incorporating preventive health and developmental screening into the TQRIS. Combining these two concepts into one rating element has been hard for providers since the strategies are different. In thinking about next steps, it could be helpful to separate the elements. In North Carolina, bringing Child Care Health Consultants (CCHCs) together to learn from each other in communities of practice has helped CCHCs feel empowered to do high quality work. And North Carolina is improving its ABCD developmental screening work by providing quality improvement support to medical providers in partnership with a health network system.

Supports to Move State Systems Forward
States were asked to discuss the connection of their ELC health-related work to state systems-building efforts in health. All of the states with health projects that are part of the ELC have other health-related early childhood systems initiatives, such as Early Childhood Comprehensive Systems (ECCS), Maternal Infant and Early Childhood Home Visiting (MIECHV), and Help Me Grow (HMG). All of the states have ECCS and MIECHV grants. Five of the states have strong statewide HMG initiatives, two others have local HMG efforts, and one state reported looking at similar elements to develop a system. Five states have state level Reach Out and Read efforts, and the others have local programs without a real systems approach. Three of the states noted having past or present Project LAUNCH grants. One state described a young child mental health system of care developed through a SAMHSA grant and sustained through state funding. By aligning the ELC with these initiatives, rather than simply creating a new one on top of them, states are making progress in their systems-building work.

Within this robust context of health-related systems-building efforts, several states acknowledge the important basis these efforts bring to the ELC work, especially the foundation of ECCS and HMG. Specific ways in which this is being done include:

- Building from existing cross-agency relationships or partnerships.
- Building from previous early learning-health partnerships.
- Sharing advisory councils or leadership groups.
- Creating or building from existing cross-discipline committees.
- Increasing capacity and expanding services or partnerships developed in other systems efforts.

When asked what facilitates effective systems development at the intersection of health and early learning, states offered several thoughts. They recognized that states are not all in the same place with regard to moving forward, and that states must start from where they are to build toward a comprehensive system. They appreciated cross-sector initiatives between federal agencies, and felt there could be incentives to states to partner in this way locally. States felt that within a health focus on QRIS, a broader array of health issues should be addressed. This could be done, for example, by assuring health is part of training and licensing requirements, and making health and wellness part of the criteria to move up the quality scale. They looked forward to future opportunities to broaden beyond a focus on health within QRIS and into the bigger picture of health in early learning. Finally, given the relatively limited experience of states working across disciplines to include health in early childhood, states welcome opportunities to learn from each other’s experiences in implementing health-related initiatives.
Conclusion
While it is too early to know the overall impact of the early learning-health work taking place within the Race to the Top-Early Learning Challenge, the excitement about its potential is significant. These states are unequivocal about the importance of health in early childhood, committed to making progress in their own states, and eager to share their experiences with others.

The complexity of implementing systemic change in cross-sector areas of focus, like developmental screening and child care consultation, is immense. Sharing the experiences of these states in some detail will inform and support the efforts of other states that are embarking on a similar journey.

Underlying the successful work of these states so far is a core commitment to health; the engagement of cross-agency leadership and of primary care medical providers; and shared leadership and oversight with a commitment to common goals. By strengthening relationships and building from existing work, these states are leveraging their efforts together to assure the optimal health and development of all young children.

Appendix: Resources for States
Several health-related systems efforts with national and state counterparts were leveraged by ELC grantee states and referred to in earlier sections. They are briefly highlighted here as potential resources for all states interested in developing an early childhood system that connects health and early learning.

American Academy of Pediatrics (AAP):
The AAP is a source of early learning and health related expertise for pediatricians, other child health providers, and for states who want to partner with them. Relevant resources follow.

Bright Futures is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community, centered on a comprehensive set of health supervision guidelines. In addition to use in pediatric practice, many states implement Bright Futures principles, guidelines and tools to strengthen the connections between state and local programs, pediatric primary care, families, and local communities. Bright Futures Child Care Handouts provide parents with tips on what child care programs will be working on with a child, based on the child's age.

Developmental Screening information is available and addresses screening at the state level, building from its policy statements and other efforts to support the optimal development of young children.

Literacy Promotion is addressed by the AAP policy statement about literacy promotion as a standard part of pediatric primary care. A toolkit is available as well.

Healthy Child Care America provides health and safety technical assistance, resources and training to early education and child care initiatives, including Early Childhood Comprehensive Systems, Child Care Development Fund State Programs, and to health care providers working with early childhood programs.

Chapter Child Care Contacts are available in each of its state chapters to provide a network of pediatric child care experts who can mobilize efforts to improve the health and safety of children in child care and engage parents in discussions about quality care and their options.

Building Bridges among Health and Early Childhood Systems: 20 states are involved in this collaborative effort between the American Academy of Pediatrics (AAP) chapters and state early childhood systems that focuses on building connections between medical home and early childhood service programs, including Head Start, Early Intervention, home visiting and others.

Early Childhood Comprehensive Systems (ECCS): Early Childhood Comprehensive Systems (ECCS) work brings together primary care providers,
teachers, families, and caregivers to develop seamless systems of care for children in the critical formative years from birth to age three. ECCS helps children grow up healthy and ready to learn by addressing their physical, emotional and social health in a broad-based and coordinated way.

**Building Health through Integration Grants** These federal grants are awarded by the Maternal and Child Health Bureau at the Health Resources and Services Administration (HRSA) to states and organizations with significant experience developing and implementing statewide strategies to build systems that improve the health of young children. There are currently ECCS grants in 47 of 50 states, including all ELC health-focused states, the exceptions being Georgia, Maine and Mississippi. Grantees partner with other providers and programs to better integrate and improve services for young children. The resulting systems:

- Increase access to health care.
- Identify and manage social, emotional, and behavioral risks.
- Improve early care and promote early learning.
- Educate parents and caregivers about healthy child development.
- Provide support for families and caregivers.

Current grantees choose one of three strategies for achieving the goals of the program:

1. Reduce negative influences on early development (often referred to as toxic stress).
2. Increase developmental screening of young children to identify and treat problems early.
3. Improve the quality of child care by increasing the adoption of accepted child care standards.

**Success and Opportunities for Early Childhood Comprehensive Systems (ECCS)**

ECCS is a powerful leader for change around linking the critical foundations of health to the achievement of early learning outcomes. ECCS leadership can be engaged and highly visible with all leadership groups in states, including governor’s offices, departments of early learning, early childhood councils, state AAP chapters, Project LAUNCH, word gap initiatives, trauma networks, and early childhood mental health. Strong linkage between ECCS and MIECHV is a lever for child health, early learning, family support and policy change. ECCS provides an opportunity to align state Title V MCH 3.0 goals with MIECHV, ECCS and state early learning goals. There is an opportunity now for ECCS, home visiting, medical home, and place-based activities to demonstrate local population improvements in child health, development, and school readiness outcomes.

**Health and Safety Checklist for Early Care and Education Programs:** The Checklist is available for use in early childhood programs and is based on *Caring for Our Children, 3rd edition.*

**Head Start National Center on Health**

The National Center on Health (NCH) provides evidence-informed health and safety technical assistance, resources, and trainings for Head Start programs. Screening for developmental, sensory, and behavioral concerns is required of all Head Start programs. NCH provides support for children to receive these and other health services and, as a result of these screenings, appropriate referrals for additional services.

**Help Me Grow (HMG):** Undetected and untreated behavioral and developmental problems in children can have a profound impact on the lives of children and families and on our society. Experts agree that early detection of at-risk children offers the best hope for optimal outcomes. Yet current efforts are primarily focused on children with significant delays and disorders and connection to early intervention programs only available to children with significant evidence of delays. Even when the needs of at-risk children are recognized and appropriate programs and services are identified, connecting children to such services often proves difficult.

Help Me Grow is a comprehensive integrated statewide system to address the need for early identification of children at-risk for developmental and/or behavioral problems. It then links these children and their families to community-based developmental and behavioral services and supports. Twenty-three states have implemented or are in the planning stages of a Help Me Grow system, and six of these are partnering this work with their ELC grants.
Help Me Grow is a proven system that builds on existing resources to assist states in identifying at-risk children, then helps families find community-based programs and services through comprehensive physician and community outreach and centralized information and referral. Ongoing data collection and analysis helps identify gaps in and barriers to the system. The four core components of a comprehensive Help Me Grow system are:

1. Centralized telephone access point for connection of children and their families to services and care coordination.
2. Community and family outreach to promote the use of HMG and to provide networking opportunities among families and service providers.
3. Child health provider outreach to support early detection and early intervention.
4. Data collection and analysis to understand all aspects of the HMG system, including the identification of gaps and barriers.

Reach Out and Read is an evidence-based non-profit organization of medical providers who promote early literacy and school readiness in pediatric exam rooms nationwide by integrating into well-child visits children's books and advice to parents about the importance of reading aloud. Reach Out and Read builds on the unique relationship between parents and medical providers by aiming to develop critical early literacy skills in children, beginning in infancy. Reach Out and Read incorporates early literacy promotion into pediatric practice, equipping parents with tools and knowledge to help their children be ready for kindergarten. The Reach Out and Read National Center is a resource for medical practices, and for those who want to partner with them.

Since 1991, the Reach Out and Read model has been studied by academic investigators in a variety of settings, providing an extensive body of peer-reviewed research on the effects of the program. The body of published research supporting the efficacy of the Reach Out and Read model is more extensive than for any other psychosocial intervention in general pediatrics. When families participate, parents served by Reach Out and Read are up to four times more likely to read aloud to their children, and their children have improved language and literacy skills compared to their peers.

Reach Out and Read is endorsed by the American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners, and is a Literacy Partner of the American Academy of Family Physicians. In its policy statement, *Literacy Promotion: An Essential Component of Primary Care Pediatric Practice*, the American Academy of Pediatrics reviews the research and references Reach Out and Read as an effective intervention to engage parents and prepare children to achieve their potential in school and beyond.

Reach Out and Read is increasingly being implemented as a community and/or state strategy within early learning systems. It is a strategy to engage parents with an evidence-based early literacy program, and a mechanism for leveraging the health care system to promote early learning.

Reach Out and Read coalitions are state and local offices affiliated with the Reach Out and Read National Center that work directly with medical practices to support high quality Reach Out and Read programs implemented with fidelity to the proven model.

About the Author

Dr. Jill Sells is pediatrician and an innovative early childhood health, development, and systems leader. After practicing general pediatrics in the Seattle area, she has spent more than a decade working on population-level strategies to support the health and development of young children in the context of their families and communities. She supported the strategic planning of Washington’s Early Childhood Comprehensive Systems Grant and State Early Learning Plan, and serves as an Early Childhood Consultant to SRI International. As a non-profit executive, she has created statewide systems to engage doctors in early childhood policy advocacy, and to integrate early literacy promotion into primary care through Reach Out and Read. Dr. Sells has unique expertise in early childhood systems, particularly at the intersections between health and early learning. She is a Clinical Associate Professor of Pediatrics at the University of Washington, and serves in early childhood leadership and advisory roles at the national, state, and local levels. She is known for her skills at translating research into policy and practice, and facilitating cross-systems collaboration to improve outcomes for children and families.
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Forward Ever for All Young Children!