SUPPORTING THE YOUNGEST GEORGIANS & THEIR FAMILIES

An Early Childhood Resource Guide

GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

www.GEEARS.org

CONTENTS

GEEARS
GEORGIA EARLY EDUCATION
ALLIANCE FOR READY STUDENTS

Setting the Foundation: The Importance of the Early Years

Early Childhood
&
Brain Development

Early learning investments are essential to Georgia's future. Military, business and law enforcement leaders are calling for greater investments in young children to ensure our national security, build our economic well-being and reduce crime.

First 2000 DAYS™
Early Investment
A LIFETIME OF RESULTS

WHY EARLY CHILDHOOD?

There are only **2,000 days** between the time a baby is born and when he or she will **begin kindergarten**.

During that time, **brain architecture** is forming.

The **FOUNDATION** for future learning, health, and behavior is built **birth to age 5**.

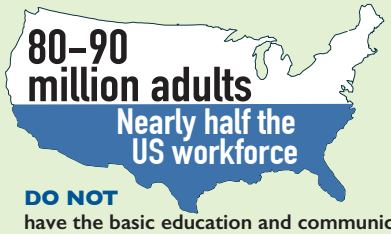
The **most rapid period of development** in human life happens from **birth to 8**.

WHY NATIONAL SECURITY?

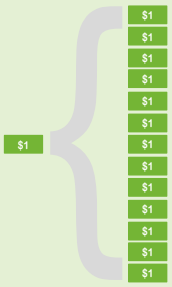
70% of Americans aged 17 to 24 do not meet the military's eligibility requirements.

Of Georgia high school graduates who try to join the military, 1 in 4 score too low on the Armed Forces Qualification Test to join the Army.

WHY ECONOMIC WELL BEING?



DO NOT have the basic education and communication skills required to acquire and advance in jobs.



RETURN ON INVESTMENT
The results of Nobel Laureate Professor James Heckman's most recent study show that every $1 invested in early education produces a yearly return of 13%.

WHY CRIME REDUCTION?

VIOLENT CRIME REDUCTION

Low-income children who attend high quality early education programs are **70% less likely** to be arrested for a violent crime by age 18.

$24 BILLION

The availability of **early care and learning in Georgia** supports annual **parent earnings** of at least $24 billion, which strengthens family economic security.

$4.7 BILLION

In 2013, the **early care and education industry** generated $4.7 billion dollars of **economic activity** in Georgia.

There are only **2,000 days** between the time a baby is born and when he or she will **begin kindergarten**.

During that time, **brain architecture** is forming.

The brain is **not** fully developed at birth. The basic architecture of the brain forms during a child's early years.

We aren't born with the skills that enable us to control impulses, make plans, and stay focused.

We are born with the **potential to develop these capacities.**

www.first2000days.org

Georgia's Campaign:
geears.org/initiatives/first-2000-days/

an initiative of NC Early Childhood FOUNDATION
buildthefoundation.org

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The Importance of Early Childhood

QUALITY EARLY CHILDHOOD MAKES A DIFFERENCE

Every experience a baby has forms a neural connection (synapse) in the brain.

During the early years, up to **ONE MILLION** synapses are formed each second, building the foundation for future learning.

The early years are **so defining** that by the time children **turn eight**, their ***third grade outcomes*** can predict future academic achievement and career **success**.

Early Childhood Investments Produce Results!

Decades of research has identified programs proven to work for young children.

Higher graduation rates. High quality early childhood programs increase graduation rates by as much as 44%.

Better health. A study of children who participated in the Carolina Abecedarian early learning project found participants experienced fewer illnesses as adults, made healthier lifestyle choices, had lower rates of high blood pressure and had significantly lower risk of heart disease than the control group that did not participate.

Greater self-sufficiency. Voluntary home visiting programs reduce health care costs, improve school readiness and success, reduce need for remedial education and increase family self-sufficiency. Participants in high quality early childhood programs contribute more taxes and are less likely to rely on government assistance.

Higher salaries. At-risk children who participated in a high quality early childhood program were more likely to be employed and earned 33% higher average salaries.

Less crime. At-risk children who participated in a high quality early childhood program were significantly less likely to be arrested for a violent crime by age 18.

References for all statistics are available online at www.first2000days.org/infographic.

First 2000 DAYS™
Early Investment
A LIFETIME OF RESULTS

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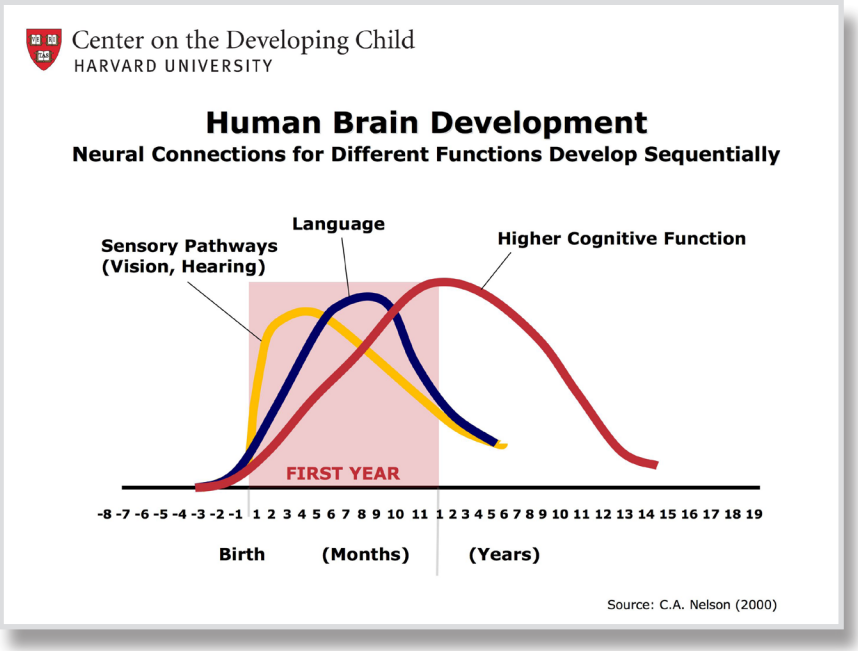
www.geears.org

A series of brief summaries of the scientific presentations at the National Symposium on Early Childhood Science and Policy.

The science of early brain development can inform investments in early childhood. These basic concepts, established over decades of neuroscience and behavioral research, help illustrate why child development—particularly from birth to five years—is a foundation for a prosperous and sustainable society.

1 Brains are built over time, from the bottom up. The basic architecture of the brain is constructed through an ongoing process that begins before birth and continues into adulthood. Early experiences affect the quality of that architecture by establishing either a sturdy or a fragile foundation for all of the learning, health and behavior that follow. In the first few years of life, more than 1 million new neural connections are formed every second. After this period of rapid proliferation, connections are reduced through a process called pruning, so that brain circuits become more efficient. Sensory pathways like those for basic vision and hearing are the first to develop, followed by early language skills and higher cognitive functions. Connections proliferate and prune in a prescribed order, with later, more complex brain circuits built upon earlier, simpler circuits.



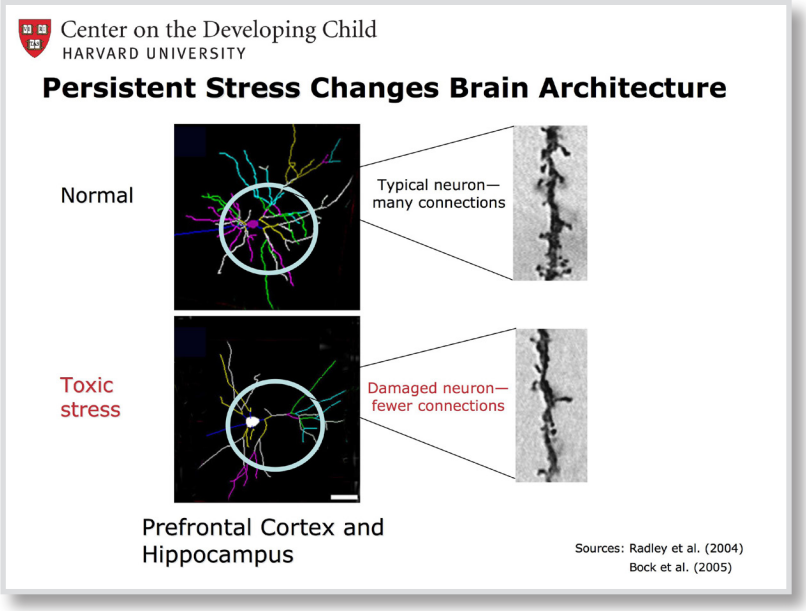
In the proliferation and pruning process, simpler neural connections form first, followed by more complex circuits. The timing is genetic, but early experiences determine whether the circuits are strong or weak.

2 The interactive influences of genes and experience shape the developing brain. Scientists now know a major ingredient in this developmental process is the "serve and return" relationship between children and their parents

POLICY IMPLICATIONS

- The basic principles of neuroscience indicate that early preventive intervention will be more efficient and produce more favorable outcomes than remediation later in life.
- A balanced approach to emotional, social, cognitive, and language development will best prepare all children for success in school and later in the workplace and community.
- Supportive relationships and positive learning experiences begin at home but can also be provided through a range of services with proven effectiveness factors. Babies' brains require stable, caring, interactive relationships with adults — any way or any place they can be provided will benefit healthy brain development.
- Science clearly demonstrates that, in situations where toxic stress is likely, intervening as early as possible is critical to achieving the best outcomes. For children experiencing toxic stress, specialized early interventions are needed to target the cause of the stress and protect the child from its consequences.

and other caregivers in the family or community. Young children naturally reach out for interaction through babbling, facial expressions, and gestures, and adults respond with the same kind of vocalizing and gesturing back at them. In the absence of such responses—or if the responses are unreliable or inappropriate—the brain's architecture does not form as expected, which can lead to disparities in learning and behavior.



Brains subjected to toxic stress have underdeveloped neural connections in areas of the brain most important for successful learning and behavior in school and the workplace.

3 The brain's capacity for change decreases with age. The brain is most flexible, or "plastic," early in life to accommodate a wide range of environments and interactions, but as the maturing brain becomes more specialized to assume more complex functions, it is less capable of reorganizing and adapting to new or unexpected challenges. For example, by the first year, the parts of the brain that differentiate sound are becoming specialized to the language the baby has been exposed to; at the same time, the brain is already starting to lose the ability to recognize different sounds found in other languages. Although the "windows" for language learning and other skills remain open, these brain circuits become increasingly difficult to alter over time. Early plasticity means it's easier and more effective to influence a baby's developing brain architecture than to rewire parts of its circuitry in the adult years.

4 Cognitive, emotional, and social capacities are inextricably intertwined throughout the life course. The brain is a highly interrelated organ, and its multiple functions operate in a richly coordinated fashion. Emotional well-being and social competence provide a strong foundation for emerging cognitive abilities, and together they are the bricks and mortar that comprise the foundation of human development. The emotional and physical health, social skills, and cognitive-linguistic capacities that emerge in the early years are all important prerequisites for success in school and later in the workplace and community.

5 Toxic stress damages developing brain architecture, which can lead to life-long problems in learning, behavior, and physical and mental health. Scientists now know that chronic, unrelenting stress in early childhood, caused by extreme poverty, repeated abuse, or severe maternal depression, for example, can be toxic to the developing brain. While positive stress (moderate, short-lived physiological responses to uncomfortable experiences) is an important and necessary aspect of healthy development, toxic stress is the strong, unrelieved activation of the body's stress management system. In the absence of the buffering protection of adult support, toxic stress becomes built into the body by processes that shape the architecture of the developing brain.

For more information, see "The Science of Early Childhood Development" and the Working Paper series from the National Scientific Council on the Developing Child.
www.developingchild.harvard.edu/library/

NGA Center for BEST PRACTICES

National Conference of State Legislatures

Center on the Developing Child
HARVARD UNIVERSITY

THE INBRIEF SERIES:
INBRIEF: The Science of Early Childhood Development
INBRIEF: The Impact of Early Adversity on Children's Development
INBRIEF: Early Childhood Program Effectiveness
INBRIEF: The Foundations of Lifelong Health

EARLY CHILDHOOD IN GEORGIA 101

KEY CHILD-SERVING AGENCIES IN GEORGIA

Georgia Department of Early Care and Learning (DECAL): DECAL licenses, monitors, and provides support for child care providers throughout the state. The agency also administers Georgia's Pre-K program.

Georgia Division of Family and Children Services (DFCS): DFCS oversees public child welfare in the state. DFCS responds to reports of abuse and neglect against children, as well as oversees foster care placement and adoption services.

Georgia Department of Public Health (DPH): DPH takes the lead in preventing disease, injury and disability; promoting health and wellbeing; and preparing for and responding to disasters from a health perspective. DPH funds and collaborates with Georgia's 159 county health departments and 18 public health districts. DPH works in the area of maternal and child health by administering the Georgia Home Visiting Program as well as the early intervention service Babies Can't Wait.

Georgia Department of Community Health (DCH): DCH oversees the administration of the statewide Medicaid program, as well as PeachCare, Georgia's need-based children's health insurance program.

Georgia Department of Education (GaDOE): GaDOE oversees public K-12 education throughout the state. GaDOE ensures that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to local school systems.

Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD): DBHDD serves people living with mental health challenges, substance use disorders, and intellectual and developmental disabilities by operating state hospitals and providing for community-based services across the state through contracted providers.

The State of Georgia's Babies

STATE OF BABIES YEARBOOK 2020

Where children are born can affect their chances for a strong start in life. Babies need Good Health, Strong Families, and Positive Early Learning Experiences to foster their healthy brain development and help them realize their full potential.

This state profile provides a snapshot of how infants, toddlers, and their families are faring in each of these three policy domains. Within each domain, view data for selected child, family, and policy indicators compared to national averages. The profile begins with a demographic description of the state's babies and families to offer the broadest context for exploring what may be very different experiences of the state's youngest children.

Georgia's Rankings

KEY G Getting Started | R Reaching Forward | O Improving Outcomes | W Working Effectively

Overall GROW Getting Started	**Good Health** GROW Getting Started
Strong Families GROW Improving Outcomes	**Positive Early Learning Experiences** GROW Reaching Forward

Demographics

Infants and toddlers in Georgia

Overview

Georgia is home to 389,110 babies, representing 3.7 percent of the state's population. As many as 48.4 percent live in households with incomes less than twice the federal poverty line (in 2018, about $50,000 a year for a family of four), placing them at economic disadvantage. America's youngest children are diverse and are raised in a variety of family contexts. In Georgia, 57.6 percent of babies are children of color and 5.7 percent of the state's infants and toddlers live in rural areas. A broad array of policies and services are required to ensure all of them have an equitable start in life.

GEORGIA | NATIONAL AVERAGE

Race/ethnicity of infants and toddlers

	Georgia	National Average
Non-Hispanic White	42.4%	49.3%
Non-Hispanic Black	33.5%	13.7%
Hispanic	15.9%	26.2%
Non-Hispanic Other	4.5%	5.9%
Non-Hispanic Asian	3.7%	4.9%
American Indian/Alaska Native	0.2%	0.8%

Working moms

	Georgia	National Average
Mothers in the Labor Force	60.3%	61.6%

Poverty status of infants and toddlers

	Georgia	National Average
Above Low-Income	51.6%	57.9%
Low-Income	24.6%	22.3%
In Poverty	23.8%	19.8%

Infants and toddlers in poverty, by race

	Georgia	National Average
Hispanic	36.0%	27.2%
Non-Hispanic Black	31.7%	37.0%
Non-Hispanic Other	22.2%	16.9%
Non-Hispanic White	14.0%	12.3%

Family structure

	Georgia	National Average
2-Parent Family	69.0%	76.7%
1-Parent Family	26.9%	20.9%
No Parents Present	4.1%	2.4%

Grandparent-headed households

	Georgia	National Average
	13.1%	8.5%

Rural/Non-metro area

	Georgia	National Average
Living Outside of a Metro Area	5.7%	8.6%

Good Health
In Georgia

GROW

What is Good Health?

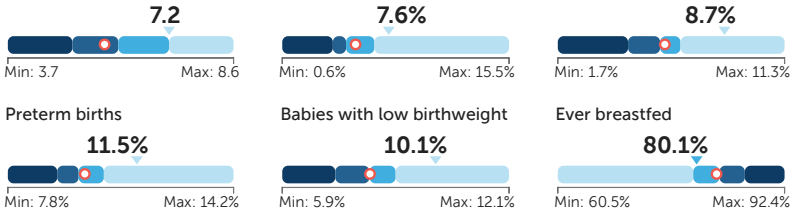
Good physical and mental health provide the foundation for babies to develop physically, cognitively, emotionally, and socially. The rate of brain growth is faster in the first 3 years than at any later stage of life, and this growth sets the stage for subsequent development. Access to good nutrition and affordable maternal, pediatric, and family health care is essential to ensure that babies receive the nourishment and care they need for a strong start in life.

Georgia falls in the Getting Started (G) tier for the Good Health domain. A state's ranking is based on indicators of maternal and child health, including health care coverage, prenatal care, birth outcomes, and receipt of recommended preventive care as well as food security, nutrition, and mental health. Georgia performs better than national averages on key indicators, such as the percentages of babies receiving preventive medical and dental care. The state is performing worse than national averages on indicators such as the percentages of women receiving late or no prenatal care and babies experiencing food insecurity. Georgia is not a Medicaid expansion state. The state Medicaid program covers 1 of 5 screenings and services that support socioemotional well-being and maternal and infant and early childhood mental health (IECMH).

Six Key Indicators of Good Health

KEY ← Range of all state values → ▼ Georgia ○ National average

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively



Good Health Policy in Georgia

Medicaid expansion state	No ✗
State Medicaid policy for maternal depression screening in well-child visits	Required
Medicaid plan covers social-emotional screening for young children	No ✗
Medicaid plan covers IECMH services at home	No ✗
Medicaid plan covers IECMH services at pediatric/family medicine practices	No ✗
Medicaid plan covers IECMH services in early childhood education settings	No ✗

Strong Families
In Georgia

GROW

What Defines Strong Families?

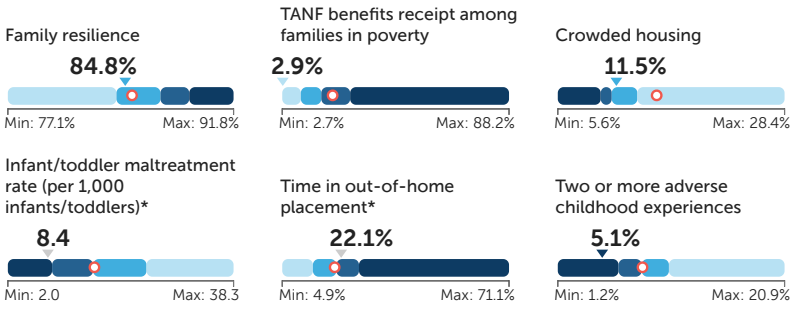
Young children develop in the context of their families, where stability, safety, and supportive relationships nurture their growth. All families benefit from parenting supports, and many—particularly those challenged by economic instability—require access to additional resources that help them meet their children's daily and developmental needs. Key supports include safe and stable housing, home visiting services, family-friendly employer policies, economic support for families with low income, and tax credits that benefit families with young children.

Georgia falls in the Achieving Outcomes (O) tier of states when it comes to indicators of Strong Families. The state's ranking in this domain reflects indicators on which it is performing better than the national average, such as the percentages of babies living in crowded housing and parents who report living in unsafe neighborhoods. Georgia is doing worse than the national average on indicators such as the percentages of families in poverty with babies receiving TANF and babies who could benefit from home visiting receiving those services. Policy-wise, the state has implemented none of 5 policies that promote strong families, such as paid sick and family leave, Temporary Assistance to Needy Families (TANF) options, the Child Tax Credit, and Earned Income Tax Credit.

Six Key Indicators of Strong Families

KEY ← Range of all state values → ▼ Georgia ○ National average

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively



Strong Families Policy in Georgia

Paid family leave	No ✗
Paid sick time that covers care for child	No ✗
TANF Work Exemption	No ✗
State Child Tax Credit	No ✗
State Earned Income Tax Credit (EITC)	No ✗

Positive Early Learning Experiences

In Georgia

GROW

What Defines Positive Early Learning Experiences?

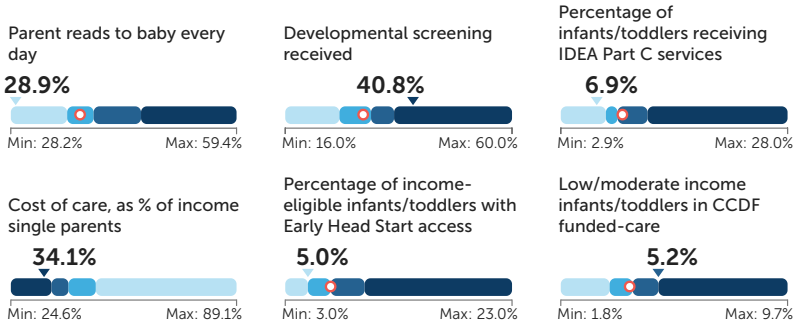
Infants and toddlers learn through play, active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. The quality of babies' early learning experiences at home and in other care settings impacts how prepared they are for life-long learning and success. Parents who work or attend school require access to affordable, high-quality care options that foster their babies' development. During this rapid period of growth, access to screening and early intervention is essential to address potential developmental delays.

Georgia scores in the Reaching Forward (R) tier for Positive Early Learning Experiences. The state's ranking in this domain reflects indicators on which it is performing better than the national average, such as the higher percentage of babies in families with low/moderate income who receive CCDF-funded care and babies received developmental screening. Georgia is doing worse than the national average on indicators such as the lower percentages of parents who read and sing/tell stories to their babies daily. Infant care costs as a percentage of the state's median income for single and married parents also contribute to the ranking. The state does not offer child care subsidy assistance to families with incomes above 200 percent of the Federal Poverty Level.

Six Key Indicators of Positive Early Learning Experiences

KEY ← Range of all state values → ▼ Georgia ○ National average

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively



Positive Early Learning Experiences Policy in Georgia

Families above 200% of FPL eligible for child care subsidy	No ✗
Allocated CCDBG funds	Yes ✓
Group size requirements meet or exceed EHS standards	No age group
Adult/child ratio requirements meet or exceed EHS standards	No age group
Level of teacher qualification required by the state	CDA or state equivalent credential
Infant/toddler credential adopted	Yes ✓
State reimburses center based child care at/above 75th percentile of market rates	No ✗
State includes 'at-risk' children as eligible for IDEA Part C services or reports that they serve 'at-risk' children	No ✗

All indicators for Georgia

G Getting Started R Reaching Forward O Improving Outcomes W Working Effectively

Good Health

W	Eligibility limit (% FPL) for pregnant women in Medicaid	**225.0** *National average: 200.0*
R	Low or very low food security	**21.0%** *National average: 15.9%*
R	Infants breastfed at 6 months	**52.4%** *National average: 54.6%*
O	High weight-for-length among WIC recipients	**10.1%** *National average: N/A*
W	Mothers reporting less than optimal mental health	**15.0%** *National average: 19.8%*
G	Babies with low birthweight	**10.1%** *National average: 8.3%*
W	Preventive medical care received	**94.5%** *National average: 91.1%*
G	Received recommended vaccines	**65.6%** *National average: 70.4%*
G	Uninsured low-income infants/toddlers	**7.6%** *National average: 5.4%*
R	Ever breastfed	**80.1%** *National average: 82.9%*
G	WIC coverage	**68.7%** *National average: 85.9%*
G	Late or no prenatal care received	**8.7%** *National average: 6.2%*
G	Infant mortality rate (deaths per 1,000 live births)	**7.2** *National average: 5.8*
G	Preterm births	**11.5%** *National average: 10.0%*
W	Preventive dental care received	**35.9%** *National average: 31.9%*

Strong Families

G	TANF benefits receipt among families in poverty	**2.9%** *National average: 21.7%*
R	Crowded housing	**11.5%** *National average: 15.5%*
R	Family resilience	**84.8%** *National average: 85.2%*
W	Two or more adverse childhood experiences	**5.1%** *National average: 8.6%*
	Time in out-of-home placement*	**22.1%** *National average: 20.2%*
G	Potential home visiting beneficiaries served	**0.6%** *National average: 1.9%*
R	Housing instability	**3.3%** *National average: 2.7%*
W	Unsafe neighborhoods	**0.5%** *National average: 5.8%*
O	One adverse childhood experience	**19.2%** *National average: 22.4%*
	Infant/toddler maltreatment rate (per 1,000 infants/toddlers)*	**8.4** *National average: 15.9*
	Infants/toddlers exiting foster care to permanency*	**97.5%** *National average: 98.6%*

Positive Early Learning Experiences

G	Parent reads to baby every day	**28.9%** *National average: 37.8%*
G	Percentage of income-eligible infants/toddlers with Early Head Start access	**5.0%** *National average: 7.0%*
W	Cost of care, as % of income single parents	**34.1%** *National average: N/A*
W	Developmental screening received	**40.8%** *National average: 31.1%*
G	Percentage of infants/toddlers receiving IDEA Part C services	**6.9%** *National average: 9.7%*
G	Parent sings to baby every day	**54.3%** *National average: 57.6%*
W	Cost of care, as % of income married families	**10.4%** *National average: N/A*
O	Low/moderate income infants/toddlers in CCDF funded-care	**5.2%** *National average: 4.2%*
	Infants/toddlers with developmental delay*	**1.6%** *National average: 1.0%*
O	Timeliness of Part C services	**98.5%** *National average: N/A*

**This indicator is not factored into the GROW tier rankings. | Note: N/A indicates Not Available.*

Too Young to Vote, Too Important to Ignore: 5 Things Legislators Need to Know About Infants and Toddlers

As a state legislator, you are serving in the policymaking arena at an extraordinary time. Your constituents selected you to help carve a path forward for your state and find solutions to the immense challenges they are facing—from coping with unemployment and the struggles of running a small business to balancing the demands of work and child care or caregiving.

You likely won't have heard, however, from your youngest constituents, the ones who may feel the aftereffects of the pandemic the longest.

For infants and toddlers, whose brains and biological systems are rapidly developing, issues exacerbated by COVID-19—food insecurity and unstable housing, among others—could have lasting consequences.

As you head into this most unusual of sessions, here are five things to consider about the infants, toddlers, and families in your state.

1. The First Three Years of Life Are Critical for Healthy Brain Development

At a million new neural connections a second, children's brains grow more in the first three years than at any later point. This uniquely sensitive period of development means the quality of a child's environment, interactions with caregivers, and

experiences can lay either a strong or a weak foundation for all the growing and learning that follow.

Warm and responsive relationships with caregivers support healthy development in infants and toddlers. Surveys of parents with young children conducted since March confirm that, due to the public health crisis, many are experiencing increased stress, conflict with partners, anxiety, and depression, all of which can compromise their ability to provide nurturing caregiving.

Absent a protective factor like another trusted adult, children may experience extended periods of stress that can “get under the skin” and affect lifelong health, learning, and well-being.

2. Roughly 40% of Infants and Toddlers, or 2 in 5, Live in Low-Income Households

Infants and toddlers are overrepresented among those living in poverty, which can slow brain development and learning. Research shows children in low-income households can fall significantly behind in language development.

Often in the early stages of their careers, parents of young children face the highest costs for care during a time in which they typically earn lower wages and have less access to financial resources. Public funding for programs and services for children age 3 and younger lags significantly behind investments in older children, forcing parents to bear the brunt of their young children’s care and education during the particularly critical window of development in the first few years of life. Without access to high-quality early learning opportunities, children from low-income households are at greater risk of falling behind their peers beginning before they enter kindergarten.

3. Disparities for Children of Color Start Before Birth

Black mothers have a pregnancy-related death rate that is three to four times higher than that of white mothers, and they are more likely to have one or more chronic health conditions. Black infants are more likely to be born preterm and with low birth weight and have twice the mortality rate of white and Hispanic infants.

Researchers attribute racial disparities in birth outcomes to inequitable access to high-quality health and prenatal care, disproportionate risks affiliated with poverty and economic hardship, discriminatory policies, bias from health care providers, and the stress and physical toll of racism.

Furthermore, people of color are overrepresented in low-wage occupations, which impacts their ability to access caregiving supports like paid family leave and high-quality child care. Parents of color are also two to three times more likely than their white

counterparts to report lacking someone to turn to if they need help, potentially jeopardizing their emotional well-being and ability to provide nurturing care.

4. Care for Infants and Toddlers Is Unaffordable for Parents and Providers Alike

Young children who attend high-quality care benefit from being developmentally supported and put on a path to school readiness, yet millions of children do not have this opportunity. Child care is often more expensive than housing or in-state college tuition, putting it financially out of reach for many families. And while there is a general shortage of child care across the country (made much worse by COVID-19), infant and toddler care is by far the least available and most expensive. Only 4% of low-income families with infants and toddlers receive financial assistance through federal funding to help them pay for care.

On the supply side of the equation, early childhood educators earn an average of $11 an hour and must stretch parents' payments to cover payroll and other business costs. Caregivers for infants and toddlers earn the lowest wages and have the highest turnover. Though research shows educating groups of young children, including infants and toddlers, requires specific knowledge and skills, early childhood educators earn about half what kindergarten teachers make and have poverty rates four to 14 times that of K-12 teachers. This financial strain can negatively affect early educators' mental health as well as their interactions with children—the linchpin of early learning.

5. Targeted Policies and Programs Can Make a Lasting Difference

Many policies and programs strengthen outcomes for infants, toddlers and their families. Paid family leave policies and earned income tax credits are linked to improved health outcomes for moms and infants and to greater family economic security. Voluntary home visiting programs support pregnant mothers and new parents and are shown to lower incidences of child abuse, neglect, preterm births and low birthweights, as well as improve school readiness for children and increase high school graduation rates for teen mothers.

Moreover, investments in early childhood programs can produce high rates of return—some studies show up to 13%—and can prepare children for success later in life in almost every way: better long-term health, lower incarceration rates, improved high school graduation rates and greater workforce productivity.

The COVID-19 pandemic has magnified preexisting issues for young children and those who care for them. These issues could have long-term effects that can be more easily, more successfully and more cost effectively addressed by fostering healthy development early in life rather than relying on remedial programs to address later-life

later-life problems. This legislative session will undoubtedly include many urgent and competing priorities. It may also be an opportunity to make cost-effective policy changes and investments to help create brighter futures for your state's youngest constituents.

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START WITH EQUITY

14 PRORITIES TO DISMANTLE SYSTEMIC RACISM IN EARLY CARE AND EDUCATION

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CHILDREN'S EQUITY PROJECT

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IN PARTNERSHIP WITH

NBCDI National Black Child Development Institute

Council for Professional Recognition

The Education Trust

Equity Research Action Coalition
UNC Frank Porter Graham Child Development Institute

naeyc National Association for the Education of Young Children

NHSA National Head Start Association

Build Initiative Strong Foundations For Our Youngest Children

NICCA National Indian Child Care Association

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START WITH EQUITY

14 PRIORITIES TO DISMANTLE SYSTEMIC RACISM IN EARLY CARE AND EDUCATION

INTRODUCTION

The founding tenet of the United States – equal opportunity for all – has eluded many Americans and has never been fully realized for many communities of color. Historically, specific groups of individuals have been the subjects of exclusion, disenfranchisement, assimilation, violence, and in the case of Indigenous communities, genocide. Centuries-long battles for human and civil rights for Black, Indigenous, Latinx, and other communities of color have resulted in critical advancements in building a more equitable society. Despite these great achievements, inequities persist across almost every aspect of life in the United States – education, housing, health, and wealth. The tragic fact remains true in this country: children's outcomes are predicted by their demographic characteristics, the color of their skin, their family's income bracket, and their home language.

These inequities begin before birth and follow children into the early care and education (ECE) system, one of the first systems with which they interact. Indeed, grave inequities in children's access to, experiences in, and outcomes during and after early learning vary drastically based on what a child looks like, where they live, what language they speak, and where they are from.

It is essential that young children receive an equitable, positive, and healthy start. That is why any policy agenda to dismantle systemic racism in this country must include bold reforms to the ECE system that concretely address **equity in access, experiences, and outcomes**. Although the challenges in our system are complex and stepping away from the status quo is not an easy task, proactive investments and policy reforms to address racial equity in ECE will ripple into other inequitable domains of life – K-12 education, employment, wealth building — and across generations.

The murders of George Floyd and Breonna Taylor at the hands of police in the Spring of 2020, and the continuous stream of police violence experienced by Black Americans for generations, coupled with the disproportionately negative impact of COVID-19 on communities of color, has thrust this nation into another moment of racial reckoning. Protestors, led by Black Americans, have forced open an opportunity for meaningful, systemic, and sweeping change that can bridge long-standing disparities in access to resources and opportunity in the United States. The fight against systemic racism is not new. We stand on the shoulders of our foremothers and fathers. But the work is unfinished and requires a continued commitment to change. The transformative change we seek requires identifying, with specificity and concreteness, the manifestation of systemic racism in our ECE system and implementing policies to dismantle it.

It is against this backdrop that the Children's Equity Project, with funding from the Heising Simons Foundation, and in partnership with the Equity Research Action Coalition, the National Black Child Development Institute, the Council for Professional Recognition, the National Indian Child Care Association, the National Head Start Association, the National Association for the Education of Young Children, The Education Trust, and the Build Initiative, is issuing a new resource that names 14 critical priorities to advance equity in the ECE system. This list of policies is not meant to be exhaustive or deprioritize other changes critical to bringing about racial equity. Rather, this policy agenda is meant to serve as one actionable roadmap with specific recommendations targeted at federal and state policymakers. **These strategies do not and cannot operate in isolation to bring about the change we hope to see. Together, paired with the work of families and advocates, we believe that this agenda will move the field forward closer to realizing racial equity for our youngest children.**

Importantly, the reforms listed here are key strategies that are possible within the confines of our current systems. They are actions we can collectively take *today* to ensure more equitable systems tomorrow. Implementing these actions now, does not preclude us from concurrently reimagining what a new system could look like in the future, a partner and critically important task.

The agenda detailed here should be part of equity strategic planning processes across all levels of government and should be paired with benchmarked milestones, aggressive timelines, and anticipated outcomes that are constantly updated and improved — informed by data. Equity strategic plans facilitate the ability by the federal government, states, tribes, and localities to track their overall progress on equity and remain accountable for improvement. At a high level, these plans must focus on equitable **access** to resources and opportunity, equitable **experiences** within systems, and **outcomes** that are not predicted by demographic characteristics. The explicit goal must be equity, and the policies listed here are a set of systemic strategies that help make progress toward that goal. **These plans should stand alongside, not replace, the intentional embedding of equity into every existing system and policy. Achieving equity will require a both/and approach.**

It is also important to keep in mind the special *trust-relationship* tribes have with the federal government and how government-to-government tribal consultation is necessary between government agencies providing services or changing policy. Too often, tribal consultation is seen as a barrier, instead of a strength, and leaves tribes out of opportunities for support and systems improvement that other states and programs benefit from.

It may be tempting to turn away from bold reforms during this uncertain and difficult time in American history – a global pandemic, economic upheaval, and the long-standing battle against racial inequality. But we believe that these challenges highlight the serious inequities and injustices at the foundation of the United States, and more specifically, within the ECE system. They make it even more urgent to use this moment to concretely identify systemic racism in ECE and to use that knowledge to re-envision a new reality for our youngest children, their families, and their communities. Congress, federal agencies, states, and tribes must partner with local communities, advocates, and families to act now.

Equitable learning systems provide access to resources, opportunities, and experiences to children and families that result in positive outcomes that are not associated with children's demographic characteristics. They actively and continuously identify and intentionally eliminate manifestations of systemic racism and other forms of oppression.

1 DISSEMINATE PUBLIC FUNDS EQUITABLY.

Resources matter. For generations, children of color have been relegated to lower-quality learning experiences and underfunded schools. Equal funding has historically been out of reach, let alone *equitable* funding. Although for most of U.S. history, white people have been explicitly prioritized for resources on the basis of race,[1] this same system of white supremacy makes it illegal today to prioritize people of color. A 2018 report by The Education Trust found that nationwide, school districts serving the most students of color receive $1,800 less per student than districts serving the least.[2] The compounded effects of chronically underfunded systems and historical marginalization of generations of children of color, including Black, Indigenous, and Latinx children, children of migrant/seasonal farmworkers, and others, make it necessary to approach funding equitably. Indeed, realizing racial equity requires equitable funding that considers historical and current marginalization — including on the basis of race, resource gaps in communities, and disparities in outcomes.

CONGRESS SHOULD:

- Informed by the proposed National Academies of Sciences, Engineering, and Medicine study referenced below, establish equitable funding formulas across learning systems that address historical marginalization and disparities in access to resources, quality experiences, and outcomes.
- Fully fund programs targeted at supporting historically marginalized communities, including Head Start,[i] IDEA, Titles I and III of ESSA, and Bureau of Indian Education (BIE) programs. Increase tribal set-asides for ECE programs to ensure that Tribal Nations, American Indian/Alaska Native (AI/AN), and Indigenous communities have equitable access to ECE funding. Increase migrant and seasonal farmworker set-asides for Head Start and Title I in order to address the complex and unique needs of children of migrant and seasonal farmworkers.
- Expand access to the comprehensive services provided in Head Start by increasing funding for the Early Head Start-Child Care Partnerships program. Expand the Early Head Start-Child Care Partnerships to preschool-age children through new Head Start — Child Care, Head Start — Pre-K, and Head Start — BIE partnership programs.

FEDERAL AGENCIES SHOULD:

- Fund a new NASEM study to examine equitable funding models across the ECE and K-12 education systems that consider historical and current marginalization, and disparities in access to resources, experiences, and outcomes.
- Require all applicants for federal ECE funding to include data on resource disparities in their communities, and describe how they will close such disparities and prioritize funding for the most marginalized communities. If funded, grantees should develop benchmarks and timelines, and report on their progress.
- Prioritize applicants for federal funding who propose to serve the most marginalized communities with less access to resources. In any existing or new competitive grants, the goal should be to *equitably* expand high-quality learning opportunities, measured in part by where, how, and to whom applicants propose to invest resources.

STATES AND TRIBES SHOULD:

- Consider historical and current marginalization and disparities in access to resources, experiences, and outcomes when allocating ECE resources, including child-care contracts, technical assistance, coaching, and professional development.
- Use tiered quality rating and improvement systems to provide larger reimbursement to programs serving historically marginalized communities and children and ensure livable wages for providers of color and those serving in these communities. Use Child Care and Development Fund quality funding to develop or expand efforts to support child care providers serving historically marginalized communities to enter rating systems. Tribes should receive additional funding to implement a quality rating system that incorporates their cultures and technical assistance when requested, and tribal consultation should be facilitated to determine how to best support tribes in this process.

[i] Early Head Start, Head Start, Migrant-Seasonal Head Start, and American-Indian Alaska Native Head Start and Early Head Start are collectively referred to as Head Start in these policy recommendations, unless otherwise specified.

2 MOVE TOWARD HOLISTIC, STRENGTHS-BASED, AND AUTHENTIC INTEGRATION.

Undoubtedly, Brown vs. Board of Education and the court cases that preceded and followed it were important victories for the civil rights of Black Americans and other people of color. Unfortunately, implementation has been incomplete and inadequate, and several court cases since have undercut and reversed some of the gains made. Today, our schools are on a trajectory, started over three decades ago, toward increased segregation.[3] And a recent study by the Urban Institute found that ECE programs are even more racially segregated than K-12 schools.[4]

Perhaps most importantly, desegregation in the years after Brown did not result in the holistic integration of children, staff, leaders, curriculum, and pedagogy. Indeed, part of the unmet potential of Brown was that it resulted only in physical desegregation of children, mainly on the backs of Black children who were physically, emotionally, and psychologically traumatized and terrorized. Desegregation orders ignored the value of Black teachers and administrators, Black-centered curriculum and pedagogy, and culturally-affirming family engagement. Implementation did not result in equity, and today, inequities in funding remain. What's more, other education levers have been exploited to re-segregate and continue this racist ideology, via gifted and talented programs, special education placement, and discipline, among others. It is critical that we continue the work started by civil rights leaders decades ago — in tandem with the other policy recommendations in this document — especially equitable funding, and move past desegregation to meaningful and holistic integration.

CONGRESS SHOULD:

- Fund a targeted, universal approach to ECE, where access to high-quality early learning experiences are accessible to all, but targeted comprehensive supports are available to those who have been most marginalized through systemic racism. This approach also requires that the most marginalized children are at the front of the line to receive services.
- In Head Start reauthorization, incentivize holistic, strengths-based, and authentic integration, especially socioeconomic integration, across all aspects of programmatic operations, that results in diverse educators and administrators, and culturally-affirming curriculum, pedagogy, and family engagement. Authorize and expand funding for the Early Head Start-Child Care Partnerships and expand the model to include Head Start-Child Care, Pre-K, and BIE partnerships.
- Fund new construction for early childhood programs, prioritizing tribal lands and physical locations that promote socioeconomic and racial integration, while not reducing access or creating more barriers for historically marginalized communities.

FEDERAL AGENCIES SHOULD:

- Prioritize ECE grant applicants who have a plan for socioeconomic and racial integration and who propose to expand slots in locations that enable greater integration.
- Issue guidance and technical assistance on funding models that bring together federal, state, tribal, and local funds for maximally integrated, inclusive, and supportive settings, and avoid siloed systems that can result in segregation by race, disability, income, or language.
- Require federal ECE grantees to use needs assessments to inform plans that increase holistic, strengths-based, and authentically integrated programs.

STATES AND TRIBES SHOULD:

- Develop plans to increase holistic, strengths-based, and authentic integration guided by community needs assessments. Collect and analyze data to inform the plan, including child demographics of enrollment by classroom and program, workforce and leadership diversity, and factors associated with culturally-affirming and responsive pedagogy.

3 EMBED EQUITY IN MONITORING AND ACCOUNTABILITY SYSTEMS.

Equity, and specifically the access, experiences, and outcomes of children from historically marginalized communities, in most cases, has not been centered in policymaking, and as a result, has been lacking or altogether absent in monitoring and accountability systems. There is no field-wide agreed-upon set of indicators for equity; but that is true of almost all ECE operations, including quality, and all of its subsidiaries, such as ratios, teacher qualifications, and pedagogy. We propose a set of indicators that can be used across standards, rating systems, and monitoring and accountability systems as a starting point, while acknowledging that there are many other possible indicators that can be tailored at the local level. Ultimately, it is critical that equity in access, experiences, and outcomes be monitored and incorporated into accountability systems.

EXAMPLE EQUITY INDICATORS FOR STANDARDS, MONITORING, AND RATING SYSTEMS

- Required training on the history of race, anti-racism pedagogy, and anti-bias approaches for all staff, starting at orientation and at least quarterly thereafter.
- Ongoing coaching and professional development on anti-racism pedagogy and anti-bias approaches.
- Culturally responsive, developmentally appropriate, and equity grounded curriculum and pedagogy.
- Curriculum, assessment, pedagogy, and family engagement linguistically accessible to families.
- Curriculum and pedagogy are delivered in a dual-language model if more than a third of children share the same home language.
- Bilingual lead teachers and other staff, if DLLs are served.
- Assessments are culturally responsive, strengths-based, and conducted in children's home language.
- Prohibition on harsh discipline and exclusionary practices.
- Ongoing disaggregated data collection and analysis to identify and rapidly address disparities.
- Policy on family engagement includes eliciting input from families on programmatic operations, stresses parent-teacher partnerships with an emphasis on relationship building to support children's learning, and promotes family wellness and leadership.
- No segregated or self-contained classrooms by funding stream that result in racial/ethnic, language, disability, or socioeconomic segregation.
- Continuously tracks and addresses racial and other forms of workforce compensation inequity.

CONGRESS SHOULD:

- ☑ Request annual Government Accountability Office (GAO) reports on equitable access to quality programming, quality experiences, and disparities in outcomes across ECE programs. Direct HHS, BIE, and ED to investigate areas of concern across each of those three measures and provide targeted technical assistance.

FEDERAL AGENCIES SHOULD:

- ☑ Ensure all federal ECE monitoring and accountability systems, including Head Start, child care, IDEA Parts C and B 619, BIE ECE programs, and Preschool Development Grants, explicitly include equity indicators (see above for examples). Ensure that these monitoring indicators inform accountability and renewals or continuations of funding.

STATES AND TRIBES SHOULD:

- ☑ Ensure all federal ECE monitoring and accountability systems, including Head Start, child care, IDEA Parts C and B 619, BIE ECE programs, and Preschool Development Grants, explicitly include equity indicators (see above for examples). Ensure that these monitoring indicators inform accountability and renewals or continuations of funding.

4 ADDRESS WORKFORCE EQUITY.

The ECE workforce is replete with inequities when examined by race, setting type, and job position, according to data from the Center for the Study of Child Care Employment at the University of California, Berkeley.[5] More white teachers are likely to be represented in school-sponsored ECE programs, which provide higher pay and benefits, but have a barrier to entry (i.e., credential) for many people of color, due to historical vestiges of racism and inequitable educational opportunities. Even when education is equated, Black ECE educators make 78 fewer cents per hour than their white peers.[6] Teachers of color are also overrepresented in aide/assistant teacher roles compared to white teachers, who are overrepresented in lead teacher roles. In addition, Black ECE educators are also overrepresented as infant/toddler teachers compared to white ECE educators. Importantly, rigorous research has found benefits to having access to same-race lead teachers. One study randomly assigned children in K-3 to a Black teacher and found that those children were significantly more likely to graduate from high school and enroll in college than their peers without similar access.[7] For dual language learners, access to lead teachers who speak their home language facilitates family engagement and is necessary for dual language instruction, which research finds is associated with improved academic and social-emotional outcomes.[8] Equitable representation in lead teacher positions and compensation — including pay, benefits, and workforce conditions — matter to the adults who do this critical work and to the children and the families whom they serve. It is critical that the ECE system address workforce inequities.

CONGRESS SHOULD:

- Increase funding for Child Care and Development Block Grant, including the tribal set aside, and direct states/tribes to use part of the funding to increase the value of the child care subsidy to increase workforce compensation.
- Increase funding for Head Start and direct grantees to increase workforce compensation, aligned with K-12 teachers in the community.
- Increase funding for existing teacher and education leadership scholarships, fellowships, and apprenticeship programs across the government, and prioritize Black, Indigenous, Latinx, other students of color, as well as bilingual students and students with disabilities. Increases in funding should include academic support services, allow students to receive college course credits for completing post-secondary courses during high school, and provide loan relief for students who are teaching or providing other ECE services in opportunity zones or child care deserts.
- Fund a new grant program that provides pathways for paraprofessionals and others in non-lead teacher roles, especially bilingual staff and staff of color, to attain the credentials, including higher education credentials, to become lead teachers.

FEDERAL AGENCIES SHOULD:

- Require pay parity, at a minimum, with K-12 teachers, across ECE programs that receive federal funds, regardless of age group taught. Strongly encourage greater compensation for non-school-based ECE programs to ensure benefit parity, including in tribal programs.
- Require states to track, report, and develop plans to address racial and other disparities in compensation and access to other publicly funded support systems, such as coaching and professional development. Work in partnership with tribal communities to track similar information.

STATES AND TRIBES SHOULD:

- Increase the value of child care subsidies to increase fairness in compensation, including pay and benefits, for child care providers.
- Track and develop plans to address racial disparities in compensation.
- Use tiered quality rating and improvement systems to provide greater compensation to bilingual ECE professionals and those serving historically marginalized communities.

5 EMBED EQUITY IN WORKFORCE PREPARATION AND DEVELOPMENT.

Equity is sorely missing or an inadequate component of ECE preparation (including higher education) and professional development systems, at all levels, including frontline staff, teachers, coaches, leadership and systems leaders. Anyone working in the ECE system should have comprehensive and sustained training on the history of race and racism, implicit bias and its manifestations in decision making, culturally responsive and sustaining practices and pedagogy, dual language learning, inclusive best practices, and building positive relationships with diverse families, among others. All credentials, including the Child Development Associate, Associate's degrees, Bachelor's degrees, and graduate degrees, should include as a condition of receiving the credential, an assessment that examines competency of working with children and families from diverse backgrounds. Recommendations to non-governmental organizations, like higher education, are outside the scope of this report. We recognize, however, that fundamental systems change must include partnership across preparation systems and government.

FEDERAL AGENCIES SHOULD:

- Bring together education, child care, and Head Start funds to develop a new technical assistance center focused solely on promoting equity in learning settings across the ECE system and the early grades, including in Tribal Nations, Indigenous communities, and migrant seasonal farmworker communities. This center would develop equity resources, training, and technical assistance for states, communities, professional preparation and workforce development systems, local education agencies, early intervention and special education systems, and ECE programs across the system, and ensure that equity is embedded in the work of other ECE technical assistance centers across both HHS and the Department of Education.
- Use executive actions to require workforce racial equity training and coaching for ECE providers working in publicly funded systems.
- Fund research on effective racial equity training models and approaches in ECE systems to work toward attaining quality control. Disseminate results through technical assistance systems, including systems that support tribal communities.

STATES AND TRIBES SHOULD:

- Ensure racial equity training content or coursework is required as part of child care, teacher, and administrator professional credentialing and licensing systems, and ongoing continuing education requirements.
- Expand the racial literacy of all coaches in the professional development system. All quality coaches, including pyramid model coaches, inclusion coaches, mental health consultants, and others, that operate in states should be knowledgeable about the history of race and systemic racism and how it manifests in learning settings, equipped to explicitly address disparity and bias, and provide coaching with an equity lens that builds on child and family strengths.

6 EXPLICITLY INCLUDE EQUITY IN THE DEFINITION OF QUALITY AND ACROSS RATING SYSTEMS.

The concept of quality drives resources and funding in the ECE system. Quality is written into legislation and regulation and has accompanying funding allocations. The ECE field has typically defined "quality" as some combination of teacher credentials, research-based curriculum and assessment, ratios and group sizes, access to comprehensive services, and teacher-child interactions among others.[9] Indicators that explicitly promote equity, via equitable experiences and equitable outcomes for children, have been almost universally excluded from this important definition and as a result, from Quality Rating and Improvement Systems (QRIS). Equitable supports for the workforce have been notably lacking, with women of color and non-center-based settings having less access to the supports needed to access and move through QRIS. As such, serious and legitimate concerns have been raised by advocates about whether QRIS is exacerbating inequities. We share these concerns and contend that substantial changes must be made to these systems. The field must explicitly include equity in the definition of quality and correspondingly, include it in every level of QRIS. A program simply cannot be deemed "quality" if its programming, experiences, and outcomes are inequitable. Just as important is ensuring publicly funded programs and their workforce – particularly programs serving children from historically marginalized communities — have the support they need to move up through QRIS. Too often, these rating systems ignore equity content in their indicators, are inaccessible to the providers who serve the most marginalized children, and penalize programs who are experiencing systemic barriers. It is critical that these systems be redesigned, in partnership with parents and providers, to center equity.

CONGRESS SHOULD:

- Ensure that any articulation of quality standards in legislation explicitly integrates equity as an indicator of quality, including issues related to access to resources, children's experiences, and outcomes.

FEDERAL AGENCIES SHOULD:

- Ensure that, moving forward, any federal funding for QRIS requires states to articulate how equity is integrated in indicators across all levels of their systems, includes parent and provider voice, and equitably gives supports to providers serving the most marginalized children, including family child care providers and others providing services in home-based settings, to move through the system.
- Provide policy guidance and technical assistance to states/tribes to encourage and support them in using their Child Care Development Fund quality funding to build more equitable systems through, for example, implementation of the policies and practices listed here.

STATES AND TRIBES SHOULD:

- Ensure their QRIS and similar quality initiatives include equity indicators at every level (see page 7 for examples) and provide targeted funding to support programs in meeting such indicators, especially programs serving historically marginalized communities and programs that have historically had less access to systemic resources, including family child care and other home-based providers.
- Use flexible federal funds intended to increase the quality of services to implement targeted state/tribal technical assistance, workforce development, and new policies to support more equitable systems.

7 ENSURE HIGH-QUALITY CURRICULUM AND PEDAGOGY ARE ACCESSIBLE AND CULTURALLY RESPONSIVE.

Curriculum and pedagogical approaches are the frameworks used to prepare the early learning environment and maximize educational opportunities for children. Unfortunately, the content of widely used pedagogies and curricula rarely (if at all) addresses equity. What's more, several pedagogical approaches and curricula that have been shown to support child development, referred to as "ideal learning approaches," have not been accessible to young children from historically marginalized communities. A recent report from Trust for Learning, *Ideals Pathways: How Ideal Learning Approaches Prepare and Support Early Childhood Educators*, cited several barriers to expanding such approaches, that have traditionally served and still often serve white and higher wealth families, such as Montessori, Waldorf, and Reggio.[10] One significant barrier is access to diverse and certified/accredited educators. For example, for educators to be certified in many of these approaches, there is a range in cost up to $70,000. Another barrier is the duration of certification programs which can vary between a series of immersive workshops to hundreds of formal study hours that require extended trips out of state. Exclusively English credentialing also serves as a barrier to many people of color. This lack of diverse high-quality pedagogical and curricula options, and the challenges associated with accessibility, further perpetuate historical marginalization.

FEDERAL AGENCIES SHOULD:

- Provide targeted technical assistance to states/tribes, communities, and ECE programs – especially those serving children from historically marginalized communities – in identifying high-quality pedagogical approaches and curricula.
- Fund research that identifies the most effective, culturally and linguistically responsive, and scalable pedagogical approaches and curricula across ECE settings.
- Develop and pilot a new measurement tool or set of tools that assess equitable learning opportunities — including pedagogy and curriculum — within ECE programs.

STATES AND TRIBES SHOULD:

- Include equitable access to learning approaches that are developmentally appropriate, child-centered, and play-based in-state/tribal QRIS.
- Provide targeted funding and technical assistance to expand access to these approaches in Pre-K and child care, prioritizing historically marginalized communities.
- Inventory schools and ECE programs currently using successful pedagogical approaches and curricula that result in closing opportunity gaps and disparities. Lift these examples up as models for other schools and programs to visit and learn from.

8 ENSURE GLOBAL CLASSROOM QUALITY MEASUREMENT EXPLICITLY ASSESSES EQUITABLE EXPERIENCES.

The most widely used global classroom quality measures include the Classroom Assessment Scoring System (CLASS) and the Environment Rating Scales (ERS). These tools have shown the importance of examining enriching opportunities, quality of teacher-child interactions, and instructional and learning supports for children.[11] Unfortunately, these observation instruments are limited in their attention to and incorporation of equity in relationships and teacher-child interactions, and do not measure bias in any form. They also do not yield information on individual child experiences and leave us with the question: if a classroom is rated a 5 in quality, does that translate to every child — particularly those who have been historically marginalized — getting a "5" experience? Considering the focus on improving classroom quality in learning settings, especially for marginalized children, there is a need to modify existing tools or develop new, practical, valid, and reliable observation tools that explicitly measure equity in opportunity inside learning settings. This will advance our efforts to identify and intervene on disparity in treatment and experiences.

CONGRESS SHOULD:

- In all upcoming ECE-related legislation, ensure that any requirements related to global classroom quality measurement include explicit measurement of equity indicators at the program or classroom level with a valid and reliable tool. Classroom quality measurements that do not explicitly address equity are insufficient in themselves.

FEDERAL AGENCIES SHOULD:

- Fund new research to identify, adapt, and develop feasible, valid, and reliable measurement tools that capture equity in global classroom quality measurement.
- Direct technical assistance system to support states/tribes and early childhood programs on measuring equity at the classroom and program levels.

STATES AND TRIBES SHOULD:

- Ensure that equity measurement at the program or classroom level is explicitly incorporated into any state or tribe funding or monitoring related to global classroom quality measurement via QRIS systems or otherwise.

9 ELIMINATE HARSH DISCIPLINE.

Harsh discipline, as defined here, includes expulsion, suspension, corporal punishment, seclusion, and inappropriate restraint. There is no evidence that these forms of discipline are effective in any sense; instead, there is an abundance of research that indicates that they are associated with negative child outcomes.[12] Research shows that suspension and expulsion, for example, are associated with school disengagement, grade retention, and school dropout.[13] Some of these forms of discipline start early and happen often. Some research indicates that the rate of *expulsion* in younger children is about three times that ofolder children, while other work on public Pre-K suspension, in particular, finds that the rate in younger children is lower than in their older peers.[14] Across all forms of harsh discipline, Black children are disproportionately affected, despite the fact that there is no evidence that they have worse or more frequent misbehavior, highlighting the insidious nature of racism and the strong presence of implicit bias in decision-making.[15] For example, recently released federal data from the 2017-18 school year indicate that Black boys make up 18 percent of male preschoolers, but 41 percent of male preschool suspensions, while Black girls make up just under one-fifth of female preschoolers, but account for more than half of female preschool suspensions.[16] American Indian/Alaska Native children are also often disproportionately affected, as are school-aged children with disabilities. This preschool pushout is perhaps the clearest manifestation of the systemic preschool-to-prison pipeline. Corporal punishment, which is legal in public schools in 19 states and in private schools in 48 states, is also a significant issue, even in young children. Federal data from the Civil Rights Data Collection indicate that 856 preschoolers were subject to corporal punishment in public Pre-K programs in the 2017-18 school year. Data on seclusion, the practice of locking children in a room alone without the ability to get out, is not collected nationally for young children, but a 2012 GAO report included case studies of young children, including a 4-year-old. These forms of discipline not only steal valuable learning time away from children, they also have devastating effects on children's feelings of safety and belonging, social and emotional development, family relationships, and school engagement. It is essential that the ECE system prohibit these harmful practices, attend to and address racial disparities in these and other forms of harsh discipline, and prioritize workforce preparation and development that is trauma-informed, explicitly anti-racist, and developmentally appropriate.

CONGRESS SHOULD:

- Pass discipline reform legislation to prohibit seclusion, corporal punishment, and exclusionary discipline in all programs that serve young children and receive public funding.
- Increase funding for culturally responsive and evidence-based social and emotional supports — via early childhood mental health consultants, counselors and psychologists, social-emotional curricula, and professional development opportunities that are grounded in anti-racist, social-emotional learning, including the development of a positive racial identity. Require state reporting on access to such supports, disaggregated by race, language, and disability.

FEDERAL AGENCIES SHOULD:

- Require states/tribes to report harsh discipline — including suspension, expulsion, seclusion, corporal punishment, and inappropriate restraint — disaggregated by race, gender, disability, and language in all ECE programs that receive public funding, including child care.
- Reinstate federal guidance to discourage the use of exclusionary and other forms of harsh discipline in learning settings. Monitor and deploy technical assistance to states with high rates and disparities.

STATES AND TRIBES SHOULD:

- Prohibit harsh discipline, including seclusion, corporal punishment, and exclusionary discipline in all ECE programs that receive public funding.
- Collect disaggregated data on the use of harsh discipline and support local communities on using discipline data systems, with an emphasis on disaggregating data to identify discipline decisions that are most vulnerable to implicit racial biases (i.e., vulnerable decision points).[17]
- Prioritize state/tribal funds for the use of interventions and personnel that positively and equitably support children's social and emotional development and wellbeing in ECE programs, including child care and Pre-K.

10 ADDRESS EQUITY IN EARLY INTERVENTION AND SPECIAL EDUCATION ACCESS, IDENTIFICATION, AND INCLUSION.

Children of color are generally underrepresented in early intervention and preschool special education services.[18] This is concerning given the robust research base indicating the importance and effectiveness of early intervention.[19] Even when children do have access to early intervention or preschool special education services, the programs are so chronically and severely underfunded that the dosage and quality of services varies widely and is often insufficient to meet children's needs. What's more, of preschoolers receiving special education services, over half receive services in settings segregated from their peers without disabilities.[20] Once children transition to the K-12 system, data indicate that racial/ethnic disparities exist in the types of disabilities children are *identified* with, with Black children being more likely to be identified under categories that require a greater degree of subjectivity in the diagnostic process; *placement*, with Black, Latinx, and Asian American children spending less time in general education settings than their peers; and *discipline*, with children of color with disabilities being disciplined at higher rates than their white peers.[21]

CONGRESS SHOULD:

- Fully fund IDEA, including Parts B Section 619 and C.
- Increase funding for Part D of IDEA to increase monitoring and accountability - particularly those related to preschool placement and the provision of the least restrictive environment; ramp up implementation of the Equity in IDEA rule;[ii] and expand technical assistance to states/tribes and communities in providing high-quality inclusive learning to children with disabilities, especially children of color with disabilities.
- Request a Government Accountability Office report on barriers to access to early intervention and preschool special education for infants, toddlers, and preschoolers of color with disabilities. Direct the U.S. Department of Education to develop and implement a plan to close that gap and ensure Tribal Nations are included in this plan.

FEDERAL AGENCIES SHOULD:

- Ensure that all IDEA data reported to the federal government – including outcome data — are disaggregated by race, disability, gender, and home language.
- Fund a new technical assistance center focused exclusively on equity in IDEA, with an emphasis on bridging disparities in access to services, identification, inclusion, and discipline across the early childhood through K-12 continuum. Publish an annual report reviewing state progress in equitably expanding opportunity across all of these measures.

STATES AND TRIBES SHOULD:

- Identify segregated preschool special education programs and invest in meaningful structural reforms to expand high-quality inclusion, including working with local communities and districts to adjust budgets and staffing structures; promote co-training and coaching with early educators, special educators, and early interventionists with an explicit focus on equity and the intersection between disability and race; invest in itinerant teaching and other co-teaching models; and facilitate formal partnerships between local education agencies and community-based early childhood programs to expand the number of inclusive slots.
- Track and address racial, income, disability, and language background disparities in access to services, identification, inclusive placements, discipline, and high-quality supports and accommodations for young children with disabilities. Use data to deploy technical assistance and support to districts/communities with the largest disparities.

[i] https://www.govinfo.gov/content/pkg/FR-2016-12-19/pdf/2016-30190.pdf

11 IMPLEMENT A DATA-DRIVEN CONTINUOUS EQUITY QUALITY IMPROVEMENT CYCLE.

The concept of continuous quality improvement (CQI) is well known and widely used across the ECE system. Research indicates that continuous data-driven decision-making contributes to improvements in academic performance, teacher effectiveness through professional development, and program quality — and is a tool for communicating with stakeholders.[22] However, CQI efforts too often lack in their focus and attention to equity. All ECE programs should engage in a CQI process that centers equity. It should include the use of disaggregated data to inform practice and policy change with the goal of closing opportunity gaps and disparities in outcomes. Access to data is also key to improving opportunities for Tribal Nations, and, as in every other domain, tribal consultation must be honored in this process.

CONGRESS SHOULD:

- Require that all data reported to the federal government are disaggregated, at the very least, by race/ethnicity, language, and disability. Across legislation, encourage the use of and funding for continuous equity quality improvement systems.

FEDERAL AGENCIES SHOULD:

- Require all child-serving programs that receive federal funding to collect and report disaggregated data on access, experiences, and outcomes, and report how they are using the data to close racial opportunity gaps and outcomes. Tribal consultation should be honored throughout this process to ensure respectful use as determined by tribes.

- Ensure all data-focused technical assistance centers provide support through an equity lens, including ensuring that all data are disaggregated, understanding how to calculate disproportionality and identify vulnerable decision points, and ensuring that data are analyzed and used to inform professional development and programmatic or school policy change.

STATES AND TRIBES SHOULD:

- Invest in coordinated ECE data systems and ensure that they are used to track access, experience, and outcome disparities, feed information back to ECE programs and districts, and use information to target resources to remedy inequities in a timely manner. Tribal consultation should be honored throughout this process.

12 EXPAND FAMILY LEADERSHIP AND ENGAGEMENT EFFORTS.

Families are children's first, primary, and longest-lasting teachers.[23] Their funds of knowledge are invaluable.[24] They must be more meaningfully centered in early childhood systems, especially Pre-K and child care systems. Head Start was founded to center families and has made the most significant strides in partnering with diverse families. The Head Start National Center for Parent, Family, and Community Engagement framework states that "parent and family engagement...is about building relationships with families that support family well-being, strong relationships between parents and their children, and ongoing learning and development for both parents and children." Family engagement is further described in Head Start's framework as focusing on building relationships and partnerships with families through reciprocal and culturally-responsive interactions with the goal of supporting families and parents to support the development and learning of their children. Thus, the outcome is the empowerment of families and parents as life-long learners and educators for the benefit of the child, family, and community. Unfortunately, ECE systems are challenged with meeting the needs of families, especially families of color, linguistically diverse families, immigrant families, and families with children with disabilities. This is particularly problematic now, as COVID-19 continues to upend typical learning systems and families play an even more critical role in education. A central focus of building more equitable ECE systems must be better, more meaningful family engagement and partnerships.

CONGRESS SHOULD:

- Promote family governance and meaningful culturally-responsive family engagement across the ECE system in legislation through standards, data reporting requirements, and targeted funding, and encourage cross-system alignment with the Head Start's Parent, Family, and Community Engagement Framework.

FEDERAL AGENCIES SHOULD:

- Collect meaningful family engagement data from federal ECE grantees, in line with the National Academies of Science Engineering and Medicine report *Parenting Matters: Supporting Parents of Children Ages 0-8*.[25]
- Require applications for federal funding to include plans for equitably fostering family engagement in culturally-responsive ways and in families' home languages with attention to shared decision-making (i.e., family governance council). Prioritize those that align most closely with the Head Start's Parent, Family, and Community Engagement framework.
- Fund new research to develop and evaluate measurement tools that meaningfully capture the effectiveness of family engagement strategies that include family participation, voice, and reciprocity. Disseminate research learnings through the technical assistance system.

STATES AND TRIBES SHOULD:

- Ensure all state/tribal needs assessments across ECE systems include data about the strengths, needs, and social capital of families, as well as inclusion of family participation, voice, and reciprocity.
- Implement a hub model for state/tribal child care systems, including family child care and family friend and neighbor care, where providers can jointly invest in — and share access to — family engagement coordinators or specialists who provide meaningful family engagement opportunities, connect families to community services as needed, conduct staff training, and engage in consultation with administrators on how to embed family engagement across programmatic operations.
- Ensure meaningful family engagement indicators are included in state standards and quality rating systems across levels (see *2016 HHS-ED Policy Statement on Family Engagement* or *Parenting Matters: Supporting Parents of Children Ages 0-8*, for examples).

13 CENTER FAMILY CHILD CARE.

Family child care is a central — and too often overlooked — part of the ECE system. In many communities, this type of setting may be more likely to be culturally responsive, with providers who share a home language with the families they serve.[26] This sector of the field has innumerable strengths and can inform other setting types. It is an especially crucial part of the infant/toddler child care system, and may be an increasingly popular choice among families during the COVID-19 pandemic. Yet, too often, family child care providers are left out of quality initiatives and do not get equal or equitable access to supports and resources, compared to center-based child care settings. The same is true, to an even larger extent, of family, friend, and neighbor (FFN) care, which serves a critically important function to support children and help families in many communities. It is imperative that an ECE equity reform agenda include and extend resources to family child care and other home-based care settings.[27]

FEDERAL AGENCIES SHOULD:

- Ensure technical assistance efforts explicitly include resources tailored to family child care and other home-based providers and leaders. Develop tools that build off of providers' strengths, and that support equitable and quality experiences for young children in their home language.
- Strongly encourage the inclusion of family child care providers — particularly those operating in child care deserts and those serving historically marginalized communities — in Early Head Start-Child Care Partnerships.

STATES AND TRIBES SHOULD:

- Ensure family child care and other ECE home-based providers are included in needs assessments, workforce development, and technical assistance efforts, and receive equitable support to access and move up QRIS.
- Use child care quality funding to develop and grow family child care networks where providers can access shared professional development opportunities, including on anti-bias and anti-racism programming, dual language immersion models, curriculum and assessment, social-emotional development, and family engagement through an equity lens. Use hubs to connect children, families, and providers to comprehensive services in the community, as needed.
- Prioritize building family child care supply and networks in child care deserts.

14 EQUITABLY EXPAND ACCESS TO DUAL LANGUAGE IMMERSION APPROACHES FOR DLLS.

Dual language learners (DLLs) make up about one third of all young children under age 8, the most of whom speak Spanish at home.[28] These children are diverse by every measure and receive ECE services across the system. They bring a host of cultural and linguistic strengths to learning settings across the country that are often overlooked, including bilingualism. Research demonstrates that bilingualism is associated with cognitive advantages early in life and economic benefits later in life.[29] DLLs who receive instruction in their home language alongside English outperform their peers in English-dominant models in math and reading, in both English and the partner language.[30] The potential social and emotional benefits, including positive racial/ethnic identity development, feelings of pride, competence, and belonging, and the more direct access for engagement opportunities for families who do not speak English are equally, if not more, critical. Unfortunately, few DLLs have access to this type of dual language programming, and most ECE settings, like K-12, provide instruction exclusively in English. This English-only approach is not aligned with science and is inappropriate for young DLLs. Although bilingual learning models are growing in popularity and expanding across the country, preliminary research shows that such expansion is not happening equitably. It appears that the very children who have the most to gain from such models, and the most to lose without them, are under-represented in these programs.[31] This disturbing pattern represents a profound inequity: Bilingualism is seen as a strength in some children, namely more affluent, white, native English speakers, and as a deficit in others, including DLLs who bring the gift of bilingualism from the home. This inequity must be addressed across the ECE system.

CONGRESS SHOULD:

- Invest in building capacity to expand dual language immersion opportunities for the youngest learners through a new grant program, and ensure that DLLs have priority for new slots. Ensure this program includes an explicit focus on countering the effects of assimilation policy for Indigenous children and offers support to expand Native language preservation programs.
- Invest in teacher preparation and alternative certification programs to increase the supply of qualified bilingual early educators, including specific pathways and supports for existing bilingual ECE staff who may be in paraprofessional or aide roles.

FEDERAL AGENCIES SHOULD:

- Add data on access to dual language immersion or other bilingual learning models in the Civil Rights Data Collection at the U.S. Department of Education.
- Invest in designing, piloting, and evaluating effective dual language and bilingual learning approaches, including Native language preservation models for Tribal Nations, in infant/toddler child care, preschool, and elementary school settings to ensure continuity. Disseminate lessons learned and embed effective models across learning settings through technical assistance systems.
- Invest in developing new program quality measurement instruments to assess the quality of bilingual learning models.
- Provide more technical assistance on the Planned Language Approach.[iii] Ensure targeted dissemination beyond Head Start, to the broader ECE field.
- Ensure that Head Start monitoring and accountability systems are in line with new Head Start Program Performance Standards that require that DLLs receive formal exposure to their home language and English through instruction and other social learning opportunities.

STATES AND TRIBES SHOULD:

- Adopt Head Start DLL standards in state-funded Pre-K and incorporate standards into monitoring and accountability frameworks.
- Invest in producing the workforce necessary to support DLLs, including by creating nontraditional pathways to becoming a lead bilingual teacher and improving existing teacher preparation pathways in higher education to reflect research on dual language learning. Ensure these efforts include an explicit focus on workforce supports targeted at expanding capacity for Native language preservation opportunities in Tribal Nations.

https://eclkc.ohs.acf.hhs.gov/culture-language/article/planned-language-approach

CONCLUSION

The reforms listed here do not work in isolation, but combined can make significant strides in bringing greater equity in **access, experiences, and outcomes** for young children. Paired with the hard work and advocacy of grassroots leaders and families across the country, these recommendations provide actionable and important steps toward ensuring our system actively identifies systemic racism and closes opportunity and outcome gaps.

Of course, young children and their families exist and interact with multiple systems, directly and indirectly, in their early years and throughout their lives. Changes to the ECE system alone will not solve the inequities and disparities in access to resources and opportunities children face, especially Black children and other children of color. Paired with these reforms, it is also critical to support policies that address the myriad of inequities that affect Black, Indigenous, Latinx and other communities of color.

It is essential to address the racial wealth gap, equitable access to health care for families; access to clean drinking water and toxin-free living and learning environments; affordable housing; humane immigration that prioritizes keeping families together; and a fair, unbiased criminal justice system.

The racial reckoning that has taken hold in small towns and large cities across the U.S. this year presents a critical opportunity to make meaningful, sustainable, and structural change in this country. The ECE system must be at the heart of that change. The priorities and accompanying policies presented here, paired with reforms across all U.S. systems, will help bring us closer to equity, inclusion, and opportunity for all, a notion that has to date, only been an illusion for too many, for far too long.

Combined, the reforms listed here can make significant strides in bringing greater equity in access, experiences, and outcomes for young children.

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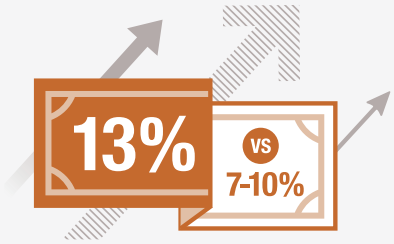
The Economics of Early Childhood

Quality birth-to-five early childhood education delivers the greatest return on investment.



HIGHER RETURNS THAN PRESCHOOL ALONE Every dollar invested in high-quality birth-to-five early childhood education for disadvantaged children delivers a 13% annual return on investment, significantly higher than the 7-10% return delivered by preschool alone.

THERE IS NO FADEOUT Unlike other early childhood programs, ABC/CARE shows lasting gains in IQ. Lasting boosts in cognition and socio-emotional skills drive better education, health, social and economic outcomes.

QUALITY PROGRAMS ARE COMPREHENSIVE Starting from birth, integrating early health and nutrition with early learning, providing reliable child care and having a developmentally focused program delivered by nurturing teachers and skilled professionals lead to better outcomes.

CHILD CARE HELPS MOMS Quality care and learning provided five days a week for five years gave ABC/CARE mothers the time to enter the workforce, build skills and advance careers and income–while their children gained the skills to become productive adults. The program pays for itself within five years just based on income gains among mothers who re-enter the work force.

RELEVANT AND READY FOR IMPLEMENTATION TODAY
ABC/CARE has informed many of today's comprehensive high-quality programs, including Educare and North Carolina's Smart Start and NC Pre-K.

It pays to invest in comprehensive, high-quality, birth-to-five early childhood education. **Learn more at www.heckmanequation.org.**

Heckman
The economics of human potential.

There's more to gain by taking a comprehensive approach to early childhood development.

James J. Heckman is the Henry Schultz Distinguished Service Professor of Economics and Director of the Center for the Economics of Human Development at the University of Chicago, a Nobel Laureate in economics and an expert in the economics of human development.

Start at birth, coordinate services into comprehensive early childhood programs and achieve greater economic and social gains. Professor Heckman's latest research, "The Lifecycle Benefits of an Influential Early Childhood Program," shows that high quality birth-to-five programs for disadvantaged children can deliver a 13% per year return on investment—a rate substantially higher than the 7-10% return previously established for preschool programs serving 3- to 4-year-olds. Heckman, his University of Chicago colleague Jorge Luis García, Duncan Ermini Leaf of the Leonard D. Schaeffer Center for Health Policy and Economics at University of Southern California, and María José Prados of the Dornsife Center for Economic and Social Research at University of Southern California, find that significant gains are realized through better outcomes in education, health, social behaviors and employment.

A past program that's very relevant today.

Lifecycle Benefits analyzes the effects of two identical, randomized-controlled preschool experiments conducted in North Carolina in the 1970's: The Carolina Abecedarian Project (ABC) and the Carolina Approach to Responsive Education (CARE). They offered comprehensive developmental resources to disadvantaged African-American children from birth to age five, including nutrition, access to healthcare and early learning. Children were randomly assigned into either the treatment group or a control group that had access to alternatives such as lower quality center-based care or in-home care. Given that many high-quality programs today include the components central to ABC/CARE, evidence from ABC/CARE is relevant today. About 19% of all African-American children would be eligible for the program today. And, research shows that the negative effects of a disadvantaged early childhood are similar across races.

Rich data provides insight into long-term benefits.

Existing research on the effectiveness of early childhood programs largely focuses on short-term academic gains when it is long-term benefits that provide a more relevant measure of value. *Lifecycle Benefits* analyzes a wide variety of life outcomes, such as health, the quality of life, participation in crime, labor income, IQ, schooling and increases in mothers' labor income as a result of subsidized childcare. ABC/CARE collected data on the participants throughout childhood and well into adulthood, allowing for an in-depth analysis of long-term effects in multiple dimensions of human development. From birth until the age of 8, data were collected annually on cognitive and socio-emotional skills, home environments, family structure, and family economic characteristics. After age 8, data on cognitive and socio-emotional skills, education, and family economic characteristics were collected at ages 12, 15, 21, and 30. In addition, there is a full medical survey at age 35 and detailed records of any criminal activity.

The Heckman Equation

The benefits of high quality starting at birth.

Children who received treatment had significantly better life outcomes than those who did not receive center-based care or those who received lower quality care. 75% of the control group children were enrolled in relatively low quality alternative childcare centers, usually after age 3; others stayed at home. Consistent with other research, results varied by gender. For females, ABC/CARE had positive effects on high school graduation, years of education, adult employment and the adult labor incomes of participants and their parents. These treatment results are higher when compared with the alternative of staying exclusively at home. The results for males show lower drug use and blood pressure, as well as positive effects on education and later labor income. The results for employment, hypertension, and blood pressure are higher when the treatment group is compared to the children who attended alternative childcare centers. Separation from the mother and being placed in relatively low quality childcare centers have far more negative consequences for male subjects than for female ones. This suggests that high program quality is necessary to generate quality outcomes.

A two-generation effect on workforce.

ABC/CARE improved the economic prospects of treated children and their mothers, allowing the latter to enter the workforce and increase earnings while their children gained the foundational skills to make them more productive in the future workforce. ABC/CARE provided childcare to the parents of treated children for more than nine hours a day for five years. Only 27% of mothers of children lived with a partner and this status barely changed during the program, making employment critical for upward mobility. Childcare generates positive effects in maternal education, labor force participation, and parental income.

Comprehensive quality care pays off.

While the costs of comprehensive early childhood education are high, the rate of return of programs like ABC/CARE imply that these costs are good investments. Every dollar spent on high quality, birth-to-five programs for disadvantaged children delivers a 13% per annum return on investment. These economically significant returns account for the welfare costs of taxation to finance the program and survive a battery of sensitivity analyses. The cost of ABC/CARE was $18,514 in 2014 U.S. dollars. The average cost of childcare alone in the United States ranges from $9,589 to a high of $23,354 with few assurances of the quality necessary to generate quality life outcomes for children.[1]

A call to do more and better for disadvantaged children.

Child poverty is growing in the United States; investing in comprehensive birth-to-five early childhood education is a powerful and cost-effective way to mitigate its negative consequences on child development and adult opportunity. Elements of the ABC/CARE program exist today through a number of often disjointed home visiting, child well-being, nutrition, early learning, childcare and preschool programs. Policymakers would be wise to coordinate these early childhood resources into a scaffolding of developmental support for disadvantaged children and provide access to all in need. The gains are significant because quality programs pay for themselves many times over. The cost of inaction is a tragic loss of human and economic potential that we cannot afford.

[1] Schulte, Brigid, and Alieza Durana. "The New America Care Report." Better Life Lab (2016): 1-104. Web. 29 Nov. 2016.

García, Jorge Luis, James J. Heckman, Duncan Ermini Leaf, and María José Prados. "The Life-cycle Benefits of an Influential Early Childhood Program." (2016): n. pag. Web.

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The Heckman Equation project is made possible with support from the Pritzker Children's Initiative.

OPPORTUNITIES LOST:

How Child Care Challenges Affect Georgia's Workforce and Economy

GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

METRO ATLANTA CHAMBER

OPPORTUNITIES LOST:

How Child Care Challenges Affect Georgia's Workforce and Economy

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Design by **GEEARS**: Georgia Early Education Alliance for Ready Students

EXECUTIVE SUMMARY

A growing body of evidence underscores the value of early childhood education for both children and their parents, providing the former with a strong educational foundation and allowing the latter to work or obtain job training. Child care challenges, whether a result of systemic barriers to access or the cumulative impact of inconsistent or unreliable care, affect parents' participation in the workforce and can have far-reaching effects for families, employers, and the state's economy as a whole. Recent reports from two states, Louisiana and Maryland, suggest that such child care challenges lead to significant costs to families, employers, and the states' economies.

Building on the work of our partners in these states, we set out to examine such issues in Georgia. In mid-2018, a polling firm surveyed Georgia parents of children under 5 to better understand the intersection of workforce participation (including participation in work training and postsecondary programs) and child care challenges. The results are alarming. Child care challenges in Georgia are leading to significant disruptions to parental workforce participation—both in the short (e.g., missed days at work or school) and long (e.g., leaving the workforce) term—and to the state's economy.

Child care challenges lead to at least

$1.75 BILLION IN LOSSES

in economic activity annually and an additional $105 MILLION in lost tax revenue.

	Economic Loss Estimate (Millions)	State Income Tax Revenue Loss (Millions)
Absences	$331.1	$19.9
Turnover	$1422.1	$85.3
Total	**$1753.2**	**$105.2**

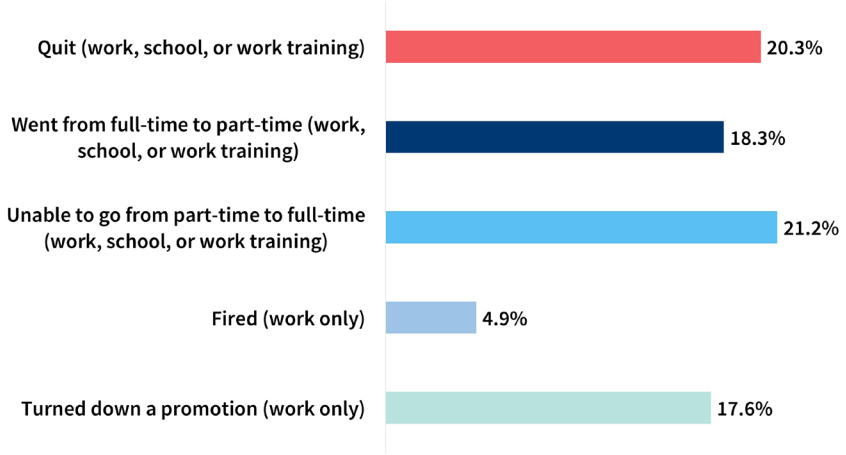
of Georgia parents of children under 5 reported a significant disruption to their or a family member's employment (quitting, not taking, or greatly changing a job) in the past year.

OPPORTUNITIES LOST:

How Child Care Challenges Affect Georgia's Workforce and Economy

Child Care Challenges Affect Georgia Parents' Workforce Participation in a Variety of Ways

Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training Resulting from Child Care Challenges



Georgia Parents Miss a Significant Amount of Work or Schooling Due to Child Care Challenges

Days Missed, Tardy, and Left Early (last 6 months) Due to Child Care Challenges

	1-5 Days	6-10 Days	>10 Days
Missed Work (among those employed)	37.4%	12.4%	7.1%
Missed School (among those enrolled)	29.8%	11.2%	22.2%
Missed Work Training (among those enrolled)	38.0%	22.2%	--------
Arrived late (work, school, or work training)	30.1%	13.0%	5.7%
Left early (work, school, or work training)	40.7%	10.2%	1.8%

The impact of child care challenges is felt by Georgia families, employers, higher education institutions, work training programs, and the state as a whole. Georgia's current and future economy depends upon an educated, stable workforce. As business and state leaders focus on increasing the number of skilled employees, particularly in Georgia's high-demand sectors, they should prioritize and pursue practices and policies that will better support both parents and our youngest learners who represent the workforce of tomorrow.

INTRODUCTION

A large and growing body of research points to the importance of children's experiences during the early years, when brains are developing most rapidly,[1] and to the benefits of early childhood education (ECE) for children, families, and society at large. Recent research from Nobel Laureate economist James Heckman suggests that comprehensive, high-quality early childhood education yields a 13% return on investment through improved outcomes in health, education, social behaviors, and employment.[2] High-quality child care affords benefits to parents, too, enabling them to support their families and further their careers, whether participating in the workforce or attending school or work training programs. In Georgia, 65% of children birth through age 5 have all available parents (i.e., either both parents or their only parent) in the workforce,[3] meaning that most parents in the state require consistent child care to attend work and support their families. Without access to reliable, quality child care, employees and employers both suffer. Parents may have to miss work, turn down advancement opportunities, or even leave a position in order to address child care challenges. Such challenges likely affect parents enrolled in school or work training programs, as well. Employee absences and turnover affect employers' bottom lines, and reduced participation in higher education and work training programs stifles the development of the state's workforce.

Despite a growing understanding of the many benefits of ECE—for children, parents, and communities—its specific impact on employers, working families, and the broader economy is less clear. This report considers how child care issues—which may reflect systemic barriers to access or the cumulative impact of inconsistent or unreliable care—affect Georgia's workforce and the state's economy. It builds on findings from similar reports recently released in Louisiana and Maryland that underscore the significant cost of child care challenges or instability. In both states, child care issues were found to lead to considerable short- (e.g., missed days) and long-term (e.g., quitting a job) disruptions to parents' participation in the workforce, school, and work training programs. In Louisiana, employee absenteeism and turnover related to child care issues resulted in an estimated $1.1 billion loss annually for the state's economy and an $84 million loss in annual tax revenue.[4] In Maryland the figures were even higher: $1.28 billion and $117 million, respectively[5]. These reports informed the present study's development and methodology. The report that follows is the first of its kind in Georgia and sheds important light on a phenomenon previously unstudied in the state. While prior research suggests that the child care industry itself generates a significant amount of economic activity in Georgia—$4.7 billion in 2013[6] —less was known about the effect of child care on parents' participation in the workforce and subsequent economic impact to the state. This report describes how child care challenges affect parental participation in the workforce, work training programs, and higher education, and, consequently, Georgia's economy. The implications are significant for families, employers, and the state of Georgia as a whole.

[1]Center on the Developing Child (2009). *Five numbers to remember about early childhood development* (Brief). Retrieved from www.developingchild.harvard.edu.
[2]García, J. L., Heckman, J. J., Leaf, D. E., & Prados, M. J. (2017). *Quantifying the life-cycle benefits of a prototypical early childhood program* (No. w23479). National Bureau of Economic Research.
[3]U.S. Census Bureau, American Community Survey (2012-16).
[4]Louisiana Policy Institute for Children (2017). Losing ground: *How child care impacts Louisiana's workforce productivity and the state economy.*
[5]Maryland Family Network (2018). Counting our losses: *The hidden cost to Marylanders of an inadequate child care system*.
[6]Georgia State University Andrew Young School of Policy Studies & University of Georgia Carl Vinson Institute of Government (2016). *Economic impact of the early care and education industry in Georgia*. Revised.

OVERVIEW AND METHODOLOGY

The present report addresses three general areas of inquiry related to parents' child care challenges and their participation in Georgia's workforce and higher education and work training programs: 1) What long-term disruptions to employment or schooling—such as quitting or significantly changing a job—do parents of children under 5 experience as a result of issues with child care? 2) What short-term disruptions—such as missing or arriving late to work or class—do parents experience? 3) What is the estimated economic impact to the state?

With assistance from the authors of the Louisiana report,[4] we created a survey instrument that included items regarding parents' employment and participation in school or work training programs, child care arrangements, and demographics. A polling firm administered interviews via telephone as well as online. Interviews were stratified by age, race/ethnicity, socioeconomic status, gender, and geography to best reflect the actual demographic composition of Georgia parents with children ages 0-4. The total sample included 400 Georgia parents with children under age 5. See Appendix A for a full description of the sample, weighting, and additional methodological details.

Respondent Demographics

GENDER

56% Female 44% Male

RACE/ETHNICITY

53% White
36% Black
4% Asian
7% Other/Multiracial

13% Hispanic/Latino

MEAN AGE

34.1 years

MARITAL STATUS

61% married
32% single
5% divorced or separated

CHILD CARE ARRANGEMENTS (PRIMARY)

Note: Multiple responses accepted for those with more than one child.

52% home with parent/guardian

26% child care center

15% with family/friend

9% local school system

5% family child care home

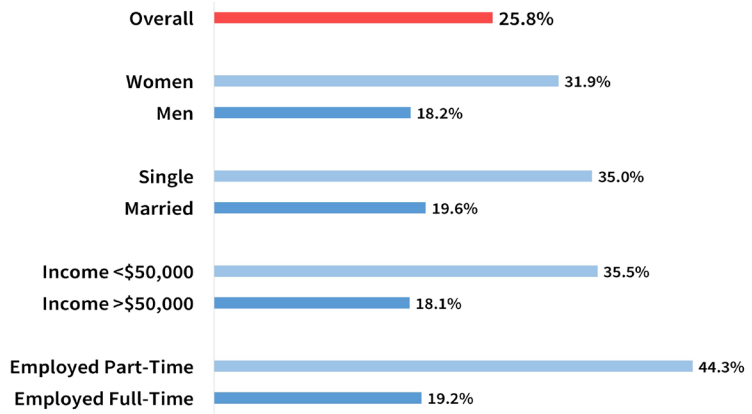
3% Head Start program

LONG-TERM DISRUPTIONS TO PARENTAL PARTICIPATION IN THE WORKFORCE

First we considered how child care challenges affected long-term parental participation in the workforce, work training programs, and higher education. In order to allow for comparisons to national data, our survey included an item that has been featured in the National Survey of Children's Health (NSCH)[7] in its two most recent administrations (2011-2012 and 2016). The NSCH asked parents of children birth through age 5: "During the past 12 months, did you or anyone in the family have to quit a job, not take a job, or greatly change a job because of problems with child care?" Over a quarter of our respondents—25.8%—responded "yes" to this question, signaling that child care challenges are causing significant disruptions to Georgia parents' participation in the workforce. 2016 NSCH data indicate that, nationally, 13.7% of parents reported such disruptions, although it should be noted that the respondents in the Georgia survey were asked a series of questions specifically focused on child care and perhaps subsequently "primed" to respond to such a question, whereas the NSCH is a broader survey of children's overall health. Those responding to the Georgia survey also reported a higher incidence of employment disruption than their counterparts in Louisiana (20.9%)[4] and Maryland (14.7%)[5], where the same[8] question was posed in their respective instruments. As indicated in Figure 1, women and those who were single, had an annual household income under $50,000, and were currently employed part-time were more likely to report employment disruptions.

More than a quarter of Georgia parents of children under 5 reported that, in the past year, they or someone in their family experienced a significant disruption to employment—quitting, not taking, or greatly changing a job—due to challenges with child care.

FIGURE 1. Incidence of Significant Job Change in Family (last 12 months) due to Problems with Child Care



[7]Health Resources and Services Administration Maternal and Child Health Bureau (2016). National survey of children's health.
[8]The Louisiana survey did not specify a time frame (i.e., "ever" as opposed to "the last 12 months").

MORE THAN 1 IN 5
Georgia parents of children under five indicated that they had quit a job, school, or a work training program due to child care issues.

Roughly 1 IN 20 Georgia parents of children under five reported having been fired as a result of missing work due to challenges with child care.

MORE THAN 1 IN 6
reported having turned down a *promotion at work* because of issues with child care.

Child care challenges can affect parents' long-term participation in the workforce in a number of ways. Parents may have to quit a job, school, or work training program, significantly reduce hours, turn down an advancement or enrollment opportunity, or even be fired. Over one-fifth (20.3%) of Georgia respondents indicated that they had quit a job, school, or a work training program due to child care issues, with 14.4% specifically reporting having left a job, 6.9% having left school, and 3.8% having left a work training program. Furthermore, roughly 1 in 20 (4.9%) reported having been fired as a result of missing work due to challenges with child care. Parents also reported having had to make significant changes to the number of hours worked—either needing to move from full-time to part-time employment or being unable to move to full-time from part time. Overall, 18.3% of parents reported having had to go from full-time to part-time employment (13.7%) or enrollment in school (6.5%) or work training programs (2.7%). Even more parents—21.2% of respondents—reported that they were unable to move to full-time employment or enrollment, with 16.3% specifically reporting such an impact at work, 7.4% at school, and 4.1% at work training programs. Finally, parents reported turning down career advancement opportunities, including promotions at work and opportunities to enroll in school or work training programs. More than 1 in 6 (17.6%) of total respondents, and a notable 40.1% of Hispanic respondents, specifically reported having turned down a promotion at work because of issues with child care. Nearly 1 in 4 (24.4%) reported having turned down an opportunity to enroll in school or work training programs, including 40.3% of those who reported their employment status as part-time. In general, as Figures 3-6 illustrate, particular respondent groups were more likely to report long-term career disruptions resulting from child care issues: women, those with a household income less than $50,000, single individuals, and those under age 30.

FIGURE 2.
Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training Resulting from Child Care Challenges

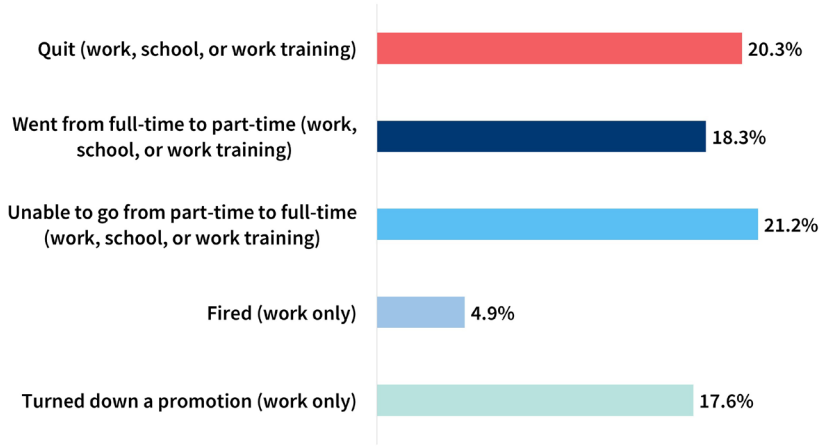


FIGURE 3. Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training, by Gender

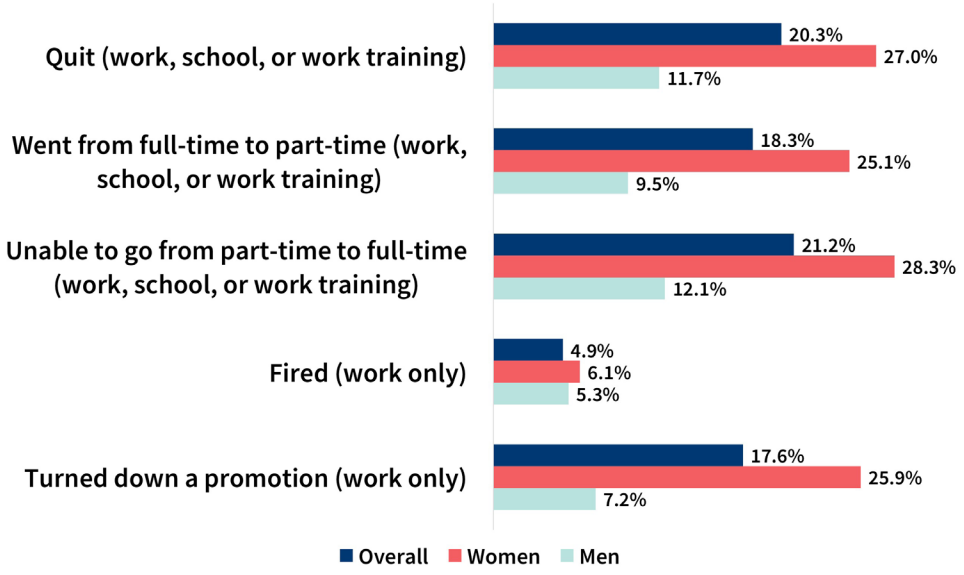
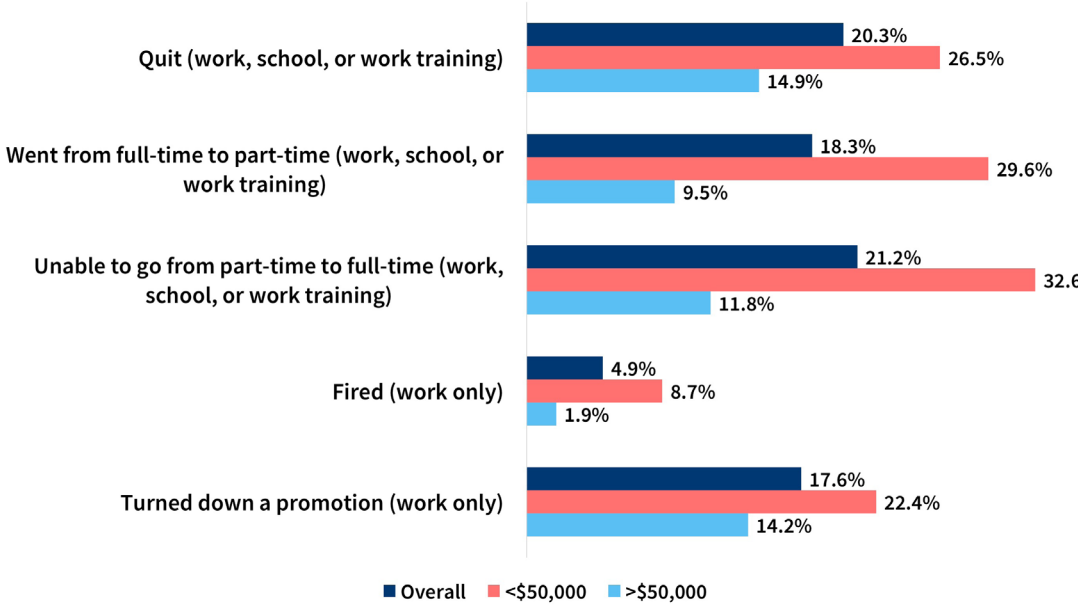


FIGURE 4. Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training, by Household Income



Impact on Postsecondary and Work Training Programs

Child care challenges disrupt not only parents' employment but also their ability to complete credentials or degrees that will advance their careers.

- **Nearly a quarter** of surveyed parents reported turning down an opportunity to enroll in school or participate in a work training program as a result of child care issues
- Overall, 7.0% of respondents reported having been dropped from a roster at school or a work training program as a result of child care issues
  - **15.9%** of those **currently attending school**
  - **30.9%** of those **currently enrolled** in a work training program
- Among those currently enrolled in such programs, **46.2%** *missed school in the past 6 months* due to child care issues, and **68.8%** missed work training, forgoing an average of **2.3** and **3.3 days**, respectively

FIGURE 5. Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training, by Marital Status

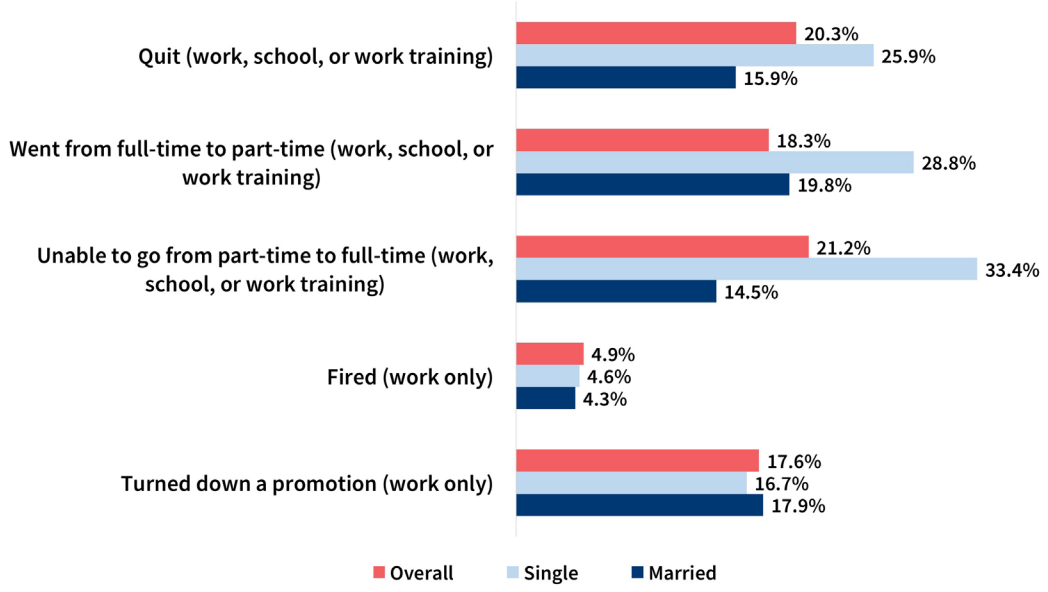
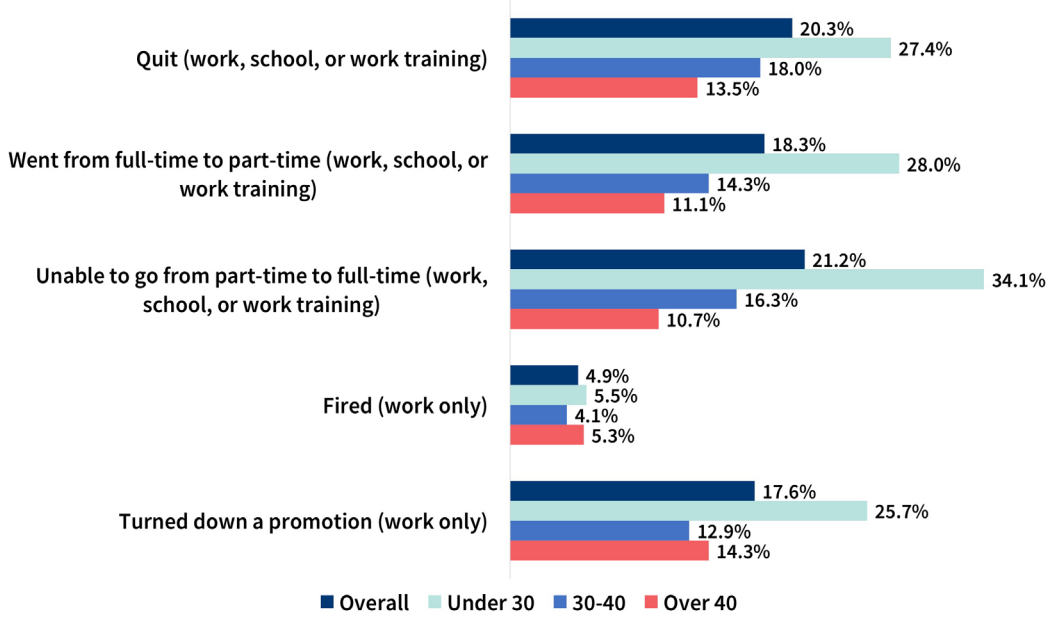


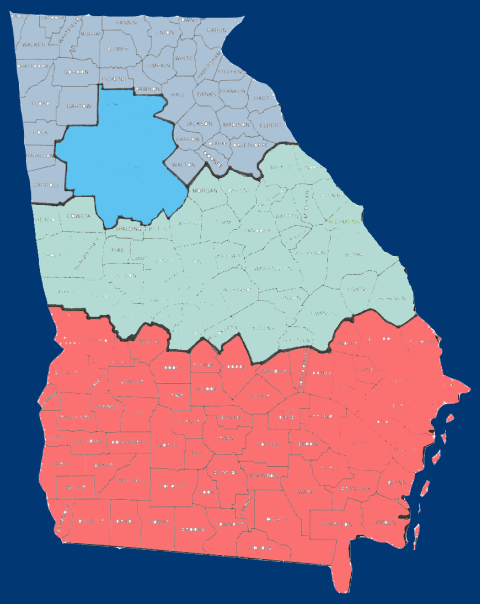
FIGURE 6. Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training, by Age



Regional Differences in Long-Term Disruptions

Parents across Georgia experience child care challenges that disrupt their long-term participation in the workforce. Families in South Georgia, however, are more likely than their counterparts in other areas of the state to report having quit a job, been fired, significantly changed hours, and turned down enrollment opportunities.

MAP 1. Georgia's Regional Boundaries



Metro North Central South

SPOTLIGHT

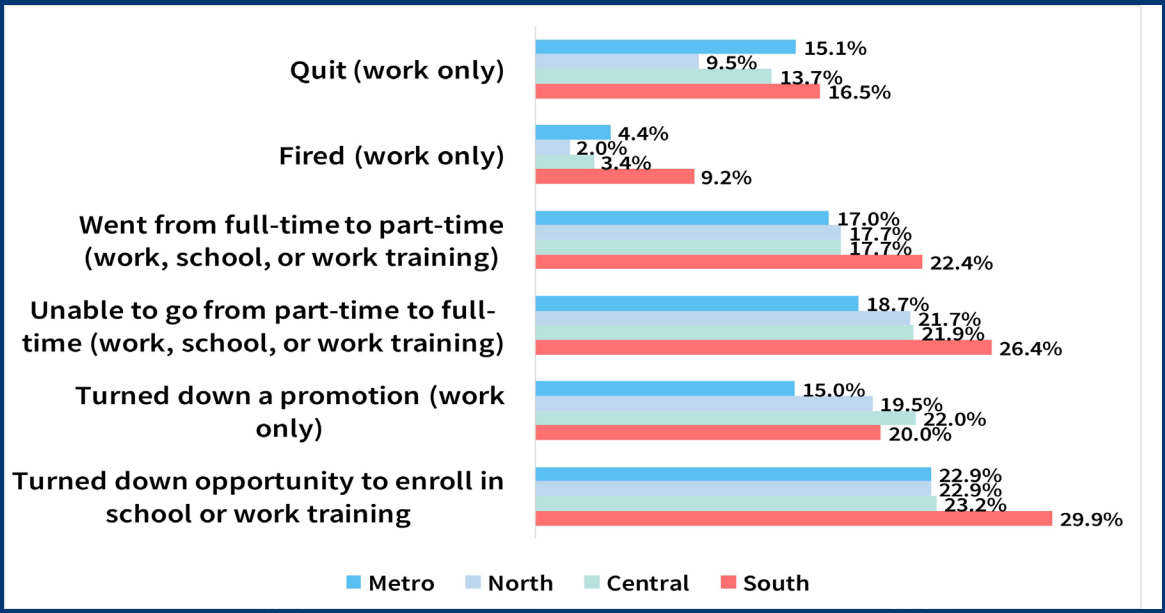
Giving Student Parents a "Boost"

Quality Care for Children (QCC) provides low-income college student parents with child care scholarships through its **Boost: Making College Possible** program. Boost is a two-generation approach to breaking the cycle of generational poverty: parents, confident their children are well cared for, can complete their postsecondary education, while infants and young children reap the lifelong benefits of high-quality early care and learning. QCC is implementing this program in partnership with four Georgia universities: Clayton State, Columbus State, Savannah State, and Georgia Southern - Savannah. Current data indicate that **62%** of parents who participated in Boost graduated on time, viewed by program administrators as a remarkable accomplishment in light of national data that suggest only 33% of single student parents complete their degree after 6 years.

"The experiences of trying to work to make enough money to pay for child care and go to school, where I took 6 to 7 classes each semester, was a hardship. Boost allowed me to quit my part-time job to focus solely on school. The first semester that I had Boost I earned a 4.0 GPA while taking 6 classes. I was able to graduate a year early because I did not have to work, I could just focus on my education. I started my Bachelor's degree in 2016 and graduated with my degree in Sociology—with honors—in December of 2017. Boost truly made all the difference for my family."

- "Jane", BOOST Parent Participant

FIGURE 7. Incidence of Long-Term Disruptions to Employment, Schooling, or Work Training by Region



SHORT-TERM DISRUPTIONS TO PARENTAL PARTICIPATION IN THE WORKFORCE

Parents may also experience more short-term disruptions—such as missing days of work or school, arriving late, or departing early—as a result of child care challenges. We asked respondents to consider such disruptions to their or their spouse or partner's employment or schooling over the course of the prior 6 months. Across all categories, parents reported that child care issues caused them to miss days of work, school, and work training (see Figure 8). Among those who were employed or whose spouse was employed, **over half (56.8%) reported missing days of work in the past 6 months due to child care issues, forgoing an average of 3.5 days.** Similarly, among those enrolled in school, 46.2% reported missing school in the past 6 months, with an average of 2.3 days missed. An even larger percentage (68.8%) of those enrolled in work training programs were affected, missing an average of 3.3 days. In many cases, parents appear to be missing a significant number of days of work, school, or training due to child care challenges. Nearly 1 in 5 (19.5%) reported missing more than a full week (6+ days) of work in the past 6 months, and close to 1 in 6 (16.4%) reported missing more than a full week of school. An even higher percentage of those enrolled in work training programs (22.2%) indicated they had missed over a full week of their program. Finally, approximately half of respondents reported that they arrived late (48.8%) to work, school, or work training or had to leave early (52.6%) as a result of child care challenges. See Table 1 for a more detailed breakdown of the short-term disruptions parents reported experiencing.

Nearly 1 in 5 reported missing more than a full week (6+ days) of work in the past 6 months.

FIGURE 8. Incidence of Short-Term Disruptions (last 6 months) to Employment, Schooling, or Work Training Resulting from Child Care Challenges

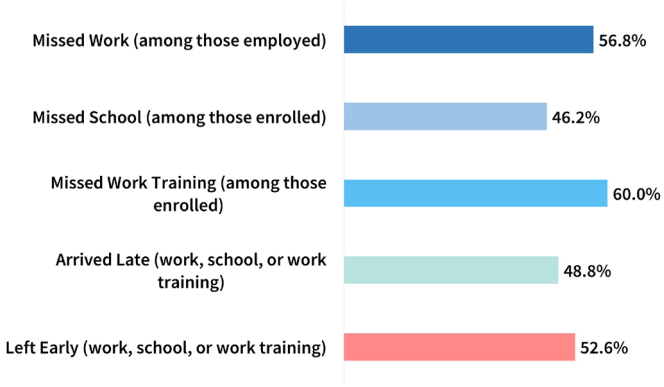


TABLE 1. Days Missed, Tardy, and Left Early (last 6 months) Due to Child Care Challenges

	1-5 Days	6-10 Days	>10 Days
Missed Work (among those employed)	37.4%	12.4%	7.1%
Missed School (among those enrolled)	29.8%	11.2%	22.2%
Missed Work Training (among those enrolled)	38.0%	22.2%	--------
Arrived late (work, school, or work training)	30.1%	13.0%	5.7%
Left early (work, school, or work training)	40.7%	10.2%	1.8%

ECONOMIC IMPACT ANALYSIS

The impact of child care challenges extends beyond families and employers. Employee absences and turnover resulting from such challenges can directly affect Georgia's ability to generate and collect revenue, potentially stifling the state's economic development. Everyone—parents, employers, and Georgia residents—loses when the state leaves potential investment dollars on the table as a result of child care challenges. Using survey data specific to two difficulties resulting from child care challenges — absences and turnover—we estimated the direct economic impact to Georgia. The estimates include two figures: the overall economic loss to the state and the subsequent tax revenue lost by the state. A full description of the methodological approach to estimating loss can be found in Appendix B.

Direct Economic Impact to Georgia's Economy

We estimate that child care challenges leading to absenteeism and turnover result in a conservative **$1.75 billion loss** in economic activity annually for the state. When parents leave jobs or forgo wages to address child care challenges, their reduced income permeates the state economy. The effects of this loss are distributed among companies of all sizes and across all sectors and revenue levels.

It is important to note that the losses estimated here represent a bare minimum of actual losses, as they do not consider the costs of tardiness or early departures (to both employee and employer), career diversions (not taking a job/promotion due to child care challenges), and education/training diversions. Our survey results indicate that these inestimable sources of loss are significant issues for Georgians with young children. Collectively those costs could, over time, be much larger than the losses estimated here.

TABLE 2. Economic Loss Related to Child Care Challenges, Georgia Estimates

Source	Economic Loss Estimate (Millions)	State Income Tax Revenue Loss (Millions)
Absences	$331.1	$19.9
Turnover	$1422.1	$85.3
Total	**$1753.2**	**$105.2**

Direct Tax Revenue Impact to Georgia

Similarly, declines in parent income caused by child care challenges can lead to lost tax revenue for the state, as working parents make earnings-based tax contributions. We estimate that child care challenges lead to a **loss of over $105 million** in state income tax revenue. Because state tax revenue supports essential public services, including K-12 and postsecondary education, health, transportation, and public safety, declines have a direct impact on families and communities across Georgia.

CONCLUSION AND IMPLICATIONS

This study, the first of its kind in Georgia, considered the costs to families, employers, and the state's economy associated with parents' child care challenges. The results are compelling: child care issues affect a significant number of parents of young children and, consequently, a substantial proportion of the state's workforce. Effects include those that are short-term—such as missing days at work or school or needing to arrive late or leave early to address child care challenges—as well as those that are long-term—such as leaving a position, significantly reducing hours, or turning down opportunities for advancement. Furthermore, child care challenges affect the majority of the employment pipeline—not only current employers and employees but also those enrolled in and serving postsecondary and work training programs that strengthen the future workforce. The economic impact of such disruptions is significant, as well. Absences and turnover resulting from child care challenges lead to an estimated $1.75 billion in overall economic loss to the state each year, with a subsequent $105 million loss in state income tax revenue. **If these challenges were addressed, Georgia's economy could be approximately $2 billion stronger each year.**

The impact of child care challenges is felt by Georgia families, employers, higher education institutions, work training programs, and the state as a whole. Parents experience lost wages and miss out on crucial career advancement opportunities, whether through a promotion or completion of degrees or credentials. Employers' bottom lines suffer. Postsecondary and work training programs may face a decline in enrollment. And the state experiences a significant and negative economic impact. These far-reaching effects can be minimized by investing in solutions that allow more parents to access consistent, high-quality, and affordable child care and encounter family-friendly policies in the workplace.

Child care issues affect a significant number of parents of young children and, consequently, a substantial proportion of the state's workforce.

SPOTLIGHT

Making High-Quality Child Care Accessible to Student Parents

The Early Childhood Learning Center at **Central Georgia Technical College**'s Macon campus recently underwent a renovation and expansion in order to serve more children. Through its participation in the Quality Rated Subsidy Grant program, the center can offer significantly reduced rates to eligible student parents.

"When we can't see a way for something to happen, often we don't try. This can be true for parents who know additional education would be helpful for them and their family. Without a plan for their child to be safe and cared for while they are in class, including how to pay for it, the dream of going back to school is as unimaginable as unattainable."

- Brett Copeland, Assistant Director, Child Care, Central Georgia Technical College

"From parents with disabilities training for a future career to guardians in the workforce searching for a reliable, quality child care setting for their little one, child care tuition supports like the Childcare and Parent Services (CAPS) program and the Quality Rated Subsidy Grant help make childcare tuition affordable for families working toward a brighter future. It is more than an initiative; it's a reality we see play out every day."

- Linda Smith, Director, Child Development Centers, Central Georgia Technical College

" I love that my child can go to class right down the hall from me! "

- Central Georgia Technical College Cosmetology student and CGTC Early Childhood Learning Center parent

Both public and private investments are needed to support Georgia families through a two-generation approach that bolsters parent employees and their young children during their critical early years. High-quality child care is out of reach for many working parents, with annual parent fees for infant and toddler programs often exceeding in-state tuition at a four-year university[9]. Support from a variety of sources—federal, state, and local government, private and corporate philanthropy, and employers—can make high-quality care more accessible for working families. Employers can implement family-friendly policies and retention strategies, such as helping employees secure and afford child care, offering flexible schedules, or providing on-site child care options, in order to support and attract working parents. Finally, postsecondary and work training programs can implement supports specific to student parents. Such investments are likely to have a high return, not only in the sense Nobel Laureate James Heckman describes[2] but also in the form of reduced costs to employers and higher earnings and tax revenue from parents.

Both public and private investments are needed to support Georgia families through a two-generation approach that bolsters parent employees and their young children.

[9]Gould, E., & Cooke, T. (2015). High quality child care is out of reach for working families. Economic Policy Institute Issue Brief, 404(4).

*Georgia's economy could be approximately **$2 billion stronger** each year.*

SPOTLIGHT

Flexible and On-Site Child Care Options Support Employee Retention and Family Well-Being

Hospitals across Georgia face significant staffing challenges, particularly in Nursing. As hospitals struggle to adjust to this tighter workforce market, some are turning to child care as a solution.

In 2018, **Piedmont Athens Regional Hospital**, with support from private donors as well as the Georgia Department of Early Care and Learning and Georgia Department of Community Affairs, opened the doors to its **Child Development Center**. The center, located on the hospital campus, provides an important resource to hospital staff and the surrounding community.

"The Child Development Center has been a huge employee satisfier and engager. Our nurse turnover in particular is the lowest it has been in years."

- Charles Peck, MD
President and CEO,
Piedmont Athens Regional Hospital

"As we made plans for what we would do with our sweet little one when he arrived, we quickly realized how difficult it would be to find child care that would work for our unique schedule. We didn't need full-time child care, but most of the part-time options in town were not going to work for us. When Piedmont Athens Regional announced plans to open a daycare, I was overjoyed and hopeful that [it] would be able to meet the unique schedule needs of hospital employees. When the center opened, Sawyer was 6 months old and we were able to enroll in the variable schedule. The variable schedule allows for flexibility in scheduling for me as a hospital employee. This type of scheduling has made all the difference in creating work/life balance for me and my family. As a hospital employee I have a deep appreciation of the time, effort and energy it took to get the center opened, and for me, it demonstrates the commitment the hospital has to the employees. Every day when we drop Sawyer off, he is excited to see his friends and his teachers. As a parent, trusting others to care for your child is difficult, but when they are an extension of your work family, it is easy. I will forever be grateful to PAR for making this investment for me as an employee but also for the difference it is making in the life of my son!"

- Lindsay, parent and employee at
Piedmont Athens Regional

APPENDIX A: SURVEY METHODOLOGY AND RESPONDENT DEMOGRAPHICS

Survey Methodology

Data for this report are based on a sample of adult residents of Georgia with at least one child under age 5 living in the household. McLaughlin and Associates conducted the survey between May 29, 2018 and June 25, 2018. The total sample includes 400 Georgia parents (or step-parents or legal guardians) who met the above conditions. Interviews were administered via telephone by professional interviewers and conducted online. Interview selection for the telephone interviews was random and respondents were contacted by both landline and cell phone. Phone numbers were obtained from list vendors where consumer and respondent specific data were utilized to isolate segments of Georgia adults who fit the specificity of this universe. For the internet interviews, respondents were carefully selected and screened from a representative platform of individuals who elect to participate in online surveys. Interviews were stratified by age, race/ethnicity, socioeconomic status, gender and geography using the 2012-2016 American Community Survey (ACS) estimates and the ACS Public Use Microdata Sample (PUMS) data to best reflect the actual demographic composition of Georgia parents with children ages 0-4. Due to some variance in the actual responses, the sample was weighted using a statistical procedure to match to the demographic composition of the intended universe. Because the internet sample is based on those who initially self-selected for participation rather than a probability sample, no estimates of sampling error can be calculated. However, a confidence interval of 95% was calculated in order to produce an error estimate of +/- 4.9% for the 400 respondents. This error estimate should be taken into consideration in much the same way that analysis of probability polls takes into account the margin of sampling error. The error estimate increases for cross-tabulations. Totals may not add up to exactly 100% due to rounding, refusals, and the ability for respondents to give multiple answers to certain questions. All surveys may be subject to multiple sources of error, including but not limited to question wording and ordering, sampling error, coverage error and measurement error.

RESPONDENT DEMOGRAPHICS

Sex	Male	Female
N=400	176	224

Race	White	Black	Asian	Multiracial	Other	*No Response*
N=400	211	143	16	16	12	2

Hispanic/Latino Origin	Yes	No	*No Response*
N=400	52	346	2

Marital Status	Married	Single	Divorced	Separated	Widowed	*No Response*
N=400	246	127	15	6	5	1

Employment Status	Full-Time	Part-Time	Stay at Home Parent	Retired	Looking for Work	Not Employed and Not Looking for Work	Other
N=400	253	56	52	6	17	8	8

Education	<High School Diploma	High School Diploma	Some College or Vocational School	2-year Degree	4-year Degree	Some Graduate Work	Advanced Degree	*No Response*
N=400	18	70	103	40	94	10	64	1

Household Income	<$10,000	$10,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000-$199,999	$200,000 or more	*No Response*
N=400	25	35	46	35	37	84	59	58	14	7

Region	Metro	North	South	Central
N=400	205	57	80	58

Number of Children Under Age 5	1	2	3	4	5
N=400	264	99	29	5	3

Primary Child Care Arrangement	Stay at Home	Stay with Family or Friend	Child Care Center	Family Child Care Home	Local School System	Head Start	Other	*No Response*
N=400*	206	59	105	18	36	10	18	3

*Note: Multiple responses were accepted from respondents with more than one child under age 5

APPENDIX B: ECONOMIC IMPACT METHODOLOGY

The table below presents estimates of economic losses to the state of Georgia because of two specific difficulties—absences and turnover—workers experience as a result of child care challenges. The estimates are based on a survey conducted by McLaughlin and Associates in May and June of 2018. The estimates come from extending the results of work published by the Louisiana Policy Institute for Children[4], as well as a similar study conducted by the Maryland Family Network[5]. The estimates are for both the overall economic loss to the state and the consequent tax revenue lost by the state.

TABLE 2. **Economic Loss Related to Child Care Challenges, Georgia Estimates**

Source	Economic Loss Estimate (Millions)	State Income Tax Revenue Loss (Millions)
Absences	$331.1	$19.9
Turnover	$1422.1	$85.3
Total	**$1753.2**	**$105.2**

The numbers are focused on only two of the many problems caused by difficulties with child care, largely because of data limitations. Turnover costs associated with job loss due to child care problems, and work days lost for the same reason present situations with specific estimable losses. Estimating losses for less well-defined childcare-related issues is more challenging. For example, the loss associated with declining a promotion because of child care issues is inestimable. Similarly, the short- and long-term losses associated with not always showing up to work on time has costs, but they cannot be estimated without extremely detailed data (and even that is problematic if a reputation of being tardy has a hidden penalty of diminished chances for promotion).

As a result, the losses estimated here represent a bare minimum of actual losses. The estimates do not consider the costs of tardiness or early departures (to both employee and employer), career diversions (not taking a job/promotion due to child care challenges), and education/training diversions. The survey results indicate that these inestimable sources of loss are significant issues for Georgians with young children. The nature of those disruptions make the costs functionally inestimable, but this does not mean that those costs are insignificant. Collectively those costs could, over time, be much larger than the losses estimated here, particularly the long-term consequences of training and education disruptions, and long-term career path disruptions.

Technical Notes:

These estimates rely on two important maintained assumptions. First, there is the obvious assumption that the methodology of the Louisiana and Maryland work is fundamentally sound. Second, there is the assumption that the incidence of child care needs in Georgia resembles that of those two states to within the margin of sampling error. This assumption seems consistent with the data as the states have very similar population shares for the under-5 age cohort: just more than 6% of the female population and about 7% of the male population for Georgia and Louisiana and slightly lower shares of both males and females in Maryland.

The estimates are derived by adopting the basic findings of both papers and adjusting it for differences between the states in fundamental issues of population size and State Median Income, both taken from Census, assumed expenditure multipliers (discussed below), and the differences found in the survey results. In this case, the share of the population forced into some form of job turnover was similar between the two states: 16% in Louisiana and 14% in Georgia. The survey result of the number of days missed, however, was quite different, with Louisiana reporting 14 days missed, Maryland 16.9, and Georgia 7.

At first glance, it would appear that the childcare dysfunction losses are proportionately less in Maryland than in Louisiana based on the size of the states and the differences in the median income. The differences are largely resolved, however, by considering the differences in the multipliers used in each study. In the Louisiana study, a decline in income was projected to result in an ultimate economic cost that was 2.0 times the initial decline. In Maryland, the multiplier applied was 1.1294.

Estimating multipliers is a very imprecise process. There are several standard and competing models, all of which are based on input-output analysis drawn from data at the local, state, and national levels. The results of these models, however, vary substantially given identical initial conditions. As the multipliers vary, so, too, do the loss estimates. For the purposes of the estimate here, a multiplier of 1.8 is used. This is an informed but judgmental number, below the multiplier used for exogenous sports or entertainment events, but above that for hospitality. It is used in cases where the change in spending crosses many economic sectors.

While there is some judgement involved in choosing the multiplier, and there are wide error bands associated with the results of the survey itself, the loss estimates presented here should be considered reasonable lower bounds on the total economic losses associated with these two segments of consequences to child care challenges.

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Polling on ECE in Georgia

2020 GEORGIA VOTER POLL

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think babies and act!

Now more than ever, Georgia voters recognize the importance of early care & learning and policies that support working families. In a divided political environment, **support for early learning is consistently strong and overwhelmingly bipartisan**. Voters support family-friendly policies, whether or not they have young children.

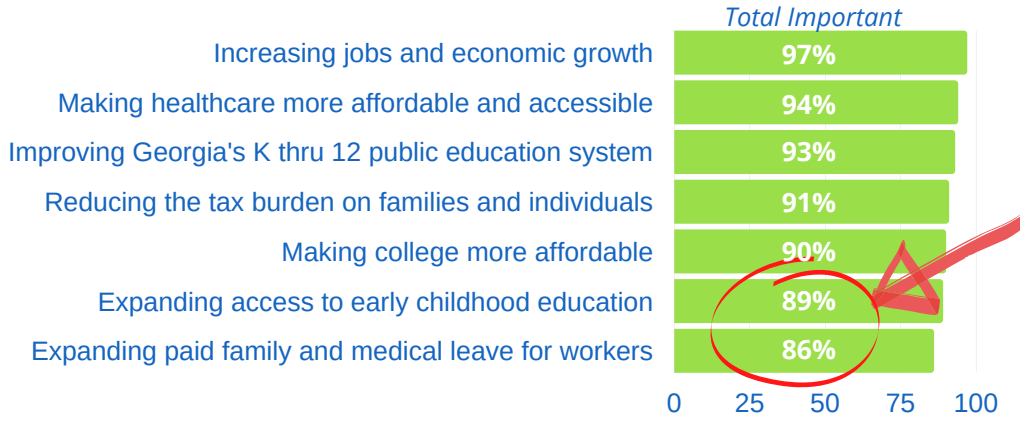
600

likely Georgia voters*

PRESSING ISSUES FACING GEORGIANS

Early Childhood Education (ECE) and paid leave are important issues to Georgians.
Expanding access to early childhood education and paid family and medical leave are priorities for Georgia voters--observed at levels similar to other top issues. Roughly 9 in 10 voters identified these issues as important.

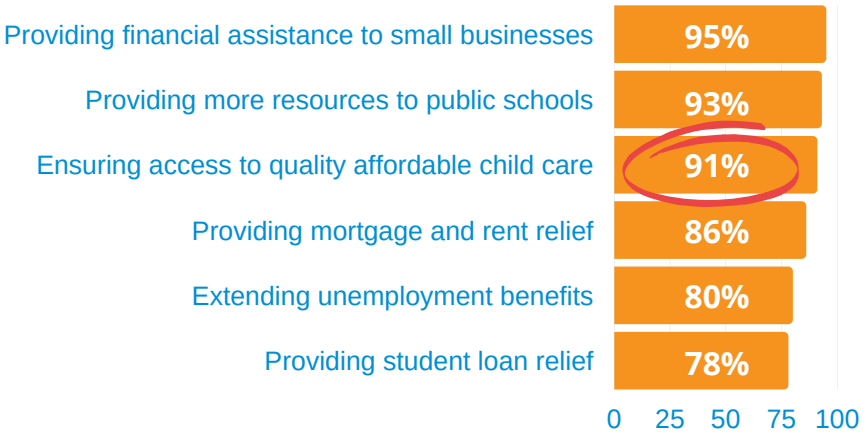
Please tell me how important each issue is to you personally – is it very important, somewhat important, not that important or not at all important?



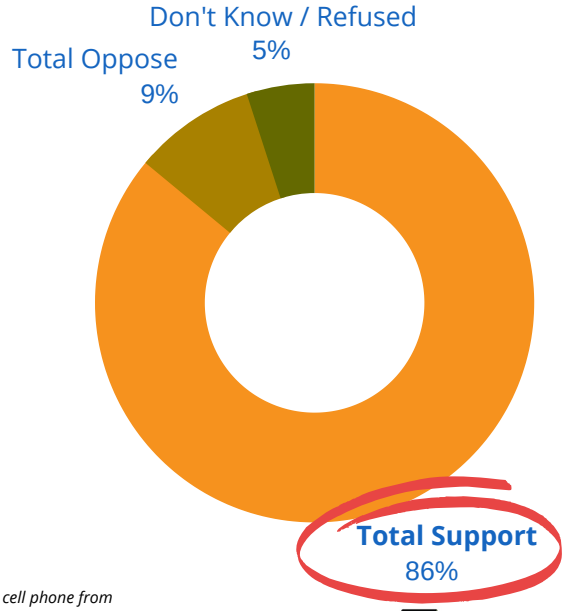
FEDERAL ACTION ON CHILD CARE

Georgians Say Congress Should Prioritize Quality, Affordable Child Care in Wake of COVID-19 Pandemic

From the following list, please tell me if each should be a high priority, somewhat of a priority, not much of a priority or not at all a priority for Congress to address as a result of the coronavirus pandemic:



Georgians Support Targeted Financial Assistance to Child Care Industry



Respondents were from across Georgia, and included a broad cross-section of likely voters. Interviews were conducted over landline and cell phone from Sept. 14-17, 2020. Selection was random and interviews were stratified by county, race/ethnicity, age and gender to correlate with current voter registration statistics and actual voter turnout from previous even-year November general elections. The poll had an accuracy of +/- 4.0% at 95% confidence interval.

McLaughlin & Associates FP FREDERICKPolls

VOTERS SUPPORT FAMILY-FRIENDLY POLICIES

Nearly 9 in 10 Georgia Voters Support Paid Family Leave

88% total | 82% Republican | 96% Democrat

for the birth or adoption of a child

88% total | 83% Republican | 96% Democrat

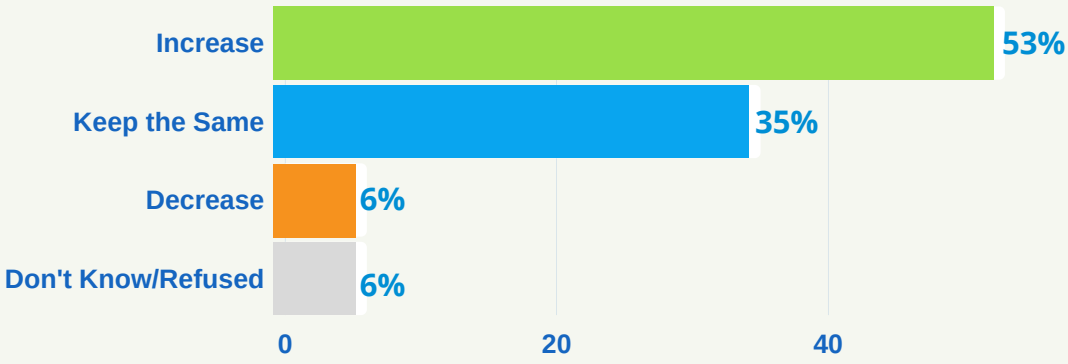
to provide child care during emergencies

90% total | 84% Republican | 98% Democrat

to care for themselves or a family member with an illness

Georgians Support Maintaining or Increasing Funding for Early Childhood Education (ECE)

The majority of voters (88%) believe funding for early childhood education should be increased or maintained.



Georgia Voters Support Variety of ECE Policies

85% support funding to increase quality & availability of child care for **infants & toddlers**

88% support funding to **help low-to-moderate income families afford child care**

88% support **comparable salaries** for early education professionals

Support for Georgia's Pre-K Is Higher Than Ever

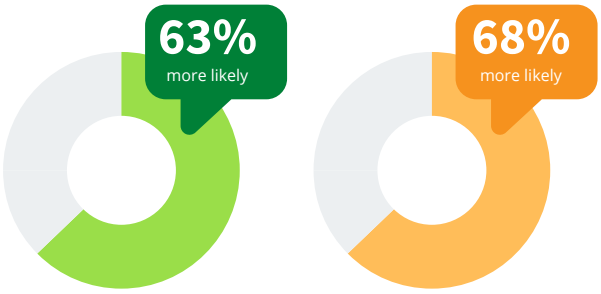
Greater than nine in ten (91%) support Georgia's free, lottery-funded voluntary Pre-K.

2010: 83%
2014: 87%
2018: 80%
2020: 91%

VOTERS SUPPORT ECE-FRIENDLY CANDIDATES

are more likely to vote for candidates supportive of early care & learning

Would you be more likely or less likely to vote for a candidate for political office who SUPPORTS policies that give more families access to quality child care and preschool?



Swing Voters | Women

See full results, including crosstabs, at www.GEEARS.org/POLLING

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Early Childhood Education

Georgia's ECE Landscape

GEORGIA'S EARLY CARE & EDUCATION LANDSCAPE

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Georgia's young children are educated and cared for in a variety of programs and settings, ranging from child care centers to family child care homes to relative-provided care to nannies or babysitters. **The state's early care and education landscape is diverse and complex, with programs varying widely by type, funding source, nonprofit status, and oversight.** Families sometimes combine different types of part-time and full-time care to meet their needs. **Together, the child care options below support the early learning and healthy development of Georgia's youngest learners.**

TYPES OF CHILD CARE

Licensed Child Care Learning Centers

are typically operated in non-residential facilities where children are often grouped in classrooms by age, with an average licensed capacity of over 100 and a dedicated director and staff members.

Licensed Family Child Care Learning Homes

provide care for small groups of children (at least three and up to six) of varying ages in a professional caregiver's home for pay.

Family, Friend, & Neighbor Care

is a type of home-based child care in which a relative, friend, neighbor, babysitter, or nanny provides care with or without pay.

Public Schools (License-Exempt)

are subject to local oversight and may offer early learning programs, typically serving 4-year-olds through Georgia's Pre-K Program.

Other License-Exempt Programs

include many part-time or faith-based programs; must apply for exemption and still meet basic health and safety guidelines.

The ***Georgia Department of Early Care and Learning (DECAL)*** is responsible for meeting the child care and early education needs of Georgia's children and their families, including licensing child care and administering key programs such as Georgia's Pre-K Program, Georgia's Childcare and Parent Services (CAPS) program, and Quality Rated.

Licensed programs are monitored at least twice a year by DECAL to measure whether they meet over 400 child health and safety rules. Eligible, licensed programs can elect to participate in Georgia's ***Quality Rated*** system that assesses program quality. Programs that are Quality Rated have demonstrated a commitment to go above and beyond licensure standards and receive a one-, two-, or three-star rating based on the demonstration of best practices (e.g., ratios, staff credentials, curriculum, etc.).

In many parts of the state, demand for child care, particularly for infants and toddlers, outpaces supply. Roughly 500,000[1] children under the age of six need child care in Georgia.

Child care in Georgia is largely privately funded through parent fees, with the average yearly infant tuition exceeding in-state tuition at a four-year public college.[2] **Some local, state, and federal initiatives exist to support access to early learning programs, including:**

	Funding Source	*Eligibility*	*Access*	*Delivery Model*
Georgia's Pre-K	Georgia Lottery	Georgia's four-year-olds regardless of parental income (subject to available seats)	Typically serves approximately 60% of the state's four-year-olds (~80,500 at the end of the 2018-19 school year, with a wait list of 4,630)[3]	Utilizes a mixed delivery system, with classrooms in both child care centers and public schools
Childcare & Parent Services (CAPS) *Georgia's child care scholarship program for low-income working families*	Primarily federally funded through the Child Care and Development Block Grant (CCDBG), which includes a required state match	Family eligibility is set at or below 50% of the state median income based on family size. Parents must also participate in approved work/education activities.	~63,000[4] children under 13 receive a scholarship. Due to limited funding, the program serves only an estimated 14.8% of income-eligible children.[5]	Families make their own decisions about what type of care is best for their child based on their needs and availability at participating programs.
Head Start & Early Head Start	Federal grant program	Head Start serves children ages four and five; Early Head Start serves infants and toddlers as well as pregnant women. Family eligibility is set at or below 100% of the federal poverty level.	~19,700 children are enrolled in Head Start and ~4,800 are enrolled in Early Head Start.[4]	Services include education, health, mental health, and family supports through center-based or family child care programs.

Georgia's early care and education landscape provides essential services for Georgia's youngest learners while allowing parents to advance their careers and provide for their families. Yet many families face **barriers in affording and accessing care that meets their needs**. Continuous and increased **support for programs** such as Georgia's Pre-K, CAPS, and Head Start will help ensure Georgia's youngest learners are prepared for school and future success.

1. U.S. Census Bureau, American Community Survey (2015-19)
2. Economic Policy Institute, The Cost of Child Care in Georgia. (October 2020)
3. Georgia Department of Early Care and Learning (September 2019)
4. Georgia Department of Early Care and Learning (July 2020)
5. Center for Law and Social Policy, Inequitable Access to Child Care Subsidies (April 2019). (PDF)

CHILDCARE AND PARENT SERVICES (CAPS):
HELPING WORKING GEORGIANS AFFORD CHILD CARE

The CAPS program provides scholarships that help some low-income working families in Georgia afford child care.

BY INCREASING STATE INVESTMENT IN CAPS, Georgia would go a long way in addressing the **AFFORDABILITY AND AVAILABILITY** of high-quality child care for low-income families, thereby strengthening the **STATE'S ECONOMY** and setting up Georgia's most vulnerable young children for **SUCCESS.**

HIGH-QUALITY EARLY CARE AND EDUCATION SUPPORTS GEORGIA'S FAMILIES BY:

- Increasing school readiness
- Supporting social-emotional development
- Improving health and well-being
- Helping parents and caregivers maintain stable employment

QUICK FACTS ABOUT CAPS

Georgia's CAPS Program aims to **SERVE 50,000 CHILDREN ANNUALLY** up to the age of 13 through early learning, afterschool, and summer programming. Families make their own decisions about what type of care is best for their child based on their needs and program availability. All components of Georgia's CAPS Program, including eligibility, are administered by Bright from the Start: Georgia Department of Early Care and Learning (DECAL).

WHY SHOULD GEORGIA INVEST IN CAPS?

ACCESS IS CRITICAL. Such care is particularly important during the earliest years of a child's life, when the brain is developing most rapidly.

With the **COST OF CHILD CARE** equaling near **40% OF THE EARNINGS** of a low-income family, many families struggle to find and afford reliable child care.[i]

ONLY AN ESTIMATED 14.8% of income-eligible children in Georgia **RECEIVE A CAPS SCHOLARSHIP.**[ii]

ELIGIBILITY

Family eligibility is set **at or below 50% of the state median income** based on family size (e.g., $36,601 for a family of four).

In addition to meeting income eligibility, participating parents and caregivers must participate in **24 hours/week of approved activities** (e.g., work, two-year degrees, and training programs).

Due to limited funding, **DECAL identified priority groups,** such as children from very low-income families, children with disabilities, and children in DFCS custody, to help ensure that children most in need are prioritized for scholarships.

HIGH-QUALITY CARE

To help ensure that participating low-income families have access to high-quality child care, **all eligible CAPS providers must be Quality Rated** through Georgia's quality rating and improvement system for child care programs by December 2020.

FUNDING

CAPS is primarily funded through the **Child Care and Development Block Grant (CCDBG)**, a federal program. The state meets the required match and has made modest, **targeted investments** in recent years, adding $5.5 million in 2017 and $500,000 in 2019 to the state budget.

AN ADDITIONAL INVESTMENT OF $10 MILLION would allow for more than **1,500 NEW INFANTS AND TODDLERS** to be served by the CAPS Program giving them access to the critical care and supports they and their families need to thrive.

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FOR MORE INFORMATION VISIT: WWW.GEEARS.ORG

CHILDCARE AND PARENT SERVICES (CAPS):
HELPING WORKING GEORGIANS AFFORD CHILD CARE

FREQUENTLY ASKED QUESTIONS

What is the difference between CAPS and other child care initiatives, such as Head Start and Georgia's Pre-K?
Georgia's Pre-K Program is the voluntary, free program available to all of Georgia's four-year-olds regardless of parental income. Funded by the Georgia Lottery, it serves approximately 60% of the state's four-year-olds.

Head Start and Early Head Start are federally funded programs that provide comprehensive early childhood education, health, nutrition, and parent engagement services to low-income children. Head Start serves 3- and 4-year-olds and Early Head Start serves infants, toddlers, and pregnant women. However, Head Start and Early Head Start programs only serve a small portion of eligible children. [iii] Although these programs play a critical role in supporting Georgia's young learners, additional support is needed to provide high-quality early care and education during the earliest years of a child's life, particularly for low-income families.

Does every eligible family receive CAPS?
No. Only an estimated 14.8% of income-eligible children in Georgia are served by CAPS, and DECAL prioritizes children to receive CAPS by identifying priority groups in order to serve those most in need. CAPS is not an entitlement program meaning that it does not serve everyone who applies and is eligible due to limited funding.

Although CAPS does not fund every eligible family, do other programs (e.g. TANF, Medicaid, WIC) make up the gaps in access to child care?
No. Programs such as TANF, Medicaid, and WIC provide critical supports, such as health care and nutrition, to eligible children and their families – many of whom are also eligible for CAPS. However, these programs do NOT provide child care to Georgia's youngest children.

How much of the cost of child care does the CAPS Program cover?
The CAPS Program covers a set reimbursement rate based on the type of care, location, and age of child minus the amount the family is responsible for, known as the family fee, which is capped at 7% of a family's annual income. However, Georgia's set reimbursement rates are often significantly lower than the current cost of care due to limited funding. Providers often pass on the additional cost to families. Low reimbursement rates can make it difficult for providers to provide high-quality care and may discourage providers from accepting CAPS.

Why is it important to keep child care costs low for low-income families?
Low-income families spend on average approximately four times the share of their income on child care relative to their higher income peers,[iv] making it difficult for low-income families to afford other essentials, such as food and housing, while maintaining stable employment.

[i] Johnson, M. (2016, July). Help Needed to Meet Georgia's Laudable Child Care Goals. Retrieved April 15, 2019, from https://gbpi.org/wp-content/uploads/2016/07/Funding-Georgia-Child-Care-Plan.pdf [ii] Ullrich, R., Schmit, S., & Cosse, R. (2019, April). Inequitable Access to Child Care Subsidies. Retrieved May 8, 2019, from https://www.clasp.org/sites/default/files/publications/2019/04/2019_inequitableaccess.pdf [iii] Georgia's Cross Agency Child Data System (2019). 2017-18 Total Unduplicated Number by Early Childhood Service [Search engine]. Retrieved from http://www.gacacds.com/Reports/Default [iv] Laughlin, L. (2013). Who's Minding the Kids? Child Care Arrangements: Spring 2011. Household Economic Studies, P70-135, 70-135. Retrieved April 11, 2019.

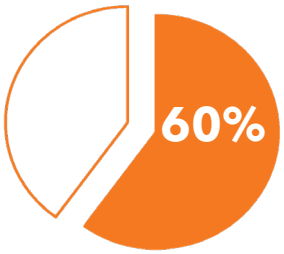
GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

Georgia's Pre-K Program

Georgia's Pre-K Program is a voluntary, free program available to all of Georgia's four-year-olds regardless of parental income. More than **1.6 million Georgia students** have been served by Georgia Pre-K since it began in **1992**.[1] The program continues to be nationally recognized for its success.

80,328 kids
were enrolled in Georgia Pre-K during the 2019-2020 school year[2]

representing



of all four-year-olds in Georgia.[3]

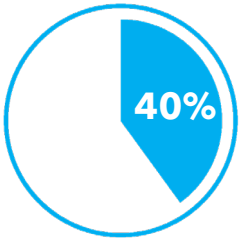
BY THE NUMBERS

3,855 Pre-K classes — operate in — **159** counties — at — **1,829** locations[4]

45% are located in a public school system[5]

55% are located in private centers[6]

Georgia is one of only eight states and D.C. that provides high-quality care to more than **50% of 4-year-olds**.[7]



of Georgia's 4-year-olds are not currently enrolled. At the end of the 2019-2020 school year, there were **4,303 kids on the waitlist**.[8]

GEORGIA PRE-K IMPROVES OUTCOMES

In 2011, the Georgia General Assembly began a multi-year evaluation led by the Frank Porter Graham Child Development Institute. The study has found that children enrolled in the Georgia Pre-K Program:

- **Are more prepared for kindergarten** compared to four-year-old's who did not attend a Georgia Pre-K program.
- **Sustain gains made in Pre-K** through kindergarten and first grade.

Children in Georgia Pre-K showed significant growth across all learning domains, including:

Math Skills

Language & Literacy Skills

Social-emotional Skills

These gains happened for all students, regardless of gender and income differences, and are sustained through the end of first grade.

www.georgiavoices.org

About Georgia Pre-K[9]

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Administered by Georgia Department of Early Care and Learning

Full day program

Maximum of **22** kids per class

Operates 180 days a year

GELDS

Required to use the Georgia Early Learning and Development Standards (GELDS)

Hearing, vision, and dental screenings are required

Required to have a lead teacher and an assistant teacher

All Pre-K lead and assistant teachers must meet credential requirements

QUALITY™ RATED CHILD CARE

791 of the Pre-K centers are Quality Rated, a voluntary, quality rating system for early and child care centers.[10]

FUNDING GEORGIA PRE-K

$378 MILLION

Georgia Lottery dollars were allocated to Georgia Pre-K in 2020[11]

For the 80,328 children enrolled in the 2019-2020 school year

$4,539 was spent per child[12]

In 2016, the Georgia General Assembly approved a $34 million increase for Pre-K salaries. Despite recent increases, Pre-K salaries are lower than similar professions. Assistant teachers make $15,873/year.[13] The average salary for lead teachers for the 2018 school year was:[14]

4-year degree	4-year degree & certified	Master's Degree
$31,638	**$40,338**	**$44,338**

Research shows a significant factor in an early childhood teacher's decision to leave the profession is **low pay**.[15]

High turnover rates have been linked to lower program quality and shown to negatively impact a child's social and emotional development and relationships between teachers, children and parents.[16]

Rev. 11/2020

Sources available here: https://tinyurl.com/GeorgiaPreK

Sources for Georgia's Pre-K Program

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14 Georgia Department of Early Care and Learning, professional communication, October 2019.

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16 Ibid

Head Start Services

Head Start programs promote the school readiness of infants, toddlers, and preschool-aged children from low-income families. Services are provided in a variety of settings including centers, family child care, and children's own home. Head Start programs also engage parents or other key family members in positive relationships, with a focus on family wellbeing. Parents participate in leadership roles, including having a say in program operations.

Head Start programs support children's growth in a positive learning environment through a variety ofservices, which include:

- **Early learning and development:** Children's readiness for school and beyond is fostered through individualized learning experiences. Through relationships with adults, play, and planned and spontaneous instruction, children grow in many aspects of development. These include social skills, emotional well-being, language and literacy skills, mathematics, and science concepts. Early learning experiences also include the cultural and language heritage of each child and family in relevant ways. Parents, including grandparents, foster parents, and other primary caregivers, are recognized as children's first and most influential teachers. Their knowledge of their children is central to each child's individualized approach. Additionally, Head Start programs work with families, school districts and other entities to facilitate a smooth transition to kindergarten for each child.

- **Health:** Health and physical development are crucial for early learning opportunities that require children to fully explore and experience their environment. Head Start programs provide safe and healthy learning experiences indoors and outdoors. All children receive health screenings and nutritious meals, and programs connect families with medical, dental, and mental health services to ensure children are receiving the care and attention they need. Children receive support for building resiliency to cope with possible adverse effects of trauma. Families also receive mental health consultation focused on each child's needs.

- **Family well-being:** Parents and families are offered program services to support family well-being and to achieve family goals, such as housing stability, continued education, and financial security. Programs support and strengthen parent-child relationships and engage families in the learning and development of their child.

Head Start programs are available at no cost to children ages birth to 5 from low-income families. Programs may provide transportation to the centers so enrolled children can participate regularly. Families and children experiencing homelessness, and children in the foster care system are also eligible. Additionally, Head Start services are available to children with disabilities and other special needs.

“Head Start” includes several different program types reflecting the needs of specific populations within the community. These include:Head Start programs deliver services through 1,600 agencies in local communities. Most Head Start programs are run by non-profit organizations, schools, and community action agencies. They provide services to more than a million children every year, in every U.S. state and territory.

- **Head Start for 3s & up:** Head Start programs promote the school readiness of children ages 3 to 5. Most of these programs are based in centers. In other programs, children and families may receive services from educators and family service staff who regularly make home visits.

- **Early Head Start (EHS):** Infants, toddlers, and pregnant women are served through Early Head Start programs. Early Head Start programs are available to the family until the child turns 3 years old and is ready to transition into Head Start or another pre-K program. Services to pregnant mothers and families, including prenatal support and follow-up, are also provided by Early Head Start. Many Early Head Start programs are provided in a child’s own home through weekly home visits that support the child’s development and family’s own goals. Other Early Head Start programs are located in centers which provide part day or full day programming for children. Early Head Start-Child Care Partnerships are programs that are dedicated to offering Early Head Start services to eligible families within the childcare system.

- **American Indian and Alaska Native (AIAN) Head Start:** Head Start programs were launched in 34 AIAN communities in the summer of 1965. Today, nearly 41,000 children of AIAN heritage are served in both AIAN and non-tribal programs. Head Start and Early Head Start programs honor the rich cultural heritage of our AIAN children, families, and communities. Based on the needs of local communities, programs offer traditional language and cultural practices to provide high-quality services to young children and their families.

- **Migrant and Seasonal Head Start (MSHS):** Migrant and Seasonal programs provide specific services to children whose families are engaged in agricultural labor. MSHS programs work with both migrant farmworker families, who migrate to a number of geographic locations annually, and with seasonal farmworker families who are permanently settled in their communities but continue to do agricultural work. MSHS programs have served children from birth to age 5 since its inception in 1967 and are currently funded to serve over 30,000 children.

Head Start programs deliver services through 1,600 agencies in local communities. Most Head Start programs are run by non-profit organizations, schools, and community action agencies. They provide services to more than a million children every year, in every U.S. state and territory.

For more information, visit: https://www.acf.hhs.gov/ohs/about/head-start

Did You Know?

Head Start grants served **24,735 children ages birth to five** in Georgia communities during 2019.

Head Start programs employed **over 7,600 Georgians** and received support from **over 23,000 volunteers** statewide in 2019.

Head Start provides **medical**, **dental**, **hearing**, **vision**, **and behavioral screening** to every child enrolled in Georgia.

Head Start helps Georgia families identify and achieve **training**, **employment**, **and parenting goals**.

Head Start

Georgia Head Start Association

What is Quality Rated Child Care?

Quality Rated is an initiative of Bright from the Start: Georgia Department of Early Care and Learning.

Parents and families need an independent, trustworthy resource to help them find high-quality child care, preschool and pre-K programs. Georgia's Quality Rated tool helps families find child care in their area that have been evaluated by credentialed early childhood experts and identified as high-quality.

A quality child care, preschool or pre-K program provides children with a nurturing and educational environment to help them learn and develop their social skills so they have a strong foundation as they grow. Quality Rated enables parents and families to easily find those quality care options for their children. They can rest assured that the program they are considering has been assessed by the State of Georgia and is committed to providing children an environment and experience that is best for their development.

Parents and families can search for child care options online and find the best program in their area that meets their needs. Through the Quality Rated tool's child care search function, they have access to specific information on each program, such as:

- safety and inspection reports;
- teacher credentials;
- hours of operation; and
- transportation options, among many other details.

Star Ratings

Quality Rated's one, two, or three star ratings allow families to easily identify high-quality child care and early education programs that are caring for and educating children based on what research has shown to work. Regardless of their star rating, all Quality Rated programs are meeting or exceeding a high set of standards.

Parents and families who use Quality Rated can have peace of mind knowing they have a tool to identify high-quality programs, so that when they search for child care, they can focus on the details that matter most to their family. Learn more at www.QualityRated.org.

Research on
Early Childhood Education

Georgia's Pre-K Program:
What the Research Tells Us

RESEARCH BRIEF
JANUARY 2021

In 2011, the Georgia General Assembly authorized a **longitudinal study** of Georgia's lottery-funded Pre-K Program to examine the links between participation in Georgia's Pre-K and children's school readiness skills, the quality of Georgia's Pre-K classrooms, and the short- and long-term outcomes of attending Georgia's Pre-K. The study follows a large sample of children over time, with the latest published results including data on performance through the third grade.

A separate analysis, conducted in 2017, **compared performance** on the third-grade Georgia Milestones End-of-Grade (EOG) assessments among children who had and had not participated in Georgia's Pre-K Program.

Taken together, these studies provide valuable insight into Georgia's Pre-K Program and the trajectory of children's learning experiences during early schooling. The brief that follows outlines key findings from these studies. **For full details on this body of work, visit** decal.ga.gov/BftS/research.aspx

HIGHLIGHTS

- Findings from the *longitudinal study* indicated that **students who attended Georgia's Pre-K demonstrated significant rates of growth**—above and beyond what is typical for children their age—**during their Pre-K and kindergarten years**, suggesting they entered kindergarten prepared to take advantage of subsequent learning opportunities. Students' observed rates of growth through first, second, and third grade were closer to what is typical for children in those grades.

- Researchers observed **differences in the quality of teacher-child interactions** in grades K-3 relative to Pre-K, with classroom quality highest in the Pre-K year and slightly lower through third grade. Students' observed rates of growth through first, second, and third grade were closer to what is typical for children in those grades.

- Findings from the 2017 *comparison study* indicated that a group of **students who had attended Georgia's Pre-K significantly outperformed their peers** who had not attended Georgia's Pre-K **across all subject areas of the third-grade Georgia Milestones assessments**.

- Collectively, these findings underscore the **importance of alignment** from Pre-K through third grade and provide an opportunity for improved coordination to build on the foundation provided by children's early educational experiences.

Research on Georgia's Pre-K helps stakeholders better understand children's early educational experiences and how they build on one another, providing details on the patterns of children's growth during Pre-K as well as kindergarten, first, second, and third grade. These findings span multiple studies and feature different types of measures, including nationally normed child-level assessments, Georgia-specific end-of-grade assessments, and measures of classroom quality.

LONGITUDINAL STUDY: PRE-K-3RD GRADE

Authorized by the Georgia Assembly in 2011 and begun in 2013-2014, this study follows an initial sample of 1,169 children who attended randomly selected Georgia's Pre-K classrooms across the state, examining their academic skills as well as classroom quality from Pre-K through fifth grade. The most recently published results include findings through children's third-grade year.

Children's Learning Over Time

Observed rates of growth varied over the five-year period. **Rates of growth were highest during the Pre-K and kindergarten years, suggesting that children were not only acquiring new skills but doing so at a rate greater than what would be expected for children their age.**

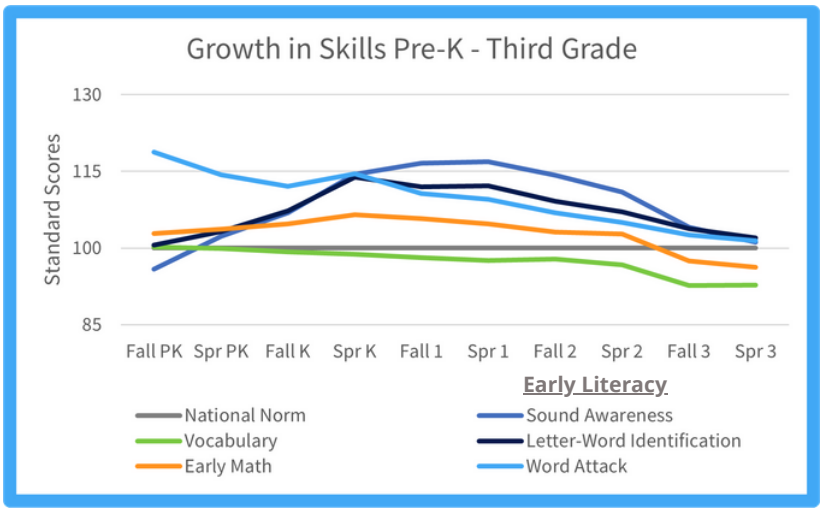
During their first- through third-grade years, observed rates of growth generally slowed, more in line with the expected rate in first grade and a slightly slower-than-expected rate in second and third.

Average standard scores (see box) were in a similar range —around the national mean—on most measures at the beginning of Pre-K and the end of third grade—but the pattern of growth across this time period varied.

STANDARD SCORES EXPLAINED

The analyses for the longitudinal study are based on standard scores on norm-referenced assessments. Based on testing with large numbers of children across the country, we expect the average child to score 100 at every age. Because standard scores take the child's age into account, children who learn an average amount during a year will have the same score at the start and end of the year (a generally "flat" line). Children who learn more than the average child will show increases in standard scores over time, and children who learn less than the average child will show decreases in standard scores. Stable standard scores suggest an average amount of growth, not a lack of learning.

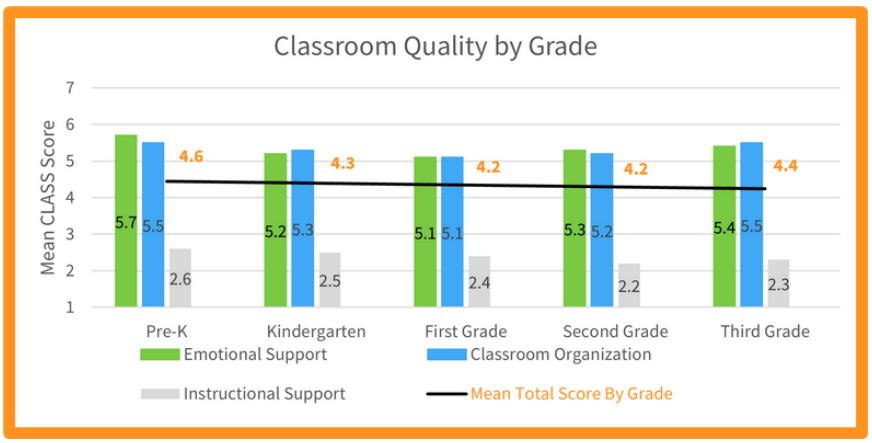
In many important early academic areas, like early reading, math, and phonological awareness,[1] rates of growth for children who attended Georgia's Pre-K were greater than the national average during those first two years, but then their rates of growth slowed so that by the end of third grade their skills were once again on par with the national average.



1. Phonological awareness is an important predictor of later reading skills and includes skills like rhyming and the ability to delete, substitute, and reverse sounds or part of words.

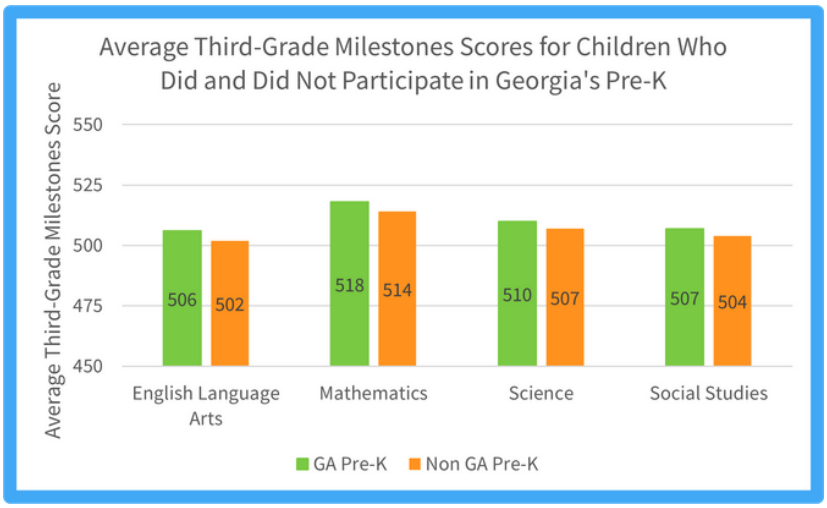
Classroom Quality

The quality of teacher-child instructional interactions, as measured by the Classroom Assessment Scoring System (CLASS), varied across domains and grades, with **higher scores observed during Pre-K than during subsequent years**. These differences were most pronounced for the Emotional Support domain, which measures aspects of the classroom like emotional connection, lack of anger or hostility, teacher sensitivity, and emphasis on students' interests. Furthermore, higher classroom quality was associated with better outcomes for some skills—those children who attended higher quality Pre-K classrooms made greater gains in calculation and vocabulary skills.



COMPARISON STUDY (2017): THIRD-GRADE ACHIEVEMENT FOR CHILDREN WHO PARTICIPATED IN GEORGIA'S PRE-K

While the longitudinal study follows a sample of children over time, a separate analysis, using data from the state's longitudinal data system, compared third-grade scores on the Georgia Milestones End-of-Grade (EOG) assessments for children who had and had not participated in Georgia's Pre-K. This 2017 analysis, which included all children in third grade in 2015-2016, matched those who had participated in Georgia's Pre-K with non-participants who were similar on key variables, such as free-or-reduced-lunch status and home language. **Children who had attended Georgia's Pre-K significantly outperformed their peers who had not participated across all subject areas—English Language Arts, Math, Science, and Social Studies.**



IMPLICATIONS

The existing research on Georgia's Pre-K suggests that **participation in the program helps set the stage for children's subsequent learning**. The observed differences between children's rates of growth and classroom quality during Pre-K and kindergarten relative to grades 1-3 highlight the importance of sustaining and building upon children's earliest school experiences in an aligned and coordinated fashion—across grade levels, learning settings, and curriculum and policy development.

Studies like those outlined above are crucial to stakeholders' understanding of children's experiences across the Pre-K-5th grade continuum. Ongoing research and data sharing—across early learning and elementary settings—can inform instruction and decision-making in this space.

GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS
GEEARS.org

Voices for Georgia's Children
GeorgiaVoices.org

Georgia Partnership For Excellence In Education
GPEE.org

Economic Impact *of the* Early Care and Education Industry *in* Georgia

EXECUTIVE SUMMARY | REVISED JUNE 2016

The early care and education industry is an important part of Georgia's economy. Access to child care increases labor force participation, boosts local economies, and helps support a stable workforce. The industry enables parents to work, allowing them to care for their families financially while contributing federal, state, and local taxes to the economy. The industry employs teachers and family child care providers, administrators, and a variety of staff that support the operation of the state's early care and education system. Workers in these early care settings subsequently spend their earnings in Georgia, which in turn distributes additional employment and spending opportunities throughout Georgia's economy.

Quality child care also helps to build Georgia's workforce of the future. For decades, research has supported the economic importance of laying a strong foundation for learning in a child's earliest years. The evidence regarding the positive impact of early education on child development and educational attainment continues to grow (e.g., Arteaga et al. 2014; Deming 2009; Heckman et al. 2012). Early education enhances children's cognitive and social development, school readiness, health, and well-being, better equipping them for the workforce and thereby contributing to the long-term economic development of the state.

PURPOSE OF THE ECONOMIC ANALYSIS

This study, a collaborative effort between researchers at the University of Georgia's Carl Vinson Institute of Government and Georgia State University's Andrew Young School of Policy Studies, builds on a similar 2008 study by quantifying the daily economic activity, also called the short-term economic impact, of the early care and education industry in Georgia. The state has approximately 6,200 licensed or regulated for-profit and not-for-profit early care and education centers, family child care homes, group child care homes, prekindergarten programs, military family child care homes, Head Start sites, and military early care and education centers. Using data collected from a unique survey sent to all of these child care providers in the fall of 2014, this study focuses on the industry in the wake of the Great Recession (2007–2009). The estimates of economic impact are based on 2013–2014 financial data.

OVERVIEW OF RESULTS

- The total annual gross receipts of the industry for a 12-month period are estimated to be $2.45 billion.
- The additional economic activity associated with the industry adds another $2.24 billion to Georgia's economy annually. Thus, **the early care and education industry generated $4.7 billion dollars of economic activity in the state** for 2013, putting it on par with industries such as pharmaceutical preparation manufacturing, printing, and health and personal care stores.

- A conservative estimate of the level of parents' annual earnings supported by the availability of child care in Georgia is $24 billion.
- Through employment and other spending in the industry and by fueling expansions in other sectors of the economy, the industry annually generates $374 million in federal tax revenue and $161.7 million in state and local tax revenues.
- Early care and education provides 67,507 jobs in the industry itself and generates an additional 17,454 jobs in other market segments.

SNAPSHOT OF GEORGIA'S CHILD CARE INDUSTRY

The early care and education industry in Georgia cares for an estimated 337,024 children each year. The data acquired through the survey of child care providers present a profile of the industry in Georgia as well as the children served.

- Centers and family child care homes serve children of need: 36.6% of children in centers and 68.9% of children in school-based programs receive meals subsidized through federal food assistance programs.
- More than 75% of centers and family child care homes operate 12 months per year; 10.9% of family child care homes and 2.8% of centers offer care on weekends (Saturday or Sunday), while larger percentages (20.6% and 7.7%, respectively) offer care in the evenings.
- The average weekly parent fee for infants ranges in family child care homes from $91 for rural providers to $127 for urban providers. Among centers, the average ranges from $99 for rural providers to $161 for urban providers.
- The average wage for administrators in centers is $15.40 per hour. Lead teachers earn an average of $12.30 per hour ($16.45 for Georgia's Pre-K or Head Start lead teachers, and $10.14 for all other lead teachers). Assistant teachers earn, on average, $9.18 per hour ($9.68 for Georgia's Pre-K or Head Start assistants, and $8.85 for all other assistant teachers). In family child care homes, paid assistants or substitutes earn an average of $8.25 per hour. In public schools offering Georgia's Pre-K, administrators or directors earn an average of $58.57 per hour, lead teachers earn $30.88, and assistant teachers $12.23.
- Paid holidays, paid leave, and paid time for training and education are among the benefits most often offered by centers to their full-time employees, regardless of whether they house Georgia's Pre-K or Head Start programs. Nearly all public schools offering Georgia's Pre-K provide paid leave, health insurance, and retirement plans for their full-time employees.

EFFECTS OF THE GREAT RECESSION

The Great Recession (2007–2009) significantly affected Georgia's labor force, with the unemployment rate topping 10% in the state. The child care and early education industry continues to feel the impacts of the recession. According to both center and family child care home providers, decreased enrollment was where they most felt the recession. For a minority of centers and family child care homes, enrollment has returned to pre-recession levels, but for many more such providers, enrollment has only partially rebounded. During the downturn, providers postponed some business improvements, lowered fees, or extended services. Since then, sizable numbers of providers have made some postponed improvements or are now less likely to discount or waive fees. Approximately 40% of center-based and family child care home providers indicate that earning enough income is one of the greatest challenges to their business, underscoring the recession's lingering effects.

LONG-TERM BENEFITS AND QUALITY OF CARE

Beyond short-term economic impact, the early care and education industry provides long-term benefits to children, parents, and society. This study also summarizes current research in this area. Heckman, Grunewald, and Reynolds (2006),Temple and Reynolds (2007), Bartik, Gormley, and Adelstein (2012), Herbst and Tekin (2012), and the U.S. Executive Office of the President's Council of Economic Advisors (2015) are among those who provide or discuss detailed analyses and cost-benefit calculations of returns on early education. These include benefits to parents and children that accrue to society through increases in short-term and long-term worker productivity and reductions in spending on social services. They find that the long-term benefits of early care and education attest to the enormous impact of the industry.

Quality of care is another important factor that influences the industry's impact. This study explores the magnitude of and ways in which high-quality early care and education increases the economic impact of the industry. Quality boosts the industry's economic impact in the short run through providers, who must hire more workers and generally spend more money per child, and in the long run through children, who are better prepared for school and thus better prepared to eventually become contributing members of Georgia's workforce.

In January 2012, Georgia launched the voluntary Quality Rated program to assess, improve, and communicate the level of quality in early education and school-age care programs. Although the program was in its early stages during the survey period, more than half (54.3%) of the responding center- and home-based Quality Rated providers indicate that the program has improved or is expected to improve teaching practices.

CONCLUSIONS

As the findings of this study demonstrate, early care and education in Georgia is a multibillion dollar industry. Despite the lingering effects of the recent Great Recession, the industry continues to generate significant economic activity daily as providers buy goods and services to operate their businesses and employ teachers, administrators, and a variety of support staff. Additional monies are spent by the industry itself and industries directly related to early care and education, generating further economic activity. Finally, the industry allows parents and families to work in a myriad of industries and businesses because care for their children is available. In coming years, the industry can look forward to an even greater economic impact as the economy continues to improve.

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The department also houses the Head Start State Collaboration Office, distributes federal funding to enhance the quality and availability of child care, and works collaboratively with Georgia child care resource and referral agencies and organizations throughout the state to enhance early care and education. For more information, go to www.decal.ga.gov.

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LEARNING POLICY INSTITUTE RESEARCH BRIEF JAN 2019

Untangling the Evidence on Preschool Effectiveness: Insights for Policymakers

Beth Meloy, Madelyn Gardner, and Linda Darling-Hammond

Abstract

Research showing that high-quality preschool benefits children's early learning and later life outcomes has led to increased state engagement in public preschool. However, mixed results from evaluations of two programs—Tennessee's Voluntary Pre-K program and Head Start—have left many policymakers unsure about how to ensure productive investments. This brief and the report on which it is based present the most rigorous evidence on the effects of preschool and clarify how the findings from Tennessee and Head Start relate to the larger body of research showing that high-quality preschool enhances children's school readiness by supporting substantial early learning gains in comparison to children who do not experience preschool and can have lasting impacts far into children's later years of school and life. Therefore, the issue is not whether preschool "works," but how to design and implement programs that ensure public preschool investments consistently deliver on their promise.

For the full report on which this brief is based, see: https://learningpolicyinstitute.org/product/untangling-evidence-preschool-effectiveness.

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Introduction

Differences in how children develop are substantially linked to their learning experiences. As early as 9 months of age, the differential experiences of children growing up in low-income households and children from more affluent homes are associated, on average, with a gap in their cognitive development. The developmental gaps continue to grow all the way through preschool, elementary, and secondary school unless other learning opportunities intervene.[1]

Evidence from early learning programs in the 1960s and '70s demonstrated enormous benefits for children (see Table 1). Those who attended these high-quality programs, the Abecedarian Project, Chicago Child-Parent Centers, and the Perry Preschool Project, were more ready for school and less likely to be identified as having special needs or to be held back in elementary school than children who didn't attend. When those children grew up, they graduated high school and attended college at higher rates, and they were less likely to become teenage parents, commit crimes, or depend on welfare. Inspired by this evidence and long-term social returns on investment as high as $17 for every $1 spent,[2] many states have invested in preschool programs to provide learning opportunities that improve children's outcomes.

A large body of research on contemporary preschool programs finds similar benefits for children's school readiness and later outcomes. However, evaluations of two programs—Tennessee's Voluntary Pre-K program and Head Start—found mixed results, leaving policymakers and the public confused about how to interpret the findings and what to do to ensure productive investments.

This brief and the report on which it is based present the most rigorous available evidence on the effects of preschool and find that well-implemented preschool programs support substantial early learning gains and can have lasting impacts throughout school. We also explain

Table 1
Early Evaluations of Preschool Programs Document Benefits Throughout Adolescence and Adulthood

Program	Age(s)	Outcomes (relative to comparison children)
Abecedarian Project	12	• Better performance on tests of intelligence and cognitive skills
	15	• Better performance on reading and mathematics assessments • Fewer retentions in grade • Fewer special education placements
	21	• Better performance on tests of intelligence and cognitive skills • More years of total education • Higher college attendance rates • Lower incidence of teen pregnancy • Lower reported rates of drug use
	30	• More years of total education • Four times more likely to have completed a B.A. or higher • More likely to have been consistently employed • Better health outcomes (lower rates of prehypertension and risk factors for heart disease)
Child-Parent Centers	14–15	• Better performance on standardized reading and math tests • Fewer retentions in grade • Less likely to be placed in special education, and fewer years receiving special education services
	18–21	• Higher rate of high school completion and lower rates of dropout • More years of total education • Lower incidence of juvenile arrest • Fewer special education placements • Fewer retentions in grade • Less likely to experience child maltreatment
	23–24	• Higher rates of high school completion • More years of total education • Higher rates of college attendance • Lower rates of incarceration and convictions • Higher rates of enrollment in health insurance • Lower rates of depressive symptoms
	35	• Higher rates of postsecondary degree completion
Perry Preschool Project	19	• Higher average high school GPA • Fewer years spent in special education during school • Higher rates of high school graduation • More likely to be employed • More likely to be economically self-sufficient • Less likely to be arrested for a minor offense
	27	• More likely to be employed • Higher rate of high school graduation • Higher average educational attainment • Higher average monthly earnings • More likely to own their own home • Lower number of adult and lifetime arrests
	40	• More likely to be employed • Higher annual median earnings • Less likely to be arrested

Note: This table reports significant positive outcomes only. Outcomes tested and found to be non-significant are not included.
Source: See Appendix D in the full report for a list of sources.

how the findings from Tennessee and Head Start inform our overall conclusion that preschool is an effective intervention. We further find that the quality of a preschool program matters for its outcomes and that the method a study uses to compare children in a program to others outside the program shapes the interpretation of the research findings. When children who attend a specific preschool program are compared to those who did not attend preschool at all—as opposed to those who attended the same or another program—the benefits of preschool are clear.

The evidence supports moving beyond the question of whether preschool "works" and focusing instead on the more pressing question of how to design and implement programs that ensure public preschool investments consistently deliver on their promise.

Our Review

We reviewed studies that used strong research designs (randomized experiments or those with well-controlled comparison groups) to understand the impacts of 21 public preschool programs at school entry and beyond. For the studies of the impact of preschool on children's school readiness, which has been extensively researched, we were extremely selective—including only evaluations with the strongest research designs (experiments and strong quasi-experiments). There are far fewer studies that follow preschool participants into the early elementary grades and beyond. For this timeframe, we included a wider range of research designs but maintained a high bar for the strength of each evaluation. Table 2 on page 11 lists the evaluations included in our review.

Note: See the full report at https://learningpolicyinstitute.org/product/untangling-evidence-preschool-effectiveness for a list of sources and a discussion of the methodology.

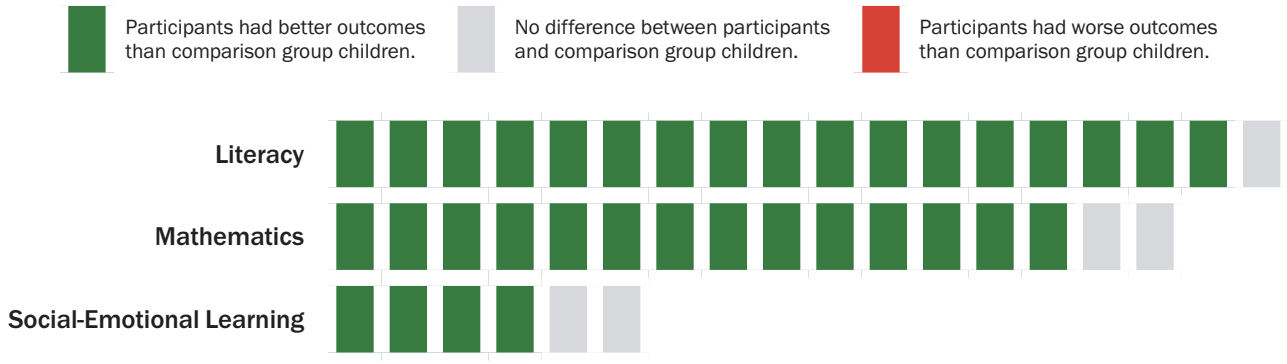
The Evidence

Most evaluations of preschool programs examine whether preschool effectively prepares children for school. These studies clearly show that children who attend preschool programs are better prepared for school than children who do not. Among the programs included in our review, researchers found clear benefits for participating children's early literacy skills in 17 out of 18 where such skills were evaluated (see Figure 1). Likewise, researchers found benefits for children's early mathematics skills in 14 out of the 16 programs where these skills were assessed. The few findings of "no difference" generally showed positive influences, though not large enough to be considered statistically significant, usually because of small sample sizes.[3]

Fewer studies examined children's social-emotional skills and executive function at school entry by measuring outcomes such as self-control and attentiveness. Of the studies that looked at these outcomes, four out of six found benefits for at least one measure, including emotion recognition and teacher reports of student engagement and behavior. In one of the "no difference" studies, the evaluators of the program suggested that difficulty in consistently measuring these skills across different grade levels and teachers may explain the lack of significant findings.[4]

Figure 1
Impacts of Preschool at School Entry

Each box represents a separate evaluation of a preschool program.



Note: Evaluations usually include many measures of child outcomes across different domains. Additional domains not included here are described in the full report.

The evidence examining whether the effects of preschool persist as children progress through school also paints a largely positive, though somewhat less consistent, picture (see Figure 2). Some studies found enduring effects, underscoring that long-lasting benefits are possible. Others, however, found few differences between children in a particular preschool program and children to whom they were compared in later grades.

As we describe later in this brief, there are often challenges in maintaining a comparison group over time that allows for clear interpretation of trends. Nonetheless, of the studies in our review that measure children's literacy beyond school entry, about half found significant benefits of preschool for children's reading performance in elementary school—in several cases persisting up to 5th grade—and the other half found little difference between the children who attended the specific preschool program and other children who remained in the comparison group throughout school.

Study methods can make a difference in results. For example, two evaluations of the same program—North Carolina Pre-K—had very different findings. One study found no effect on children's literacy skills at the end of kindergarten,[5] and the other found benefits for children's performance on standardized reading tests in 3rd through 5th grade.[6] The two studies had very different designs and measured literacy skills using different tests. They also used different comparison groups. The differences in findings are likely due to these differences in research methods and timing.

Of the 13 studies that examine children's mathematics performance throughout school, 10 document significant benefits, including some that persist well into middle school. One other study found a positive influence, though not large enough to be considered significant. Two of the studies, however, found that preschool participants performed less well than the children to whom they were compared on at least one measure of mathematics skills in the early elementary grades. These evaluations of Head Start and the Tennessee Voluntary Pre-K program are discussed in depth later in this brief. In both cases, we discuss concerns with the study design and comparison group composition in later grades. We also discuss how issues related to both program and later elementary school quality can affect the interpretation of these results.

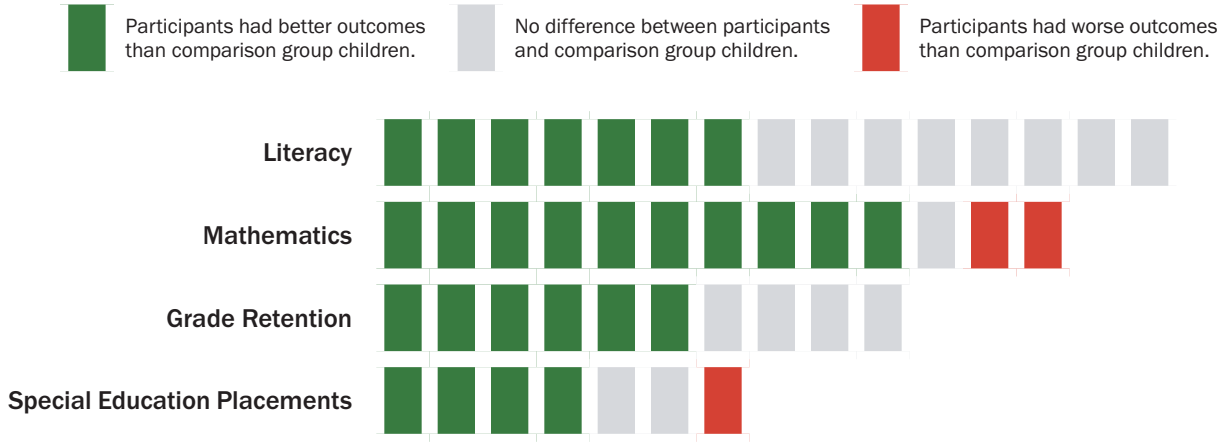
Finally, some preschool evaluations also examine impacts on grade retention and special education placements. Among the studies that examined special education placements, most (4 out of 7) found reductions in special education placements in elementary school for participating children, and two found no effect. The other study—of Tennessee Voluntary Pre-K—found that children who participated in preschool were significantly more likely to be placed in special education when they entered elementary school.[7] In that case, involvement with the public school system at an earlier age likely led to earlier identification of underlying developmental delays.

Of the studies that measured grade retention, most (6 out of 10) found a reduction for participating children in being held back in grade. Two evaluations of Tulsa's early childhood education programs did not find evidence of a difference between preschool participants and those in the comparison group. Both studies found fairly low rates of grade retention for all children, and in both cases, the evaluators suggested that many of the children to whom participants were compared attended other high-quality preschool programs, meaning both groups may have benefited equally from their early learning experiences.

Lower rates of grade retention and special education placements come with significant and immediate cost savings for school systems and society. School districts spend an average of $13,119 per child each year,[8] a cost that is doubled whenever a student is retained in grade. Retaining a child in grade also increases the likelihood of future retentions, compounding the associated costs.[9] Furthermore, the annual cost of providing special education services can be more than twice that of a general education program, and early identification of special needs—and education that addresses them early on—can reduce the number of years that special services are needed, further reducing the overall costs to schools and society.

Figure 2
Impacts of Preschool Throughout School

Each box represents a separate evaluation of a preschool program.



Note: Evaluations usually include many measures of child outcomes across different domains. Additional domains not included here are described in the full report.

Research Design Can Have Substantial Implications for Study Findings

Determining a preschool program's effectiveness requires researchers to compare children who attend that preschool program to similar children who do not, so that any differences can be attributed to the program. Early studies of early childhood education compared children who attended preschool to those who had no formal early learning experiences because preschool was not widely available.

In contrast, most contemporary studies compare children in a specific preschool with children who have a different early learning experience that may be in an equally high-quality preschool. In a case such as this, the findings of "no difference" mean that the children in the preschool program of interest do about as well as children who attended other preschool programs. Preschool may still have a positive effect, as both sets of children may be performing better than they would have without preschool and better than children who did not attend preschool at all. The only way to test the question of whether preschool matters is by comparing outcomes for children who did attend the preschool program under study and those who attended no preschool at all.

Researchers typically strive to ensure similarity of children being compared, and they may account for the early learning experiences of children who do not attend the program under study. Their success in creating comparable groups—and in making the appropriate comparisons within them—has important implications for the strength of their conclusions. However, not all studies are able to accomplish this goal.

Sometimes researchers are able to randomly choose which children can attend a program. Essentially, whether a child is able to enroll is determined by the flip of a coin. Those who do not attend become part of the comparison group. Evaluations using this approach have been particularly influential in the preschool debate because the children being compared should be quite similar if the selection is truly random and the sample size is large enough. Meanwhile, their early learning experiences, it is presumed, should be quite different. However, in practice, when a child is not chosen for the program being evaluated, her parents are often likely to enroll her in another preschool program. And, for many reasons, children chosen for the comparison group may drop out of the study, often making the groups no longer comparable. Both of these circumstances can influence the evaluation's findings and weaken the strength of its conclusions.

Whether—and how—researchers account for the early learning experiences of children in the comparison group also matters to the interpretation of findings. Studies that account for the early learning experiences of children in the comparison group can answer two questions: (1) What are the benefits of the preschool program for all eligible children, including those with the means and motivations to access high-quality alternatives? and (2) What are the benefits of the program for those children who live in homes or communities that lack those alternatives? These are critically important questions to be able to answer in early childhood research, as differences in the experiences of comparison groups often account for different findings.

Note: See the full report for an in-depth discussion of the methodology.

The implications of research design are clear in the case of one famous Head Start study. The study participants, who had attended Head Start, were compared to children who had either also attended Head Start, had attended another preschool program, or had attended no preschool program. Thus, the results were difficult to interpret and, in fact, showed little difference between the groups. As described in the box that follows, when Head Start participants were compared to children who did not attend any preschool program, the positive benefits of Head Start were obvious.

Do Head Start Gains "Fade Out"?

Head Start is a comprehensive, nationwide program for 3- and 4-year-old children in families with low incomes. Over the 50-year existence of Head Start, numerous evaluations have found benefits for children who participate compared to similar children who did not attend.[10] However, in 2012, the Head Start Impact Study found that early benefits of the program were undetectable by 1st grade: that is, the Head Start participants were not performing noticeably better than children in the comparison group.[11] The findings left policymakers with a lingering question: Do Head Start gains disappear?

The answer is: not necessarily. There are many possible explanations for these findings. For example, many of the children who were not admitted to Head Start by random assignment (and were not considered Head Start participants by evaluators) still attended preschool—and many of them attended other Head Start programs. As a result, in part, the study compared Head Start participants to other Head Start participants, masking the true effects of the program.[12] A recent re-analysis compared Head Start participants who would have stayed home if the evaluation had not allowed them to attend Head Start to children who did stay home when they didn't have access to Head Start. The study found large positive impacts on children's vocabulary in 1st grade for Head Start participants.[13] This evidence suggests that the benefits of Head Start may be larger and longer lasting for children without access to alternative care arrangements.

Several other evaluations of Head Start also showed benefits for longer term outcomes, such as grade retention, graduation rates, and educational attainment in adolescence and adulthood, despite finding similar "fade-out" on short-term outcomes like test scores.[14] Collectively, the evidence suggests that Head Start effectively prepares young children for school and that the relative size of the persistent benefits is more substantial when Head Start graduates are compared to children who were unable to attend preschool.

Furthermore, evidence suggests that policymakers should look beyond the Head Start years to the quality of elementary education to understand why the effects appear more or less lasting. A 2017 analysis found compelling evidence of the relationship between later school quality and the apparent impact of Head Start on child outcomes.[15] The study compared the adult outcomes of children who were differentially exposed to increases in Head Start spending and public k–12 school spending, and it found that for children from low-income families, the longer term benefits of Head Start spending were larger when followed by access to better funded schools. Likewise, the increases in k–12 spending were more impactful when children were exposed to greater early childhood spending. This evidence suggests that investments in elementary school may be critical to sustaining gains from preschool.

Research indicates that successful programs incorporate common elements of preschool quality, such as well-qualified educators, a developmentally appropriate curriculum, and adequate learning time.[16] Most or all of these elements are present in the programs that demonstrate the strongest and most persistent impacts on children.[17]

In studies of the longer term effects of preschool programs, the importance of quality teaching in early elementary grades also should not be discounted. In addition to findings that investments in elementary schools influence the strength of ongoing preschool effects,[18] researchers have found that the level of challenge provided by kindergarten teachers matters for later outcomes. A national study of kindergarten instruction found that many kindergarten teachers provide relatively uniform instruction that covers basic skills, even when alumni of a preschool program have likely already mastered these skills.[19] It also found that too much time spent on this basic content suppresses learning gains, whereas more time spent on more advanced content is positively associated with student learning. If kindergarten does not build on what children have learned in preschool and allow them to explore new ideas, preschool attendees may become disengaged and gradually lose ground relative to their peers.

Considerations of program quality as well as the nature of the comparison group in the Tennessee study have been raised as concerns that may account for its unexpected findings, as described in the box below.

Does Tennessee's Evaluation Prove That Preschool Doesn't Work?

Tennessee's Voluntary Pre-K program began as a success story: Initial results showed the program enhances children's school readiness in language, literacy, and mathematics. However, a follow-up evaluation appears to show no differences between program participants and comparison children on language development by 1st grade, and found that children in the study's comparison group actually surpassed program alumni on mathematics and reading skills by 2nd grade.[20]

These results understandably received attention, in part because of the study's design, which allowed the evaluators to randomly choose children either to attend the program or not. However, many of the children who were not chosen to participate in the program dropped out of the study at the start, and only one third of the remaining children agreed to additional developmental assessments in 3rd grade.[21] These were children whose parents returned a set of permission forms, calling the comparability of the comparison children to program alums into question.

A more recent follow-up evaluation of the Tennessee Voluntary Pre-K program accessed 3rd grade state achievement test scores and was able to include a broader group of comparison children.[22] This study, like its predecessor, found that children in the study's comparison group scored higher than program alumni on both reading and mathematics tests in 3rd grade. Do these findings mean that the Tennessee Voluntary Pre-K program—or that preschool as an intervention—doesn't work?

Not necessarily. There are a few other possible explanations. First, methodological issues may contribute to the study's findings. For example, in the Tennessee evaluation, the group of children to whom participants were compared was more advantaged than program alumni in nearly every way reported by the program evaluators.[23] These children were older, more likely to be White, less likely to be Black or Hispanic, and more likely to be native English speakers. Although these differences were not large enough to be statistically significant, it is possible that the cumulative impact of these advantages influenced the study's overall findings.

Further, it is possible that the more advantaged group of children to whom participants were compared went to better resourced elementary schools. Recent research has demonstrated the impact of elementary school investments on the magnitude and persistence of the impacts of early childhood programs.[24] If participant children attended more poorly resourced, lower quality elementary schools, their kindergarten teachers may have been ill equipped to support the development of children who varied substantially in the knowledge and skills they brought into the classroom.

In addition, the evaluators did not account for the early learning experiences of children who did not attend the program, some of whom attended other preschools.[25] Without direct comparisons of participants to children who did and did not attend other preschool programs, the results are difficult to interpret. It is impossible to know from the analysis whether the effects of the program were different for children without access to alternative early learning experiences, as was the case with Head Start.

Notably, earlier reports out of Tennessee foreshadowed this trend of initial gains for preschool participants followed by convergence or, in some cases, lower scores for program attendees in elementary school. Therefore, the quality of Tennessee's program, which evidence suggests may have been meaningfully different from programs that demonstrate effectiveness, is likely the more compelling explanation for these findings.[26] The evaluation's findings clearly demonstrate that program participants saw immediate benefits from program participation; however, it is possible that the quality of early instruction children received in their preschool year did not instill the type of deep understanding of mathematical and literacy concepts that would set the foundation for continued growth.

This explanation is supported by an evaluation of the quality of a sample of Tennessee Voluntary Pre-K classrooms. The study found substantial variation in observed teacher-child interaction quality, with some classrooms scoring quite high and others extremely low.[27] In the low-quality classrooms, teachers spent only a little more than half of their time engaged in learning activities, which may reflect poor classroom management or difficulties embedding learning into everyday routines and play. Further, critical elements of quality were completely missing from the program. For example, researchers observed that teachers received little support for professional development to improve instruction. The evidence suggests the quality of Tennessee's program may have been meaningfully different from programs that demonstrate effectiveness. In a recent assessment of statewide program quality, Tennessee's program met only 5 of the 10 new quality benchmarks set forth by the National Institute for Early Education Research (NIEER).

Given these considerations, it seems that the results of the Tennessee program evaluation warrant further investigation to understand their meaning, both in Tennessee and in relation to preschool more broadly.

Note: See the full report for a list of sources.

Conclusion

The weight of a sizable body of evidence indicates that preschool programs make a substantial difference in preparing children for school.[28] The evidence about continued effects beyond school entry is also positive, but less consistent. Sorting out these findings requires an examination of the way that different studies construct comparison groups—whether children in those groups are truly comparable to the children who attended the preschool program under study and whether they themselves attended a different preschool.

In order to generate meaningful impacts, early learning experiences need to be rich and engaging.[29] Implementing a high-quality preschool program well—offering compensation and support that attract and retain a highly qualified workforce; a program day that provides adequate, productive learning time and activities; and child assessments used to individualize learning—is complex and often expensive.[30] Finally, although preschool quality is important, even the highest quality preschool cannot inoculate children from the detrimental effects of poverty or poor elementary and secondary schools. Sustained benefits likely require investments in children and their families that are also sustained from preschool through grade school and beyond.

Preschool Pays for Itself

Preschool programs are often held up as savvy investments, in large part due to economic analyses signaling large returns on investment. Estimates of returns on investment in preschool range from the modest—$2 for every $1 invested when examined just a few years after preschool[31]—to the substantial—$17 for every $1 invested when tracked through adulthood.[32]

What explains this variability? The timing of cost-benefit analyses and the outcomes that evaluators measure directly affect the size of an estimated return. The largest returns have been observed among high-intensity programs that have documented long-term benefits such as lower rates of incarceration and higher earnings well into adulthood. More modest returns from contemporary programs, on the other hand, are usually based on short-term benefits such as reductions in special education placements and grade retention in elementary and middle school.[33] These can be expected to predict longer term benefits as children grow into adulthood and are more likely to graduate and gain productive employment.

Importantly, however, no cost-benefit analysis of a preschool program has ever found zero return, and any return that exceeds $1 for every $1 spent means the program more than pays for itself.

Table 2
Programs and Studies of Outcomes Included in This Analysis

Program	Timing of Evaluation: School Entry	Throughout School [a]
Arkansas Better Chance Program	Husted, Barnett, Jung, & Thomas (2007)	Jung, Barnett, Husted, & Francis (2013)
Boston Public Schools K1	Weiland & Yoshikawa (2013)	
California Transitional Kindergarten	Manship, Holod, Quick, Ogut, Brodziak de los Reyes, et al. (2017)	Manship, Holod, Quick, Ogut, Brodziak de los Reyes, et al. (2017)
Connecticut School Readiness Program	The Connecticut Academy of Science and Engineering (2016)	
Florida Pre-Kindergarten Early Intervention		Figlio & Roth (2009)
Florida Voluntary Pre-K		Miller & Bassok (in press)
Georgia's Pre-K Program	Peisner-Feinberg, Schaaf, LaForett, Hildebrant, & Sideris (2014)	Cascio & Schanzenbach (2013)[b]
Head Start	U.S. Department of Health and Human Services (2010)	U.S. Department of Health and Human Services (2012); U.S. Department of Health and Human Services (2010); Deming (2009)
Michigan Great Start Readiness Program	Wong, Cook, Barnett, & Jung (2008)[b,c]	
New Jersey Abbott Preschool Program	Frede, Jung, Barnett, Lamy, & Figueras (2007)	Barnett, Jung, Youn, & Frede (2013)
New Mexico Pre-K	Hustedt, Barnett, Jung, & Friedman (2010)	
North Carolina Pre-K	Peisner-Feinberg & Schaaf (2011)	Peisner-Feinberg, Mokrova, & Anderson (2017); Dodge, Bai, Ladd, & Muschkin (2016)
Oklahoma 4-Year-Old Program	Wong, Cook, Barnett, & Jung (2008)[b]	Cascio & Schanzenbach (2013)[b]; Smith (2016)
San Francisco Preschool for All	Applied Survey Research (2013)	
South Carolina 4K and First Steps to Success	Wong, Cook, Barnett, & Jung (2008)[b]	
Tennessee Voluntary Pre-K	Lipsey, Farran, & Durkin (2018)	Lipsey, Farran, & Durkin (2018)
Tulsa ECE Programs: CAP Tulsa Head Start	Gormley, Phillips, & Gayer (2008)[b]	Phillips, Gormley, & Anderson (2016)
Tulsa ECE Programs: Universal Pre-K	Gormley, Phillips, & Gayer (2008)[b]	Hill, Gormley, & Adelstein (2015); Gormley, Phillips, & Anderson (2017)
Virginia Preschool Initiative	Huang (2017)	Virginia University Research Consortium on Early Childhood (2015)
Washington ECEAP		Bania, Kay, Aos, & Pennucci (2014)
West Virginia Pre-K	Wong, Cook, Barnett, & Jung (2008)[b]	
Total Studies and Programs	**14 studies of 18 programs**	**19 studies of 14 programs**

[a] To capture a robust cross-section of literature on outcomes beyond school entry, we include studies of both early elementary school (grades k–3) and later grades (grade 4 through adulthood) where possible. In cells where multiple studies are listed, evaluations of both grade spans met the methodological bar for inclusion.

[b] This is a multi-program study.

[c] Following our review, a new and expanded version of this evaluation was released. For more information see: Barnett, W. S., Jung, K., Friedman-Krauss, A., Frede, E. C., Nores, M., Hustedt, J. T., Howes, C., & Daniel-Echols, M. (2018). State prekindergarten effects on early learning at kindergarten entry: An analysis of eight state programs. *AERA Open, 4*(2), 1–16.

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GEEARS
GEORGIA EARLY EDUCATION
ALLIANCE FOR READY STUDENTS

Health & Well-Being During Early Childhood

Maternal & Child Health

GEORGIA

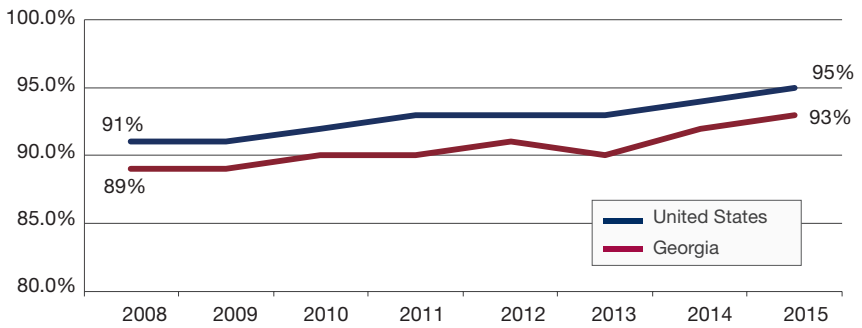
Snapshot of Children's Coverage

How Medicaid, CHIP, and the ACA Cover Children

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Children's health insurance coverage has reached historic levels in the U.S. and Georgia, thanks to Medicaid, CHIP, and the ACA.



Medicaid **1.3 million**

children in Georgia relied on Medicaid and CHIP at some point in FY 2016 to access the health care they needed to be healthy

PeachCare for Kids (CHIP) **232,050**

Marketplace **41,000**

children in Georgia were enrolled in Marketplace plans at the end of the 2016 open enrollment period

Medicaid and PeachCare for Kids (CHIP) serve Georgia's most vulnerable children.

A large share of at-risk children rely on public coverage, as reflected by the percentage of Georgia children in each group below that depend on Medicaid and PeachCare for Kids (CHIP) for health care they need to thrive:

76%  **Children living in or near poverty.**

48%  **Infants, toddlers, and pre-schoolers** during the early years that are key to their healthy development and school readiness.

46%  **Children with disabilities or other special health care needs** such as juvenile diabetes, congenital heart conditions, or asthma.

100%  **Children in foster care** who face poverty, family dysfunction, neglect, and abuse that result in high rates of chronic health, emotional, and developmental problems.

54%  **Newborns in families** to assure a healthy delivery and strong start during their critical first year of life.

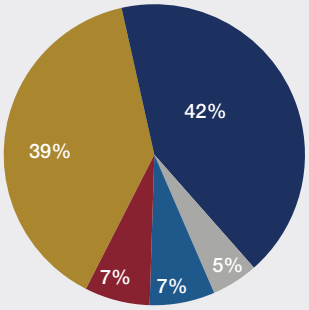
How Kids Are Covered

Medicaid is a primary source of coverage for children. Each state has the flexibility to design its program within federal guidelines and receives federal matching funds. For children, Medicaid provides guaranteed coverage, pediatrician-recommended services, and cost-sharing protections.

The Children's Health Insurance Program (CHIP), known as PeachCare for Kids in Georgia, builds on the foundation of Medicaid to cover children in working families who are not eligible for Medicaid and lack access to affordable private coverage. Each state designs its program within federal parameters but all CHIP programs provide affordable coverage with pediatric-appropriate benefits and networks. Nearly half (24) of all states provide Medicaid benefits to all children enrolled in CHIP.

The Affordable Care Act (ACA) established marketplaces where families can purchase health insurance and receive financial assistance. Marketplace plans provide essential health benefits, including pediatric services like dental and vision care.

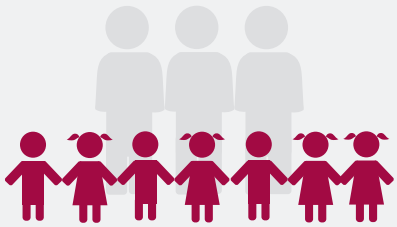
Sources of Children's Coverage in Georgia



- Medicaid and PeachCare for Kids (CHIP)
- Employer-Sponsored Insurance
- Purchased directly from an Insurer, including Marketplace plans
- Other including Medicare, Tricare, VA
- Uninsured

Medicaid and CHIP are critical to children's healthy development and success in life.

Medicaid covers preventive services including well-child check-ups, immunizations, and dental care. Through the program's definitive standard of care for children—known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)—Medicaid provides children with access to the care they need at a cost their parents can afford. EPSDT covers a comprehensive array of services for children, including developmental, vision and hearing screenings, so that health problems and developmental delays can be diagnosed and treated as early as possible, or averted altogether.



70%

of all Medicaid/CHIP enrollees in Georgia are children.

Medicaid provides affordable access to the care children need.

Administrative costs in Medicaid at the national level are half the rate typical in private insurance. In 2015, children accounted for 41 percent of individuals enrolled in Medicaid nationwide but represented only 19 percent of Medicaid spending, with an average annual expenditure per child of $3,389.

Medicaid helps children grow up to reach their full potential. Children enrolled in Medicaid:

Miss fewer school days due to illness or injury

Do better in school

Are more likely to graduate high school and attend college

Grow up to be healthier as adults

Earn higher wages

Pay more in taxes

What's at Stake?

Protect Children's Coverage

The ACA enacted critical protections that also benefit children and young adults covered by private insurance:

- Young adults between the ages of 19 and 26, an age group with the highest uninsured rates before the ACA, are able to stay on their parents' health plan.
- Children with asthma, cancer, or disabilities cannot be excluded from coverage due to their pre-existing condition.
- Insurance companies cannot impose annual or lifetime benefit limits, which would be especially hard on families with children who have special health care needs.

Keep Medicaid Strong

Medicaid is a federal-state partnership that guarantees coverage for the most vulnerable children, and covers 35 million children in the U.S. Restructuring Medicaid with reduced federal funding will force states to pit children's needs against other vulnerable groups, including individuals with disabilities and the elderly. Currently federal matching funds to states expand or shrink as the number of individuals enrolled or the cost of providing services changes based on need. Proposals like block grants or per capita caps that set limits on federal Medicaid funding—which accounts for 49 percent of all federal funding received by Georgia—will shift financial risk to the state to fill the gaps.

Support CHIP Funding

CHIP funding expires at the end of fiscal year 2017. CHIP works because it stands on the shoulders of Medicaid. CHIP funding must be extended to provide certainty and stability for families who depend on it.

49%

of total federal funds received by Georgia is for Medicaid.

This fact sheet was created by the Georgetown University Center for Children and Families and the American Academy of Pediatrics.
For data sources used, see http://ccf.georgetown.edu/2017/04/19/snapshot-source-2/.

For more information on Medicaid, CHIP, and the ACA, visit our websites at:
www.georgetown.ccf.edu www.aap.org

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2020 MARCH OF DIMES REPORT CARD

In the 2020 Report Card, we highlight the latest key indicators to describe and improve maternal and infant health in the United States (U.S.). Preterm birth and its complications are the second largest contributor to infant death in the U.S., and preterm birth rates have been increasing for five years. Prematurity grades are assigned by comparing the 2019 preterm birth grade to March of Dimes' goal of 8.1 percent by 2020.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

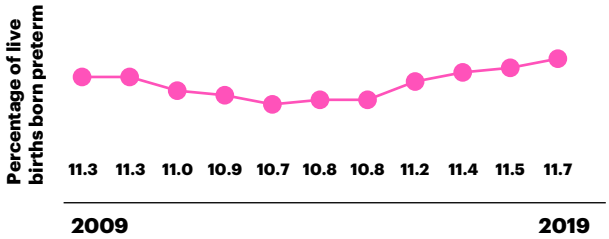
GEORGIA

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.7%

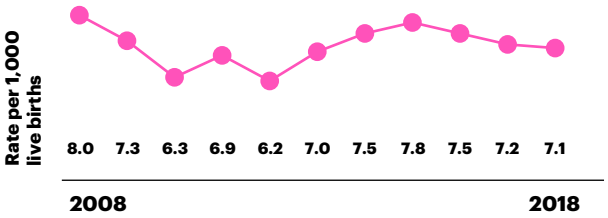


INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

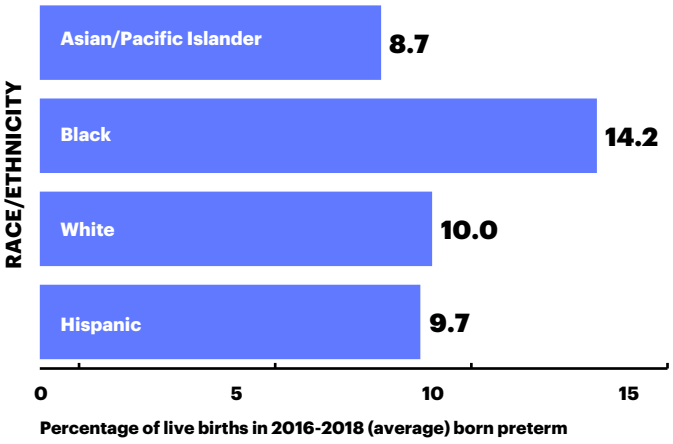
INFANT MORTALITY RATE

7.1



PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Georgia, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.30

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Atlanta	D-	11.4%	Better

MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

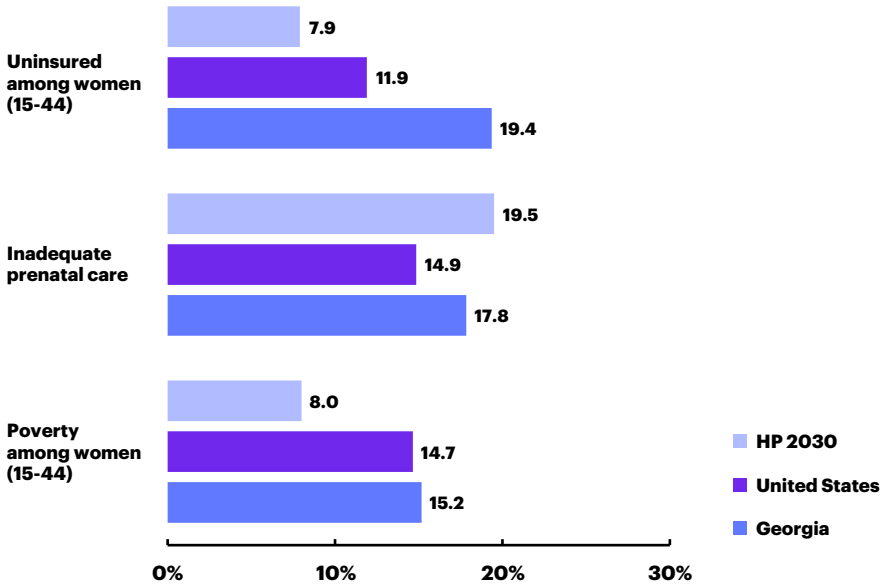
March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit **Policy & Action.** For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit **www.marchofdimes.org**.

Scan for details

GEORGIA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.



MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant health care.

Legend

- State has or is developing the indicated organization/policy
- State has the indicated organization and is CDC funded
- State does not have or is not developing the indicated organization/policy
- State is above estimated U.S. cost
- State is below estimated U.S. cost

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

Additional details on these future measures can be found **here.**

MORE INFORMATION **MARCHOFDIMES.ORG/REPORTCARD**

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2020 MARCH OF DIMES REPORT CARD TECHNICAL NOTES

PRETERM BIRTH: DEFINITION AND SOURCE

Preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the National Center for Health Statistics (NCHS) natality files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.[1] This national data source was used so that data are comparable for each state and jurisdiction-specific report card. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to timing of data submission and handling of missing data. The preterm birth rates shown at the top of report card was calculated from the NCHS 2019 final natality data. Preterm birth rates in the trend graph are from the NCHS 2009-2019 final natality data. County and city preterm birth rates are from the NCHS 2018 final natality data. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2016-2018 final natality data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

GRADING METHODOLOGY

Expanded grade ranges were introduced in 2019. Grade ranges remain based on standard deviations of final 2014 state and District of Columbia preterm birth rates away from the March of Dimes goal of 8.1 percent by 2020. Grades were determined using the following scoring formula: (preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and District of Columbia preterm birth rates. Each score within a grade was divided into thirds to create +/- intervals. The resulting scores were rounded to one decimal place and assigned a grade. See the table for details.

GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Preterm birth rate less than or equal to 7.7%.
A-	Preterm birth rate of 7.8 to 8.1%.
B+	Preterm birth rate of 8.2 to 8.5%.
B	Preterm birth rate of 8.6 to 8.9%.
B-	Preterm birth rate of 9.0 to 9.2%.
C+	Preterm birth rate of 9.3 to 9.6%.
C	Preterm birth rate of 9.7 to 10.0%.
C-	Preterm birth rate of 10.1 to 10.3%.
D+	Preterm birth rate of 10.4 to 10.7%.
D	Preterm birth rate of 10.8 to 11.1%.
D-	Preterm birth rate of 11.2 to 11.4%.
F	Preterm birth rate greater than or equal to 11.5%.

INFANT MORTALITY RATE

Infant mortality rates were calculated using the NCHS 2018 period linked infant birth and infant death data. Infant mortality rates were calculated as the number of infant deaths divided by the number of live births multiplied by 1,000. Infant mortality rate in the trend graph are from the NCHS 2008-2018 period linked infant birth and infant death files.

PRETERM BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother's race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 20 or more preterm births in each year from 2016-2018. To calculate preterm birth rates on the report card, three years of data were aggregated (2016-2018). Preterm birth rates for not stated/unknown race are not shown on the report card.

PRETERM BIRTH BY CITY

Report cards for states and jurisdictions, except District of Columbia, display the city with the greatest number of live births. Cities are not displayed for Delaware, Maine, Vermont, West Virginia and Wyoming due to limited availability of data. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2018 city preterm birth rate to the 2017 rate.

PRETERM BIRTH DISPARITY MEASURES

The March of Dimes disparity ratio is based on Healthy People 2020 methodology and provides a measure of the differences, or disparities, in preterm birth rates across racial/ethnic groups within a geographic area.[2] The disparity ratio compares the racial/ethnic group with the lowest preterm birth rate (comparison group) to the average of the preterm birth rate for all other groups.

To calculate the disparity ratio, the 2016-2018 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2016-2018 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2010-2015) among groups that had 20 or more preterm births in each year from 2010-2015. A disparity ratio was calculated for U.S. states, the District of Columbia, and the total U.S. A disparity ratio was not calculated for Maine, Vermont, and West Virginia. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

MORE INFORMATION **MARCHOFDIMES.ORG/REPORTCARD**

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit **Policy & Action.**
For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit **www.marchofdimes.org.**

Scan for details

PRETERM BIRTH DISPARITY MEASURES

Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2016-2018 disparity ratio to a baseline (2010-2012) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020.[2] If the disparity ratio significantly improved because the average preterm birth rate for all other groups got better, we displayed "Improved" on the report card. If the disparity ratio significantly worsened because the lowest group got better or the average of all other groups got worse, we displayed "Worsened" on the report card. If the disparity ratio did not significantly change, we displayed "No Improvement" on the report card.

The report card also provides the percent difference between the racial/ethnic group with the 2016-2018 highest preterm birth rate compared to the combined 2016-2018 preterm birth rate among women in all other racial/ethnic groups. This percent difference was calculated using only the racial/ethnic groups displayed on the state or jurisdiction-specific report card. This difference was calculated for each U.S. state with adequate numbers and the District of Columbia.

SELECTED SOCIAL DETERMINANTS OF HEALTH

March of Dimes recognizes the importance of certain risk factors that are associated with preterm birth. Three of these contributing factors are highlighted for each state. We reference target goals for these three measures from Healthy People 2030.[3] These risk factors are poverty in women (age 15-44 years), lack of health insurance in women (15-44 years) and inadequacy of prenatal care.

A woman was considered uninsured if she was not covered by any type of health insurance.[4] The uninsured percent is calculated among women ages 15-44 in 2018. Persons in poverty are defined as those who make less than 100% of the poverty threshold established by the US Census Bureau.[5] The Federal poverty threshold for a family of three was $20,598 in 2019. Poverty is reported for women 15-44 years in 2017-2019. Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant's gestational age.[6] Inadequate prenatal care is defined as a woman who received less than 50% of her expected visits.

MATERNAL AND CHILD HEALTH INDICATORS

MEDICAID EXPANSION — A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.[7,8]

Medicaid Expansion is provided from the Kaiser Family Foundation as adopted or not adopted. Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.[9]

MEDICAID EXTENSION — Advocacy for Medicaid extension by the Equitable Maternal Health Coalition (EMHC) supports that adoption of the policy allows women to avoid disruption to healthcare during the postpartum period and by maintaining access to healthcare, improves both maternal and child health outcomes.[10] Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.[10] Medicaid extension status is provided by the American College of Obstetricians and Gynecologists (https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage) as adopted and/or in development or not adopted and/or not developing. States who have had the following actions- the policy extension introduced, enacted or is currently implemented to some degree, are categorized as having recent action.

PRETERM BIRTH COST — Updated average preterm birth cost (2016) for state and District of Columbia utilized the 2007 Institute of Medicine's (IOM) study.[11] Preterm Birth: Causes, Consequences and Prevention served as the foundation for updating costs to 2016 and for providing separate estimates for each state and the District of Columbia.[12] Costs were updated adjusting for price changes over time and for variation in prices of services between states. Changes in the rate of preterm birth, the distribution of preterm birth by gestational age (GA), and the rate of infant mortality by GA at the national and state levels were also incorporated. This cost of preterm birth estimates are the most comprehensive national estimates to date, and provide the first profile of such costs by state for every state and the District of Columbia. Measure is provided as either above or below the calculated U.S. average.

MATERNAL MORTALITY REVIEW COMMITTEE — The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations.[13] The majority of pregnancy-related deaths are preventable.[14] States that have an MMRC are better equipped to prevent pregnancy-related deaths by having a better understanding of what is causing them in their state or city. The measure is provided by the CDC ERASE MM Program (https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html) and is categorized as having or developing the committee, having the committee with funding from CDC, or not having or developing the committee.

PERINATAL QUALITY COLLABORATIVE — The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. PQC's work focus on collaborative learning among healthcare providers and the PQC.[15] Data is provided by the CDC at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html and the measure is reported as either having or developing the collaborative, having the collaborative with funding from CDC, or not having or developing the collaborative.

2020 MARCH OF DIMES REPORT CARD TECHNICAL NOTES

CALCULATIONS

All natality calculations were conducted by the March of Dimes Perinatal Data Center. Calculations for the cost of premature birth were conducted by the University of Utah.

REFERENCES

[1] National Center for Health Statistics, final natality data 2016-2019.

[2] Talih M, Huang DT. Measuring progress toward target attainment and the elimination of health disparities in Healthy People 2020. Healthy People Statistical Notes, No 27. Hyattsville, MD: National Center for Health Statistics. 2016.

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GEORGIA:
MATERNAL MORTALITY

THE NUMBERS
(2012- 2016)

66
PREGNANCY-ASSOCIATED DEATHS
PER 100,000 LIVE BIRTHS

26
PREGNANCY-RELATED DEATHS
PER 100,000 LIVE BIRTHS

70%
WERE PREVENTABLE
PREGNANCY-RELATED

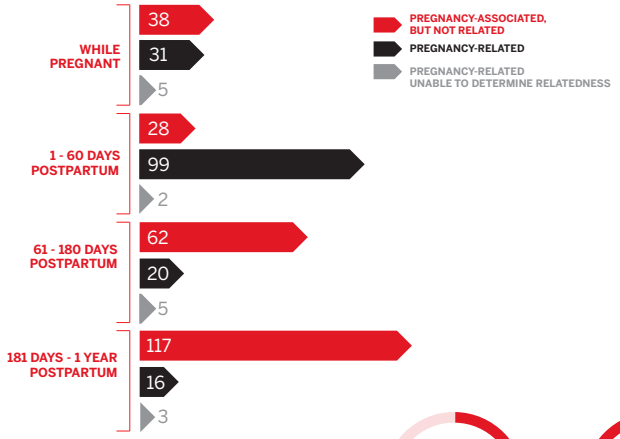
2.7x
BLACK WOMEN
NON-HISPANIC
MORE LIKELY TO DIE FROM
PREGNANCY-RELATED CAUSES THAN
WHITE WOMEN
NON-HISPANIC

PREGNANCY-ASSOCIATED, BUT NOT RELATED:
A death during pregnancy or within one year of the end of pregnancy due to a cause that is not related to pregnancy.

PREGNANCY-RELATED:
A death during pregnancy or within one year of the end of pregnancy from pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

THE LEADING CAUSE OF DEATHS (PREGNANCY-RELATED)
• Cardiomyopathy • Cardiovascular / Coronary • Hemorrhage • Embolism
• Preeclampsia + Eclampsia

PREGNANCY ASSOCIATED DEATHS BY RELATEDNESS + TIMING OF DEATH IN RELATION TO PREGNANCY IN GEORGIA



PREGNANCY-ASSOCIATED DEATHS OCCURRING AFTER DELIVERY BY PAYOR
(WITH A KNOWN PRIMARY PAYOR),

MATERNAL MORTALITY REVIEW COMMITTEE
RECOMMENDATIONS

- Georgia should **mandate an autopsy** be performed on all pregnancy-associated deaths.
- Obstetric Providers, insurance providers, and birthing hospitals **should ensure case management is provided** for women **during pregnancy and postpartum**.
- Georgia should **extend Medicaid coverage up to one year postpartum**.
- Obstetric providers should **use a validated instrument for screening perinatal mood** and **anxiety disorders** at the first prenatal visit, in each subsequent trimester, and at the postpartum visit.
- Obstetric, Primary Care and other Providers should **initiate pre-pregnancy counseling on all women of reproductive age**, in accordance with the American College of Obstetricians and Gynecologists recommendations to optimize health, address modifiable risk factors, provide education about healthy pregnancy, and family planning counseling.

For more information: **www.dph.ga.gov/maternal-mortality**

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Babies Can't Wait

Voices for Georgia's Children

Babies Can't Wait (BCW) is Georgia's evidence-based, community-centered early intervention program that provides screening, treatment, and support services for certain infants and toddlers (from birth to age 3) with disabilities and developmental delays.

A child's brain develops extremely rapidly from birth to age three. **This is a critical window of opportunity to detect and address developmental delays before they become significant barriers to healthy development.** BCW staff work with physicians to identify children showing signs of certain degrees of developmental delays so that needed supports can be provided early on – and long-term development challenges can be prevented or mitigated.

WHO QUALIFIES FOR SERVICES?

BCW serves children 0-36 months who have a documented* developmental delay or chronic health condition that leads to developmental delays.

A free developmental evaluation is given to families to determine eligibility for services and supports under the program.

Services provide support and resources to assist family members/caregivers to enhance children's learning and development in the child's natural environment (e.g., home or community setting).

Anyone can refer a child to Babies Can't Wait[2]

Parents

Childcare Providers

Doctors

HOW THE PROGRAM IS FUNDED

babies can't wait is funded by state and federal dollars, and housed within

DPH Georgia Department of Public Health

HOW SERVICES ARE PAID FOR

First, services are billed to the child's health insurance (where applicable and with parent permission)

A sliding fee is determined based on income and family size

Services are then paid for by the BCW program as payor of last resort, if needed

CHILDREN SERVED BY BABIES CAN'T WAIT

Approximately **19,000** children are served** every year in Georgia

The number of children that are referred and eligible is increasing each year[1]

It's likely that more children are in need of services than BCW can currently serve, given existing constraints

* According to the Georgia Department of Public Health, children must score 2 standard deviations from the mean in one area of development, or 1.5 standard deviations in two areas of development on one of the approved standardized eligibility test tools. If a child does not show a documented delay per the test results, the team can determine eligibility based on informed clinical opinion.

**All children received Service Coordination or case management services to guide them through the program and to assist in developing the Individualized Family Service Plan (IFSP). Should a child need additional services determined by the IFSP team, it is added to the plan and coordinated by the Service Coordinator.

www.georgiavoices.org

STEPS TO RECEIVE EARLY INTERVENTION SERVICES

1

Referrals are given by a pediatrician, care provider, or a parent or guardian for assessment. Assessment of children must start within 45 days of referral.

2

Intake is conducted by BCW coordinators in order to assess potential delays or diagnoses. Early Intervention Coordinators (EIC) and Service Coordinators ensure that children receive assessments and services in a timely fashion and align with the care plan; they also ensure that timely and complete data is collected.

3

Public health care coordinators create an Individualized Family Services Plan (IFSP) based on each child's needs. These coordinators serve all 18 public health districts.

4

Children and families receive services for conditions based on their IFSP up until their 3rd birthday. Services are provided by BCW staff and contracted physical therapists, speech therapists, and other providers.

5

The child's progress is evaluated annually or as needed based on their IFSPs. BCW coordinators work with providers and families to determine if additional services are needed.

6

Transition plans begin at 27 months. BCW coordinators help develop a plan with parents to determine which next step will meet the child's needs after they are no longer eligible for BCW. Options for next steps include private physical therapy, behavioral therapy, or other health services. Transitions may also include creating an educational plan comparing private child care, public preschool, and Head Start.

CHALLENGES TO THE SUCCESS OF THE BABIES CAN'T WAIT PROGRAM

While Babies Can't Wait is implemented in all 18 public health districts, the program has encountered challenges with having enough contractors, particularly in rural areas of Georgia, to meet all the service needs of the children enrolled. **Understaffing ultimately results in children/families not receiving the support they need.**

RECOMMENDATIONS TO STRENGTHEN THE BABIES CAN'T WAIT PROGRAM

- Assess and address staff retention issues.
- Prioritize coordination and follow-up coordination/communication between referral source (e.g. physician) and program staff.
- Recruit providers to serve in all districts at numbers that meet the demand for services.
- Leverage telehealth for providing services to parents/caregivers where possible.
- Continue to explore whether there are early intervention services provided by the state which could be billed to Medicaid and/or private insurance (e.g. provider-to-provider consultations to coordinate services). If feasible, this would allow greater flexibility for IDEA Part C grant funds to support case management.

Babies Can't Wait is a federally regulated program under the Individuals with Disabilities Education Act, specifically, Part C of the law. The program is to be a statewide, coordinated, multidisciplinary inter-agency system that provides early intervention services for infants and toddlers, and coordinates developmental, educational, and community supports for those children. However, eligibility criteria may vary state to state.

Rev. 12/2020
Sources available here: https://tinyurl.com/BabiesCantWait

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Childhood Lead Poisoning

Voices for Georgia's Children

Lead is a heavy metal found in the earth's crust that does not break down in the environment.[1] When someone inhales or swallows lead, they can suffer serious health consequences, up to and including death.[2]

WHAT IS CHILDHOOD LEAD POISONING?

The Centers for Disease Control and Prevention (CDC) recommends intervention for children with a blood lead level presence of 5 or more micrograms per decileter.[3] Currently, Georgia law recommends intervention when blood lead levels are 15 or more migrograms per decileter of lead within the body.[4] Children under age 6 are at the greatest risk of lead poisoning.[5]

EFFECTS OF LEAD POISONING ON CHILDREN

Children's bodies absorb lead more easily, affecting brain and other physical development, like in organs and the nervous system.[9] Even low levels of lead can result in:

- Speech, language, and behavioral problems
- Learning disabilities and Attention Deficit Disorder
- Lower IQ
- Nervous system damage

Prenatal exposure can cause **miscarriage**, premature birth, and damage to baby's brain, kidneys, and nervous system[6]

In 2020, 94,484 of Georgia's children were screened for lead poisoning. Of those, **1,942 children** had **lead poisoning measuring 5 ug/dL or more.**[8]

DISPARITIES ON LEAD EXPOSURE

According to 2019 Georgia Department of Public Health data, childhood lead poisoning is more prevalent in Asian, Black, and Multi-racial children than White children.[7]

All children enrolled in Medicaid or PeachCare for Kids are supposed to be tested for lead poisoning at age 12 months, 24 months, and – if they haven't yet been tested – between 36 and 72 months. However, according to CMS data, only half of all eligible 12-24 month old children in Georgia were screened for lead poisoning in 2019.[11]

DID YOU KNOW?

Higher levels of lead - also called elevated blood lead levels - can cause coma, convulsions, intellectual disabilities, developmental disabilities, seizures, and death. Elevated blood lead levels can require expensive medical treatment and exacerbate health conditions like asthma.[10]

Where is Lead Found?

Paint

Older homes and buildings are more likely to have lead-based paint. While the use of lead in residential paints was banned in 1978, lead is present in many buildings built prior to that date.[12]

Soil

Yards and playgrounds may become contaminated from exterior lead-based paint flakes, industrial sources, or even contaminated sites. Also, lead is naturally occurring and can be found in high concentrations in some areas.[20]

Water

This can be caused by corrosion of plumbing materials (e.g. pipes and fixtures). Homes built before 1986 are more likely to have lead pipes, fixtures and solder.[14]

Small metal objects

Which can be swallowed by children.[15]

Toys and Other Items

May be present in those imported from other countries.[16]

Herbal or folk remedies

Greta and azarcon, which are traditional Hispanic medicines, as well as other traditional medicines from India, China, Bhutan and others can contain lead.[13]

PROTECT YOUR FAMILY

- Have your child tested
- Get your home checked for lead hazards
- Test your water
- Clean regularly
- Remove shoes or wipe off soil before entering house

REPORTING LEAD HAZARDS IN YOUR HOME

Landlords and home sellers are required to provide information on any known lead-based painting hazards in homes built before 1978.[17]

Sellers must provide a 10-day period for the buyer to test the home for lead.[18]

FOUR THINGS TO DO TO HELP LOWER YOUR CHILD'S LEAD LEVELS[19]

1. Make a plan with your child's doctor.
2. Find the lead in your home using a licensed lead inspector.
3. Clean and dust windowsills, baseboards, and floors.
4. Eat foods high in calcium, iron, and vitamin C. These vitamins and minerals help keep lead out of the body.

POLICY RECOMMENDATIONS

- Update Georgia law to comply with the Centers for Disease Control and Prevention standards for childhood lead poisoning (5µg/dL) and recommended interventions (DPH)
- Expand Georgia law to include blood lead level monitoring and mitigation strategies for women of childbearing age (DPH)
- Develop and implement multi-year lead test and mitigation strategies in built environments and drinking water at schools, childcare facilities, and other non-home locations where children spend time.* Explore federal and other public or private funding mechanisms to cover costs.
- Expand partnerships to increase blood lead level testing sites (e.g., clinics, labs, point of care) (DPH)
- Encourage Care Management Organizations (CMOs) to increase well-child visits and mandatory Medicaid child lead screenings.** (DCH)
- Assess and address built environment for each child whose blood lead level is equal to or greater than the CDC action level, especially for children under 3 years old (DPH, GEPD)

*Lead testing and mitigation strategies for drinking water may consider the Georgia Lead Poisoning Prevention Act of 1994, which addresses lead-based paint.

**Medicaid federally requires that every state provides at least 80% of Early and Periodic Screening, Diagnostic and Treatment recipients with timely medical screens, including lead screening for under age six.[21] Federal data show that from 2015 to 2019, Medicaid lead screening rates steadily declined in Georgia (from approximately 108,000 to 96,000) for ages 0-6.[22]

Rev. 10/2021

Sources available here: https://tinyurl.com/GAChildhoodLeadPoisoning22

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Early Childhood Social-Emotional Health

RESEARCH BRIEF
SEPTEMBER 2019

What Policymakers in Georgia Need to Know About Infant-Toddler Social-Emotional Health

THE IMPORTANCE OF INFANT AND TODDLER SOCIAL-EMOTIONAL HEALTH

A child's brain develops most rapidly in the first three years of life, forming more than one million new neural connections every second.[1] Nurturing relationships with caregivers and positive experiences during this time support brain growth, emotional well-being, and social competence, leading to healthier, more successful children, teens, and, eventually, adults.[2]

Healthy social-emotional growth in infants and toddlers, also known as infant and early childhood mental health (IECMH), provides an essential foundation for early learning, school readiness, and long-term success.[3] Three key capacities make up infant and early childhood mental health.[4] These are the capacity:

- **to form a close, secure relationship with the adults who care for them;**
- **to experience and express a range of emotions, and over time, learn to manage these (e.g., cope with frustration); and**
- **to feel comfortable exploring their environment.**

Social-emotional development is intertwined with cognitive development. This connection and its role in learning can be observed in everyday behavior. An infant who joyfully participates in back-and-forth "conversation" with a parent is learning language and turn-taking skills. While trying to stack blocks, the curious, confident toddler gains motor skills and spatial knowledge. In moments like these, we see that healthy social-emotional growth propels infants and toddlers to seek out and fully engage in learning experiences through interactions with trusted caregivers and exploration of the environment. While social-emotional capacities look different at later ages, they continue to be essential to learning and positive relationships through children's school years and continuing into adult work and family life.

IMPORTANT TERMS:

- **IECMH**: Infant and Early Childhood Mental Health (also known as Infant and Toddler Social-Emotional Health)
- **DC 0-5**: a system and manual for diagnosing mental health and developmental disorders in young children
- **Screening tools**: questionnaires completed by parents or healthcare providers to determine if a young child has social-emotional challenges
- **Dyadic Treatment**: a treatment approach to addressing social-emotional concerns in which a therapist treats an infant/toddler and caregiver together
- **IECMH Consultation**: a specialist who works with child-serving professionals, such as pediatricians or educators, to promote the social-emotional health of infants and toddlers

GEEARS GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

NCCP National Center for Children in Poverty
Putting research into action to improve lives

MENTAL HEALTH CHALLENGES OF INFANTS AND TODDLERS

Just like positive experiences support the social-emotional and cognitive development of young children, negative experiences and prolonged stress can have adverse impacts on their development. Recent estimates suggest that between 9 and 14 percent of children under age 6 experience emotional and behavioral problems.[6] Along with genetic predispositions, Adverse Childhood Experiences (ACEs) such as the death of a parent, toxic stress in the form of repeated and prolonged stressful events such as neglect or abuse, and maternal depression can derail healthy brain development and potentially contribute to diagnosable mental health conditions in infants and toddlers.[7] Conditions include anxiety (both general and related to separation from a parent or other caregiver, as well as phobias), depression, and sleep and eating disorders. Descriptions of mental health conditions specific to early childhood (birth to age five) are described in a widely used, research-informed diagnostic system, DC:0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood).[8]

While many behavioral problems during infancy and toddlerhood are short-term in nature, some mental health conditions diagnosed during this period can persist, particularly for those infants and toddlers with more than one type of condition.[9] Very early mental health conditions also significantly increase the chance that children will experience both mental health and learning difficulties in their school years.[10] The prevalence of young children experiencing mental health challenges is markedly higher in families facing economic hardship and other stressful circumstances, such as maternal depression.[11]

STRATEGIES TO ADDRESS AND PREVENT INFANT-TODDLER MENTAL HEALTH CONDITIONS

Infants and toddlers with mental health conditions are likely to miss out on critical learning and developmental experiences during the first three years, and beyond. A persistently sad, withdrawn infant is likely to engage less in the kinds of interactions with caregivers that build the child's vocabulary, and a fearful toddler will be less eager to learn through play with new objects and exploration of the environment. These children are at risk of entering kindergarten lacking key school readiness competencies. One study found that social-emotional skills measured at kindergarten entry predicted a range of long-term outcomes, including educational achievement in high school and adult employment, substance use, mental health, and criminal activity.[12]

Fortunately, there are effective means of identifying infants and toddlers who can benefit from further evaluation and treatment with evidence-based interventions for diagnosed conditions. There are also promising approaches to helping professionals who work with infants, toddlers, and families – pediatricians, child care providers, early intervention specialists, and home visitors – address infant and toddler mental health needs.

The following are examples of key interventions and strategies that a growing number of states are using to help ensure the best long-term outcomes for infants and toddlers.

Child and Parent Screening and Diagnosis

As reflected in guidance by the American Academy of Pediatrics (AAP), screening in pediatric settings with valid tools is highly effective in identifying young children, beginning in infancy, who may have mental health conditions.[13] The use of tools, such as the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE),[14] that are specifically designed to screen for social-emotional delays, are better at identifying children than broad developmental screeners or the pediatrician's clinical judgement.[15] An increasing number of states are training clinicians in the DC:0-5, which helps them consider diagnoses specific to early childhood when evaluating infants and toddlers who have positive screens.[16] The AAP also recommends screening parents for depression, a key risk factor for child social-emotional and developmental problems.[17] Because maternal depression during and after pregnancy is associated with children's short- and longer-term mental health conditions, it is critical to identify mothers who may need further evaluation and treatment.[18]

Many states provide Medicaid coverage for both child and parent mental health screening in the first year, and beyond. Social-emotional screening of infants and toddlers can also be used to identify children in need of further evaluation in early care and education settings, early intervention, and home-visiting. Georgia Medicaid currently reimburses for maternal depression screenings but does not cover social-emotional screenings for infants and toddlers.[19]

Dyadic Treatment

In dyadic treatment, the young child and caregiver (the dyad) are treated together. A therapist guides the caregiver to engage in warm, responsive interactions with the child, giving both the chance to enjoy positive exchanges and to build a nurturing relationship. Examples of evidence-based dyadic treatment models include Parent-Child Interaction Treatment (PCIT) and Child-Parent Psychotherapy (CPP). The benefits of dyadic treatment, found in numerous studies, include enhanced parenting skills, reduced parent stress, improved parent-child relationships, and fewer child behavior problems.[20] Dyadic treatment with parents who are experiencing depression has been found to improve cognitive development in children.[21] While there are providers who offer dyadic treatment in the state of Georgia, they are not currently eligible to receive Medicaid reimbursement for this critical intervention.

Parenting Programs

To prevent and treat early childhood mental health conditions, some infants, toddlers, and their families can benefit from evidence-based parenting programs. Evidence-based/research-informed models include Incredible Years, Triple P, and Circle of Security. These parenting programs have been shown to reduce problem behavior in infants and toddlers.[22] Some Early Head Start programs across the state have begun providing access to these parenting programs, but, like dyadic treatment, they are not currently covered by Medicaid in Georgia.

The Washington State Institute for Public Policy has analyzed several dyadic treatment programs used with children from birth to three, including Child-Parent Psychotherapy (CPP) and Triple P (Positive Parenting Program).
In the treatment of trauma, CPP was found to produce benefits of $57,205 per participant in the form of higher labor market earnings and reduced health care costs.
In the treatment of disruptive behavior, Triple P was found to produce benefits of $5,115 per individual if delivered individually and $3,591 if delivered in a group setting.[23]

Infant and Early Childhood Mental Health Consultation

Specialists in infant and early childhood mental health can work with pediatricians, home visitors, early intervention specialists, and child care providers to help them identify and support very young children who are at risk of or demonstrating mental health conditions or social-emotional delays. These specialists, called IECMH consultants, understand the importance of working in settings where young children already spend a significant amount of time. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends IECMH consultation (IECMHC) as a critical tool for child-serving professionals and has established a Center of Excellence on IECMHC.[24]

In early care and education settings, IECMH consultation has been found to help teachers and providers use more effective strategies and support reductions in challenging behavior.[25] The study of IECMHC in other settings is currently more limited, but emerging evidence suggests that it can be a promising approach in home visiting for helping providers understand young children's mental health needs and increasing knowledge of options for addressing these needs within visits and through referrals.[26] Healthy Steps, an evidence-based model that embeds an early childhood mental health and developmental specialist in pediatric settings, has been found to improve children's behavior.[27] In a few pockets around the state, the IECMH consultation model has been implemented in Early Head Start and some child-serving public health programs.

GEORGIA'S ROLE IN PROMOTING INFANTS' AND TODDLERS' HEALTHY SOCIAL-EMOTIONAL DEVELOPMENT

States across the country are investing in the social-emotional well-being of their infants and toddlers, recognizing the long-range value of optimal development in the earliest years. In order to keep pace with other Southern states, Georgia must begin by putting into place a core set of policies that serve as a foundation for supporting the needs of our youngest children. Longer term, the addition of other strategies can create a strong system of IECMH supports designed to help Georgia's children thrive.

Policy Innovations
that Support Young Children and their Families

- In 42 states (including Mississippi, Alabama, and South Carolina) Medicaid programs **cover infant and toddler social-emotional screening.** Georgia is just one of 8 states that does not.[28]
- Tennessee, along with 6 other states, allows providers to **use DC: 0-5 for child diagnoses along with a crosswalk to ICD-10 to receive Medicaid reimbursement** for their services.[29]
- Arkansas created **specific infant and early childhood mental health billing codes** in their Medicaid provider manuals.[30]
- In 42 states, **Medicaid reimburses for dyadic (parent-child) treatment**, with about one-third requiring use of an evidence-based model.[31] Georgia is one of 8 states that does not use Medicaid for reimbursement of this treatment for children under 5.
- In 16 states, **Medicaid covers parenting programs**, such as Triple P, Circle of Security, and Incredible Years, that address infant and early childhood mental health conditions.[32]

Foundational Recommendations:

Ensure Medicaid and CHIP coverage for and access to infant and toddler social-emotional health screenings and services, including evidence-based dyadic treatment and parenting programs such as Incredible Years and Circle of Security:

- Updated Medicaid provider codes should include language that specifies age-appropriate treatment for children 0-47 months and incorporates evidence-based dyadic treatment and parenting programs.
- These codes should allow for treatment in medical, child care, and home settings.

Arkansas implemented Medicaid codes that specify reimbursement for dyadic treatment and parenting programs such as Triple P and Incredible Years for children 0-47 months. (Sections 252.114 & 252.115)[33]

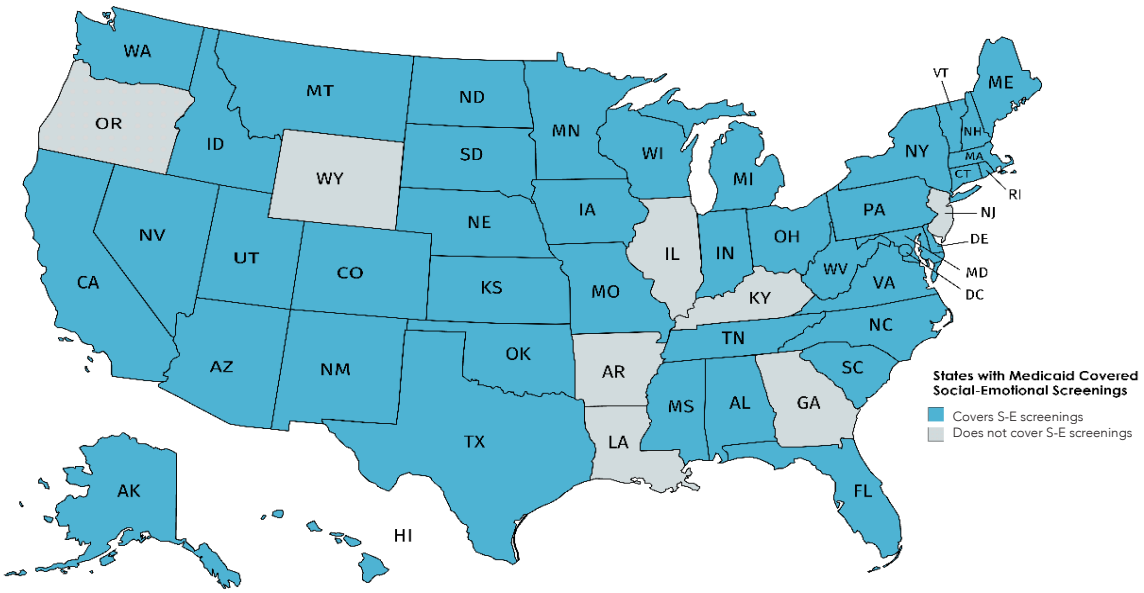
Adopt DC:0-5 for diagnosis of infant-toddler mental health disorders:

DC:0-5 provides developmentally appropriate diagnoses for young children experiencing mental health challenges. Require that mental health clinicians use DC:0-5 for IECMH diagnosis and treatment planning, and formally recognize DC:0-5 in public and commercial insurance programs, including Medicaid.[34]

IMPORTANT TERMS:

- **System of Care (SoC)**: a spectrum of community-based services and supports for children and youth at risk for mental health or other challenges and their families. Georgia's SoC State Plan, a "roadmap for improving the child and adolescent behavioral health system in the state," is outlined for individuals ages 4-26.
- **Babies Can't Wait**: Georgia's early intervention program for children up to 36 months with developmental delays and/or certain diagnosed conditions that have a high probability of resulting in delays
- **Home Visiting**: evidence-based and voluntary programs that provide support and services to families of young children through in-home visits and group settings

States with Medicaid Covered Social-Emotional Screenings



Improve social-emotional screening:

Promote the consistent use of social-emotional screening tools in pediatric settings – and not solely for the purpose of identifying children who may have Autism Spectrum Disorder. Tools such as the ASQ:SE can identify very young children who may have social-emotional delays and require further evaluation. These screenings should be used as part of the Bright Futures Periodicity Schedule recommended by the American Academy of Pediatrics.

Expand Georgia's behavioral health System of Care State Plan to include children younger than 4:

The current System of Care State Plan, which specifies service delivery for children ages 4-26, is due to be evaluated in 2020. The Interagency Directors' Team (IDT), led by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), should be encouraged to extend the Plan to children younger than 4.

Arkansas' Medicaid program developed **an approval process for clinicians providing mental health services to children 0 to 4**. In order to receive Medicaid reimbursement, clinicians must complete a **DC:0-5 training** to learn this system of diagnosis tailored to young children. They must also be trained in an **approved evidence-based dyadic treatment model**; Child-Parent Psychotherapy or Parent-Child Interaction Treatment are the most commonly used dyadic treatment models in the state. Training for providers is offered free of charge and funded with federal and state dollars. Approved providers are able to use billing codes that reimburse at a 10 percent higher rate.[35]

Six states have developed a **crosswalk** between ICD codes, the system **Georgia Medicaid** currently uses for diagnoses in older children and adults, and **DC: 0-5** so that providers can easily provide a diagnostic code for **children under 4** for Medicaid billing purposes.[36]

Each of Louisiana's 19 home visiting teams has an embedded **IECMH consultant** who provides consultation to home visitors related to infant-toddler mental health concerns and maternal depression. These consultants also provide Child-Parent Psychotherapy, an evidence-based dyadic therapy model, as needed. In some regions of the state, IECMH consultation is available to pediatric and Part C Early Intervention providers. These providers can call a full-time resource and referral hotline to receive information about mental health resources in the community. Specially trained masters-level clinicians provide individualized consultation over the phone. Additional consultation with a psychiatrist is available as needed.[37]

Long-Term Investments in Infant-Toddler Social-Emotional Health:

Invest in training for clinicians who can deliver evidence-based dyadic treatment and parenting programs:

Offer free or low-cost training for mental health clinicians serving young children in evidence-based dyadic therapy such as PCIT and CPP, and parenting programs such as The Incredible Years and Circle of Security. Offer training, based on research-informed models, to clinicians who want to become IECMH consultants.

Finance infant and early childhood mental health consultation:

Infant and early childhood mental health specialists should be reimbursed for providing IECMH consultation to pediatricians, child care providers, early intervention specialists, and home visitors that helps them identify and address social-emotional difficulties and work with families to support children's well-being and healthy development. These child-serving entities should be encouraged to seek out IECMH consulting.

Increase the capacity of Babies Can't Wait and the Georgia Home Visiting Program to serve more children and to meet their social-emotional needs:

While the number of children in need of these services has continued to grow, the capacity of these critical programs has not. For example, the Georgia Home Visiting Program is currently available in only 20 counties, and the number of children referred to Babies Can't Wait continues to outpace the supply of eligible providers.

CONCLUSION

These recommendations lay the groundwork for growing our state's ability to support young children and their families, innovations that are sorely needed in Georgia. Investing in supports during the critical early years when children's brains are developing most rapidly prevents the need for later, more expensive remediation and should be considered as a cost-effective measure to ensure Georgia ranks among the best places to raise a child.

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Infant and Early Childhood Mental Health Systems and Supports Developing the Workforce

2020

As a professional area of practice, infant and early childhood mental health (IECMH) has grown around the country. States have formalized their work within this area and developed diverse strategies for increasing workforce capacity and addressing ongoing training and support needs. There are concrete examples of how states have operationalized a SOC for IECMH, including ways in which an infrastructure has been developed to support the workforce.

The field of IECMH is a specialty area of practice within children's mental health care that can be delivered across a variety of settings, including childcare locations, Head Start/Early Head Start programs, family homes, and traditional mental health clinics. The workforce is comprised of a range of professionals and paraprofessionals, each with distinct needs related to training and support. Across practice settings, IECMH professionals focus heavily on the relationship between the parent/caregiver, seeking to empower and build caregiver capacity to promote young children's healthy social-emotional development. In addition, the workforce may engage in activities such as clinical observations and assessment of the caregiver and child relationship, provide direct clinical intervention, consult with early childhood educators and other care providers, provide home visiting services, and connect families to additional supports.

Infrastructure for IECMH Workforce

State approaches to the development of infrastructure for an IECMH workforce vary, and there is typically a partnership among key state agencies. The collaborating agencies depend on the existing state resource related to early childhood care, Medicaid, public health, and behavioral health. The system-level design often includes more than one public entity. Because federal funding is passed to states for early childhood health and education initiatives via various mechanisms, mapping of these programs and their oversight is a critical step in creating connections and thinking about areas for innovation.

Many states have furthered the development of IECMH workforce infrastructure through the establishment of a statewide association for IECMH professionals, such as an Association for Infant Mental Health (affiliates of the Alliance for the Advancement of Infant Mental Health), which serves as the credentialing and training entity for the field. These associations are membership-driven organizations for a range of professionals working in the IECMH field within a state and provide the backbone infrastructure for workforce initiatives such as credentialing and reflective supervision.[1] Many states across the Southeast have already established an Association for Infant Mental Health, including Tennessee, Alabama, Florida, North Carolina, South Carolina, and Louisiana. Funding to kick-start and sustain these associations is varied and includes grant funds from federal sources, such as the Substance Abuse & Mental Health Services Administration (SAMHSA), state-level budget allocations, private foundation grants, and membership dues.

Additional models for workforce support include Project ECHO for IECMH, a consultation model in use by Alabama. Children's Project ECHO: Behavioral Health brings together diverse clinical professionals in Alabama working in early childhood mental health in a small consultative group setting. A series of sessions are facilitated with this small, committed group of clinicians with rotating opportunities for each member to share his/her unique expertise. There is also an opportunity to bring current cases of children being served to the group for interprofessional consultation.[2] Project ECHO is a well-known model for peer-to-peer consultation for health specialty areas, and creates unique opportunities for virtual connection with colleagues that may be geographically distant or otherwise inaccessible.

[1] Reflective supervision is a framework for the clinical supervision practice of IECMH professionals. Standards of reflective supervision guide the supervisor-supervisee relationship through reflection, collaboration and regularity. https://www.zerotothree.org/resources/412-three-building-blocks-of-reflective-supervision

[2] https://www.childrensal.org/project-echo-behavioral-health

Training and Ongoing Support for the Workforce

It is widely accepted that IECMH practice requires a range of skills and a supportive clinical supervision model that can address the special challenges, and opportunities that arise in treating the caregiver-child dyad. Interest in evidence-based interventions (EBI) such as Child-Parent Psychotherapy (CPP), Circle of Security, and Parent-Child Interaction Therapy (PCIT) continues to grow among policymakers and practitioners alike. Each EBI comes with its own training requirements and costs, and may include ongoing requirements for training and fidelity monitoring to maintain certification. South Carolina is one example of how states have leveraged grant funds to roll out EBI trainings for the public mental health workforce. Through funding from SAMHSA, the South Carolina Department of Mental Health Services has trained and certified therapists based in safety-net community mental health centers to provide EBIs such as CPP, Attachment and Bio-behavioral Catchup or PCIT.

State and Local Partnerships for Training

Partnerships among state agencies are critical to ensuring that a diverse workforce has access to quality training and the professionals have opportunities for networking and learning collaboratively. Training on IECMH is needed for a range of professional and paraprofessional roles, including home visitors, early care providers and educators, IECMH clinicians and supervisors, and pediatricians, among others. In Louisiana, the Title V Home Visiting Program developed a 33-hour training program on infant mental health for its home visiting workforce, and the training is now also available to partners from child welfare and early intervention services. This collaboration among public health, child welfare and Medicaid has extended the reach of the training to the workforce across multiple delivery settings.

Examples of state-level efforts throughout the Southeast region to support development of workforce infrastructure and to provide ongoing training support for the field are provided next:

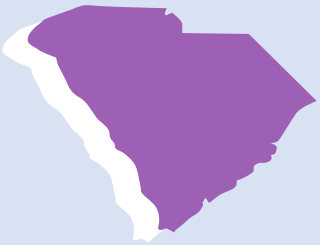
Alabama

Alabama Department of Early Childhood Education leveraged a $10.6 million grant to develop a 0–5 system of care infrastructure. **Through a partnership with Troy University, they developed a graduate career path**, implemented a training plan for IECMHC, and increased the number of licensed clinicians trained in Child-Parent Psychotherapy.[3]

Alabama is piloting a learning collaborative aimed at building capacity to add reflective supervision to IECMH consultation and training.

First 5 Alabama offers early childhood mental health endorsement for a range of professionals. Alabama Medicaid has agreed to support the IMH and ECMH Endorsement® of mental health professionals by requiring those who treat children and families, birth through age 5, to be endorsed in order to bill for services.

Alabama is working to develop a guidance document to be used by any professional working with very young children. The document will help professionals understand how to bill for mental health services, not just through Medicaid, but through private insurance and Alabama's children's health insurance program as well. It will also crosswalk the DC:0-5 with DSM-5, ICD-10, and CPT codes.[4]



South Carolina

South Carolina Department of Mental Health Services has been awarded multiple rounds of funding through SAMHSA to extend training to clinicians in the field, including safety-net providers. Training/certification on evidence-based interventions for infants and toddlers **includes Attachment and Bio-Behavioral Catchup and Parent-Child Interaction Therapy.**

The state established the **South Carolina Infant Mental Health Association in 2017** to provide support to the workforce and infrastructure for professional development, quality supervision, and credentialing[5].

Louisiana

Early on, the Louisiana Maternal, Infant and Early Childhood Home Visiting (MIECHV) program saw a lack of mental health services for children younger than 5 years old or pregnant women. Because of this, they developed a 33-hour training on infant mental health. **Foundational Infant Mental Health training is now offered to all MIECHV home visitors.** The training is also available to community partners from Early Intervention and the Department of Family Services.

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[3] Alabama presentation in 2020 to the Georgia House Study Committee on Infant and Toddler Social-Emotional Well-being

[4] DC 0:5 is the diagnostic classification manual of early childhood disorders, DSM-5 is the fifth edition of the Diagnostic & Statistical Manual of Mental Disorders (for ages 5 through adulthood), ICD is the International Statistical Classification of Diseases and Related Health Problems, 10th Edition. CPT codes are billing codes used by health insurance companies to identify services provided to a patient.

[5] https://www.scimha.org/

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ISSUE BRIEF
AUGUST 2020

Early & Effective Diagnosis and Treatment

DC:0-5™ Is Key For Infant and Early Childhood Mental Health Services

The first five years of a child's life are a critical time for brain development. It is estimated that the brain forms over a million new neural connections each second during the first years of life. Experiences and relationships during this time help build a child's brain architecture, providing the foundation for future behavior, health, education, and career.

When experiences are positive and caregiving relationships are safe, responsive, and predictable, children are more likely to develop healthy coping responses to stress or adversity. However, when experiences are negative or caregiving relationships are not supportive, young children, even infants, can experience emotional and mental health challenges.[1] Mental health challenges in very young children can emerge through a number of contexts (environment, physical health, developmental issues) and understanding and treating these problems requires supportive relationships.

When infants and young children experience these challenges, professionals who work with them use the **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)** to diagnose their mental health and/or developmental disorders. Currently, Georgia does not recognize DC:0-5 for diagnostic or billing purposes.

WHAT IS DC:0-5™?

DC:0-5 is a diagnostic classification system that provides age-appropriate diagnoses for mental health and developmental disorders presenting during infancy and early childhood. It considers young children's emotions, behaviors, environment, closest relationships, developmental competencies, physical conditions, and cultural norms.

GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

KEY TERMS:

- **DC:0-5:** *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*; used to diagnose mental health and developmental disorders in infants and young children.
- **IECMH**: *Infant and Early Childhood Mental Health* (also known as Infant and Toddler Social-Emotional Health.
- **EPSDT**: *Early and Periodic Screening, Diagnostic, and Treatment*; a core tenant of Medicaid that requires comprehensive coverage of medically necessary services, including preventative services, for children under 21.
- **DSM:** *Diagnostic and Statistical Manual of Mental Disorders*; used to diagnose mental health disorders in older children and adults.
- **ICD:** *International Classification of Disease*; the diagnostic classification standard used for billing purposes.
- **Dyadic Treatment**: A treatment approach to addressing social-emotional concerns in which a therapist treats an infant/toddler and caregiver together.

HOW IS DC:0-5™ DIFFERENT FROM THE DSM, AND WHY DO PROFESSIONALS WHO WORK WITH YOUNG CHILDREN NEED DC:0-5™?

DC:0-5 was created because the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) does not adequately address and describe mental health disorders that occur in infancy and early childhood, though clinicians encounter them in young children and understand the importance of the earliest possible diagnoses and interventions.

In addition, diagnostic manuals primarily written for use with older children and adults do not take into consideration the specific circumstances of very young children, such as lack of verbal ability to discuss their mental state and the influence of familial relationships. DC:0-5 better describes how one might see or understand symptoms in very young children and stresses the importance of relationships, particularly in understanding whether these symptoms are impairing to the child and family.

Infants and young children demonstrate a wide range of emotions, from joy and excitement to fear, sadness, anger, and frustration. It is when emotions and behaviors are persistent, pervasive, and out of the range of what might be seen typically for children at a given age that diagnosis may be considered. DC:0-5 provides criteria for diagnosis that helps professionals determine whether a child's symptoms go beyond typical or expected emotions and behaviors and reach levels of clinical significance to warrant diagnosis and treatment. Young children can experience a variety of mental health disorders, including mood disorders like Depressive Disorder of Early Childhood, anxiety disorders, such as Separation Anxiety or Global Anxiety Disorder, or even disorders like Post Traumatic Stress Disorder.

Diagnosing mental health disorders requires both an understanding of symptoms and evidence that such symptoms are impairing. Looking at the example of depression, both DSM-5 and DC:0-5 have similar criteria for symptoms, including sadness, lack of interest, and irritability, accompanied by lack of sleep, reduced appetite and growth, and lack of activity. However, **there are significant differences between DC:0-5 and DSM-5** in describing how these symptoms might contribute to impairment in functioning:

Major Depressive Disorder (**DSM-5**): The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.[2]

Depressive Disorder of Early Childhood (**DC:0-5**): Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly affect the young child's and family's functioning in one or more of the following ways:

- Cause distress to the young child
- Interfere with the young child's relationships
- Limit the young child's participation in developmentally expected activities or routines
- Limit the family's participation in everyday activities or routines
- Limit the young child's ability to learn and develop new skills or interfere with developmental progress[3]

DC:0-5 takes the relationships of the child into account when making any diagnosis. Since young children develop in the context of relationships, DC:0-5 considers how impairment affects both the child and the family. **This focus on relationships is critical to understanding infant and early childhood mental health.**

Treatment for young children's mental health challenges employs a similar relationship-based framework. Known as dyadic treatment, this approach centers around the caretaker-child relationship, known as the dyad, and relies on observations and assessment of the relationship.

WHY IS DC:0-5™ IMPORTANT FOR POLICYMAKERS?

DC:0-5, while critical to clinicians, is also relevant to policymakers. The adoption of DC:0-5 within billing infrastructures in Medicaid and private insurance allows for easier reimbursement for clinicians who work with young children, leading to earlier, more accurate diagnosis and treatment. Additionally, adopting DC:0-5 helps states better comply with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate of Medicaid, which requires that states provide comprehensive mental health services, including preventative services. Early intervention and preventative services result in better long-term outcomes and can save money by preventing later, more intensive treatment. Recognizing DC:0-5 as part of our state's behavioral health infrastructure is critical for the clinicians who work with young children and their families and would result in more developmentally appropriate services for the youngest Georgians.

HOW SHOULD STAKEHOLDERS IMPLEMENT DC:0-5™?

DC:0-5 is not only a critical tool used by professionals who work with young children, it is essential to ensuring proper diagnosis and early intervention for this age group. In order to promote better long-term outcomes for young children, practitioners and policymakers should consider the following recommendations:

RECOMMENDATIONS

STATES, HEALTH CARE PROVIDERS, AND INSURERS:

- Recognize DC:0-5 for treatment and billing purposes.
- If necessary, a crosswalk to the currently recognized diagnostic manual should be used for billing purposes.

PRACTITIONERS:

- Consider developmentally appropriate assessments and interview protocols to formulate diagnosis consistent with DC:0-5 and determine needed interventions.
- Assessment of infants and young children should allow for the recommended 3 – 5 sessions before diagnosis.

STATES, HEALTH CARE PROVIDERS, AND INSURERS:

- Consider investing in training for practitioners on how to properly use DC:0-5.
- Since development occurs in the context of relationships, it is necessary to have reimbursement policies for dyadic or family treatment involving the caregiver and the child together and sometimes separately.

[1]Center on the Developing Child, Harvard University.

[2]*Diagnostic and statistical manual of mental disorders: DSM-5*. (2017). American Psychiatric Association.

[3]*DC:0-5: Diagnostic classification of mental health and developmental disorders of infancy and early childhood. (2016)*. Zero to Three.

Georgia General Assembly

House Budget and Research Office

This report is submitted pursuant the following resolution,

HR 421

which created the House Study Committee on Infant and Toddler Social and Emotional Health to which members were appointed by the Speaker of the House of Representatives.

Katie M. Dempsey

Representative Katie Dempsey, Chair

THE FINAL REPORT OF THE GEORGIA HOUSE OF REPRESENTATIVES STUDY COMMITTEE ON INFANT AND TODDLER SOCIAL AND EMOTIONAL HEALTH

COMMITTEE MEMBERS

Honorable Katie Dempsey, Chair
Representative, District 13

Honorable Wes Cantrell
Representative, District 22

Honorable Pam Dickerson
Representative, District 113

Honorable Robert Dickey
Representative, District 140

Honorable Mary Margaret Oliver
Representative, District 82

"The first three years of life represent the time of the greatest and fastest brain development...one million neural connections [form] every second, and a child's early experiences are really determining how that takes place. We know brains are built from the bottom up, just like a house; if you have a strong foundation what comes later is going to be stronger. All the domains of development: physical, cognitive, literacy, and speaking...are really intertwined."

-Jamie Colvard, Zero to Three

"In 2018, the youngest child on record in Georgia to take their life was 9 years old. Increasingly, we are seeing children as young as 4 and 5 in the emergency departments with self-harming behavior. So the idea that we're here today...to focus on starting early in promoting positive social and emotional development is more critical now than ever before."

-Dr. Erica Fener-Sitkoff

"What we want to do is to promote resiliency in our children and one way of doing that is to promote the social and emotional wellbeing of infants and toddlers. It is critically important that we do so because that forms the basis of mental health as an adult; it can also plant the seeds for mental illness if we do not meet children's needs when they are young. It also determines the capacity to learn, because the way the brain gets wired depends on one's experiences."

-Judge Peggy Walker, Douglas County

INTRODUCTION

House Resolution 421 (2019 Session) created the House Study Committee on Infant and Toddler Social and Emotional Health. The committee was formed to study early intervention and prevention of infant and toddler mental health issues by focusing on the critical social and emotional development that occurs during the first few years of life. The study committee also sought to examine current state programs surrounding childhood mental health, areas for improvement, and the impact of not addressing infant and early childhood mental health.

The committee was chaired by Representative Katie Dempsey (13th) and included four additional members: Representative Wes Cantrell (22nd), Representative Pam Dickerson (113th), Representative Robert Dickey (140th), and Representative Mary Margaret Oliver (82nd). The House Budget and Research Office staff member assigned to facilitate the meetings was Sara Arroyo. The Legislative Counsel staff member assigned to the committee was Betsy Howerton.

The committee held five public meetings in Georgia to hear from infant and early childhood organizations, pediatricians, mental health clinicians, members of academia, childcare providers, and state agencies. This included presentations and testimony from Zero to Three, Voices for Georgia's Children, Easterseals of North Georgia, Georgia Early Education Alliance for Ready Students (GEEARS), Georgia Child Care Association, Georgia Psychological Association, Evidence-Based Associates, University of Georgia School of Social Work, Chattahoochee Technical College, Department of Behavioral Health and Developmental Disabilities, Department of Community Health, Department of Early Care and Learning, Division of Family and Children Services, and Department of Public Health.

The following individuals presented testimony to the committee:

September 12, 2019
Jamie Colvard, Zero to Three; Dr. Erica Fener-Sitkoff, Voices for Georgia's Children; Judge Peggy Walker, Douglas County; Dr. Veda Johnson, MD, FAAP; Dr. David O'Banion, MD, FAAP; Michele Hill, KIDazzle Child Care; and Tyese Lawyer, Our House.

September 23, 2019
Dr. Trasie Topple, Ph.D., LCSW, Director, Infant and Childhood Mental Health Resource of Georgia and Part-time Instructor, University of Georgia School of Social Work; Karen Higginbotham, Office of Early Learning, Clarke County School District; Angie Moon de Avila, Head Start and Early Head Start, Clarke County School District; Marsha Hawkins, Head Start and Early Head Start, Clarke County School District; Jeannine Galloway, Maternal and Child Health Division, Department of Public Health; Sherrita Summerour, Maternal and Child Health Division, Department of Public Health; Kathy Bragg, LCSW, CHRIS 180; and Donna Davidson, Easterseals:Incredible Years.

October 16, 2019
Catherine Ivy, Director of Medicaid Waiver Programs, Department of Community Health; Dante McKay, Director of Office of Children, Young Adults, and Families, Department of Behavioral Health and Developmental Disabilities; Susan Adams, Deputy Commissioner, Department of Early Care and Learning; Jeannine Galloway, Department of Public Health; Kathleen Toomey, Commissioner, Department of Public Health; Mary Harvak, Deputy Director of Child Welfare, Division of Family and Children Services; Chris Hempfling, Deputy Director and General Counsel, Division of Family and Children Services.

October 17, 2019
Dr. Trasie Topple, Ph.D., LCSW, Director, Infant and Childhood Mental Health Resource of Georgia and Part-time Instructor, University of Georgia School of Social Work; Dr. Marianne Celano, Ph.D.,

ABPP, Professor, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine; Melissa Haberlen, Voices for Georgia's Children; Ellen Reynolds, Georgia Child Care Association; Wande Okunoren-Meadows, Little Ones Learning Center; Marcy Smith, Chattahoochee Technical College; Tamika Brundidge, Chattahoochee Technical College; Amy Jacobs, Commissioner, Department of Early Care and Learning; and Callan Wells, Georgia Early Education Alliance for Ready Students (GEEARS).

November 25, 2019
Melissa Carter, Barton Child Law and Policy Center, Emory University School of Law; Dr. Suzie Henderson, Principal, Alto Park Elementary School; Dr. Anita Brown, Georgia Psychological Association; Dr. Dan Edwards, Evidence-Based Associates; and Dallas Rabig, State Coordinator for Alabama Infant and Early Childhood Mental Health.

EARLY CHILDHOOD BRAIN DEVELOPMENT

Harvard University's Center on the Developing Child estimates that 1,000,000 new neural connections form every second during the first few years of life, the most active period for establishing neural connections. Dr. Veda Johnson, Assistant Professor in the Department of Pediatrics at Emory University, explained to the study committee that every child is born with 80 to 100 billion brain cells – coming into the world with the capacity to change it – but the cells are not yet connected. The neural connections that form in early childhood can provide a strong or weak foundation for future physical, social, and emotional development.[1]

When a child has a responsive relationship with their caregiver, it helps to strengthen the brain's architecture; this can be demonstrated with "serve and return," the positive back and forth interaction between the child and caregiver. If a caregiver's responsiveness to the child is unreliable, inappropriate, or absent, brain development is negatively impacted.[2] The study committee watched a short video illustrating the "still face paradigm." In the video, the mother interacts with her 10-month-old child and the baby makes gestures and points. The mother responds positively with words, eye contact, and physical touch. In the video, Dr. Edward Tronick, Director of the Child Development Unit at Harvard University states the mother and baby are "coordinating their emotions." In the second half of the video, when the mother creates "still face" and is unresponsive, the baby tries to regain "serve and return" by gesturing, smiling, and pointing, but when the infant child fails to receive a response, they react negatively by turning away and demonstrating stress through crying.[3]

Dr. Johnson stated a child experiencing stress is a healthy part of development, but long-term, toxic stress, in the absence of protective relationships, can disrupt the architecture of the child's brain; in extreme cases of neglect, a child's brain will stop growing in size. Stress raises cortisol levels. When cortisol levels are elevated for extended periods of time, it disrupts the number of neural connections made and diminishes established connections. The amygdala and hippocampus are areas of the brain most affected by cortisol, and both assist in memory, learning, and emotions.

Genes and experiences construct brain architecture together; it is almost always nature and nurture.[4] Dr. Trasie Topple, from the University of Georgia School of Social Work, explained epigenetics, a field of science that tells us early childhood experiences, when the brain is developing rapidly, can influence whether, when, and how genes release their instructions for building future capacity. Negative experiences, such as malnutrition, drugs, or toxic stress before birth or in early childhood are not forgotten, but built into the developing brain and create a "biological memory." This may have negative impacts on the physical and mental health of the child as well as learning capacity and behavior.

INFANT AND TODDLER SOCIAL AND EMOTIONAL HEALTH

Jamie Colvard from Zero to Three, a national non-profit organization that specializes in early childhood development, defined strong social and emotional development of a young child as the capacity for the child to experience, regulate, and express emotions; form close relationships; and explore their environment; and learn. The capacity for development is always in the context of the family and community. According to late Pediatrician Donald Winnicot, "there is no such thing as a baby...there is a baby and someone." A strong social and emotional foundation in a child is demonstrated as self-confidence, the ability to develop good relationships with peers and adults, make friends and get along

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[1] https://developingchild.harvard.edu/science/key-concepts/brain-architecture/#neuron-footnote
[2] https://developingchild.harvard.edu/science/key-concepts/serve-and-return/
[3] https://www.youtube.com/watch?v=apzXGEbZht0
[4] https://developingchild.harvard.edu/resources/what-is-epigenetics-and-how-does-it-relate-to-child-development/

with others, follow directions, identify and communicate feelings and emotions, and constructively manage strong emotions.

There are several risk factors for a weak social and emotional foundation, such as parental loss, parental substance abuse, parental mental illness, and exposure to trauma. Warning signs include developmental delays and behavioral issues that could lead to anxiety, depression, and post-traumatic stress disorder. Over time, these disorders could negatively impact a child's physical health, have an adverse effect on educational attainment, and increase the risk for criminal justice involvement. Ms. Colvard also explained that a child's behavior often indicates a potential unmet need or a skill that still needs development.

Dr. Johnson spoke to the multiple touchpoints the pediatrician has with the child and family in the first few years of life. During every well-check, the pediatrician should be reinforcing social and emotional health as well as screening parents for risk factors that will ultimately impact the child.

One way in which pediatricians screen is through the adverse childhood experiences (ACE) survey, a list of ten questions about topics such as physical abuse, parental mental health, exposure to domestic violence, and physical neglect. Each positive answer provides one point on the survey, for a maximum of ten points. Forty-five percent of children have at least one ACE and 10 percent of children have three or more ACEs. Children with three or more ACEs are three times more likely to fail academically, six times more likely to develop behavioral problems, and five times more likely to experience attendance problems. Also, Dr. Johnson indicated the ACEs survey does not paint a complete picture and other factors should be screened for as well, such as poverty, discrimination, poor housing quality, lack of mobility and social capital. However, Dr. Johnson highlighted that children can be protected from trauma-induced developmental issues if they have a strong relationship with their caregiver.

Douglas County Juvenile Court Judge Peggy Walker shared her experiences in the courtroom with children and families. She stated education is the pathway out of the criminal justice system, but when a child is removed from foster care placement, expelled from daycare, or suspended from school, the educational trajectory is disrupted. For those children with interrupted education, they may fall academically behind their classmates; it's easier to be suspended from the school than be identified as illiterate or having a learning disability. If behavioral issues are not addressed early, a child will reach an age when the adult becomes less important and the peer becomes more important. Those children may then surround themselves with peers that engage in risky behavior, such as alcohol, early sexuality, and drug use. They may also be drawn into gangs, which give them a sense of belonging and power.

Dr. David O'Banion, Assistant Professor of Pediatric Medicine at Emory University, discussed the Perry Research Project, a longitudinal study conducted between 1962 and 1967 that showed quality preschool interventions that focused on social and emotional development had long-term, generational, positive impacts. The results of the study provided an equation for human investment in childcare programs. By the age of 40, there was a 13 percent return on investment for the intervention group, with the greatest benefit from criminal justice system savings.[5]

[5] https://highscope.org/perry-preschool-project/

INFANT AND EARLY CHILDHOOD MENTAL HEALTH PREVENTION, INTERVENTION, AND TREATMENT

Infant and Early Childhood Mental Health (IECMH) is a field of practice where a mental health professional provides a continuum of services to children and families through promotion, prevention, intervention, and treatment of social and emotional issues. Dr. Topple emphasized that even intervention and treatment is considered prevention of future physical, educational, and emotional problems. IECMH providers work with both families and children and put a lot of emphasis on that relationship; services are provided in-home or at a center. Services include early childcare and education consultation, relationship assessment, emotional support, concrete assistance through case management and advocacy, and child-parent psychotherapy. IECMH professionals use a number of different assessment tools, such as Ages and Stages Questionnaire-Social Emotional (ASQ-SE), ACEs scores, parental stress index, and the Child Behavior Checklist to provide the right intervention and treatment to children and families. IECMH intervention and treatment, from birth to 5, can include Child-Parent Psychotherapy (CPP), Circle of Security (COS), or Parent-Child Interaction Therapy (PCIT).

Dr. Topple spoke to the work being done in Clarke County between the Clarke County School District and the Early Learning Center, specifically Head Start and Early Head Start, Preschool Special Education, and Pre-K. After seeing children struggle with literacy and additional literacy interventions not produce results, the school system conducted a root cause analysis and determined 57 percent of children in the school system had three or more ACEs. The school system applied for a Governor's Office of Student Achievement grant for professional development for teachers. Currently, the program uses Circle of Security, which can be implemented in the individual or group setting, and helps parents and teachers understand what the child's behavior is telling them. All 65 teachers at the Early Learning Center are trained in Circle of Security and 30 families have graduated from the program. The program encourages parents to reflect on their own childhood experiences, and realize their children don't know how to organize their emotions because they were never taught. The program also provides visitation services to 100 families through Early Head Start; 20 of those families include an expectant mother. While the program in Clarke County is still in development, they are already seeing both academic and social and emotional gains.

In FY 2014, Georgia was awarded a five-year grant through the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) to address children's health. The Georgia Department of Public Health chose Muscogee County for the pilot program due to high negative rates of childhood health. The program sought to increase the number of referrals to public health programs and this was accomplished by screening 3,000 children ages 2 months to 5 years old, over the life of the grant. A partnership was created with the local Head Start Program to provide a screening tool in every registration packet. Through a memorandum of understanding with the school system, a Project LAUNCH mental health consultant was housed within the school, providing services to teachers and administrators. By year three, 35 children that were screened received mental health consultations. Project LAUNCH also worked with Brookes Publishing to provide screening for evidence-based home visiting. Evidence-based home visiting is different than home visiting through Babies Can't Wait or Children's 1st. Evidence-based home visits involve multiple visits with the child and family and typically lasts one year. The Project LAUNCH home visitor conducted 17 Edinburgh Depression Screens, finding three mothers tested positive for depression; they were referred to the proper support. The program also provided support to families through Parent Cafés, creating a Parent to Parent support position, and holding a Parent Leadership Academy. Despite 2019 being the last year of the SAMHSA grant, the work will be continued through various community partnerships.

CHRIS 180 provides behavioral health services to families with children from birth to 12. In 2019, CHRIS 180 received a five-year SAMHSA grant to provide Child-Parent Psychotherapy (CPP) to

families in Fulton, Gwinnett, and Dekalb Counties. Dr. Topple describes CPP as one of the most evidence-based treatment programs, focusing on long-term intensive treatment lasting one to two years. The team at CHRIS 180 is comprised of a therapist, a therapist trainer, a behavior aid (in classroom), and a registered nurse. CHRIS 180 uses a two-pronged approach focused on providing trauma-related training to educators and school employees and wrap-around services to families. The resources provided to educators and school employees involves trauma-informed training, including information on brain development and social and emotional health. In 2019, CHRIS 180 trained 407 teachers between the months of May and August, including the YMCA, Sheltering Arms, and other independent centers. CHRIS 180 hopes to expand training to other providers.

Judge Walker explained that, traditionally, Georgia's stance is children under 7 years old do not receive mental health services, but that is not the trend nationally. Due to the lack of workforce to serve children under 7, the Douglas County Board of Commissioners provided a grant to the courts to contract with Louisiana State University (LSU) to deliver training to 28 clinicians to provide Child-Parent Psychotherapy. The therapy included 26 intensive sessions over the course of a year where the therapist worked with the child and family on how to shape behaviors, interact with the child, and promote self-regulation with that child.

Easterseals of North Georgia provides an Early Childhood Mental Health Program through Early Head Start, Head Start, and Georgia Pre-K. In 2005, Easterseals of North Georgia noticed an increase in the number of children with social and emotional challenges, but could not find community partners that served children younger than 5. The program was developed and provides early identification through screening, follow-up assessments with identified children, and treatment through the Incredible Years, an evidence-based program. The Incredible Years provides training and technical assistance to classroom teachers, mental health consultation, small group treatments (10 to 18 weeks), and parent workshops. The program has a Georgia licensed professional counselor and four Master's level professional counselors who are acquiring documented supervision toward full licensure.

Dr. Marianne Celano, of Emory School of Medicine, uses Parent-Child Interaction Therapy (PCIT) in her clinic. PCIT is for children ages 2 to 7 with disruptive behaviors, where the child and parent are in therapy together. The therapy occurs as parents are coached through live interactions with their child using a one-way mirror, where the parent is wearing an ear piece and interaction with the child is coached by the therapist. Treatment typically lasts 12 to 20 sessions and the parent and child move through treatment by mastering criteria. Progress is assessed with the Dyadic Parent-Child Interaction Coding System (DPICS-IV) and the Eyberg Child Behavior Inventory (ECBI). Assessment determines coaching goals for each session, allows for feedback to parents, determines when skills are mastered, and quantifies the quality of the parent-child interaction.

Dr. Suzie Henderson, Principal at Alto Park Elementary School in Rome, Georgia spoke about social and emotional issues in K-12 education. Early intervention is essential, but K-12 schools often encounter students with poor social and emotional health; those children need intervention too. Dr. Henderson stated three students at Alto Park Elementary School have been hospitalized this year for making suicidal ideations. Dr. Henderson had the opportunity to attend the Trauma Informed Schools Conference in Colorado in November of 2019. At the conference, Dr. Henderson learned about the dramatic change experienced at Lincoln High School, in Walla Walla, Washington, after they became a trauma informed school. Lincoln High School saw a decline in out of school suspension, an increase in graduation rates, and higher participation in post-secondary education. The success at Lincoln High School is attributed to every employee at the school being trained in trauma-informed care, from the janitor to the teacher. Once the social and emotional needs of students were met, the academic indicators improved. Dr. Henderson stated that trauma-informed education is not something added to a teachers list of responsibilities, but rather "who we are" when teachers and school employees interact with students.

Dr. Dan Edwards spoke to the study committee regarding his work at Evidence-Based Associates (EBA). EBA provides assistance to several states, including Florida, Georgia, Virginia, and Washington DC, in the implementation of different evidence-based programs, mostly surrounding juvenile justice. For the past seven years, EBA has partnered with Georgia's Criminal Justice Coordinating Council (CJCC) to reduce the number of children incarcerated or placed in residential treatment facilities. Juvenile justice reform in 2013 allowed judges the option to provide evidence-based programs instead of detention. Funds were provided through the Juvenile Justice Incentive Grant Fund (JJIGF) and the state created a list of seven available evidence-based programs. Half of the counties worked with EBA and the other half chose programs on their own. In 2017, out-of-home placements for counties that used EBA declined by 65 percent; the reduction in out-of-home placement was 46 percent for counties that did not use EBA. Dr. Edwards stressed, for a program to be successful "you have to pick the right evidence-based program for the right child and deliver the program with fidelity."

Dr. Edwards also pointed the study committee to a new Centers for Disease Control (CDC) resource, "Preventing Adverse Childhood Experiences, Leveraging the Best Evidence."[6] The resource provides background and context on ACEs and provides a resource list of multiple evidence-based programs, such as Nurse-Family Partnership, Parents as Teachers, Parent-Child Interaction, SafeCare (based at Georgia State University), Functional Family Therapy, and Multisystemic Therapy.

STATE AGENCY PROGRAMS

The Department of Community Health (DCH) administers Georgia's Health Check Program under the federal Early Periodic Screening, Diagnostic and Treatment Services (EPSDT), which requires every Medicaid-eligible child under 21 to be screened based on developmental stages and receive treatment if deemed medically necessary; this includes mental health screening and treatment.

The Children's Interventions Services (CIS) Program is for children with physical disabilities or developmental delays. Most children would be referred through the Babies Can't Wait Program, administered by the Department of Public Health. Other services covered by Medicaid for specific diagnoses include Georgia Pediatric Program (GAPP) for medically fragile children and Autism Spectrum Disorder Services.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) stated the current System of Care state plan starts at age 4. The System of Care is developed by the Interagency Director's Team and focuses on children, young adults, and emerging adults (ages 4 to 26) with a serious emotional disturbance. The three-year plan is up for renewal within the next year and there is consideration to expand the plan to include children from birth. DBHDD administers the APEX program which provides mental health services for children in K-12, with most clinicians serving high school-age children. The APEX program has found a sustainability model; if the clinician can bill 60 percent of services to private insurance or Medicaid, they become self-sustaining. However, there are non-billable services a clinician can provide that are also important, such as classroom observation. The study committee learned that the Clarke County School District, through their coordinated care, leveraged APEX to support teachers around secondary trauma.

The Department of Public Health (DPH) administers several relevant programs. Children's 1st is a program that identifies and triages support for children birth to 5 who are at risk of poor health outcomes and developmental delays and refers them to the appropriate interventions. Children's 1st

[6] https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf

is the central point of access for child health services for DPH. In FY 2019, Children's 1st received 29,920 referrals, 27,918 screens, and provided 18,983 referrals to intervention programs.

Babies Can't Wait (BCW), Part C of the Individuals with Disabilities Education Act (IDEA), is an early intervention program for families of infants and toddlers with developmental delays. Children qualify if they fail the ASQ in one or more areas of development or have a diagnosed medical condition. BCW contracts with the majority of providers, such as audiologists, occupational and physical therapists, speech language pathologists, and board-certified behavioral specialists. Families are assisted through the transition process to other providers, such as Head Start, private therapy services, or public preschool before the child's third birthday. In FY 2019, BCW had the capacity to serve 19,275 children.

Home Visiting, also administered by DPH, is an evidence-based program that supports pregnant women and parents of children ages 0 to 5 to ensure that children are physically, socially, and emotionally ready to learn. Home Visiting screens and assesses for referrals to additional services in 22 of Georgia's 159 counties. In 2018, Home Visiting had the capacity to serve 1,489 families with 19,385 home visits completed, including 316 pregnant women. Of those served by Home Visiting in 2018, 70 percent of families were low-income, nine percent had a child with a developmental delay, and eight percent had previous involvement with child protective services. Performance measures from 2018 show 78 percent of children received on-time screening for developmental delays; 95 percent of children had someone who sang or read to them every day; 69 percent of caregivers were specifically assessed for their parent-child interactions; and 29 percent of primary caregivers who positively screened for depression received mental health services.

The Families First Prevention Act (FFPSA) is federal child welfare legislation signed in 2018 that made substantial changes to federal child welfare laws by focusing on the child entering the system. Title IV-E, the largest dedicated federal fund source for child welfare, provides funding for FFPSA. Funds are used for payments for the daily care and supervision of eligible children, administrative costs to manage the program, and training staff and foster care parents.

Under the new FFPSA, Title IV-E funding can be used for evidenced-based programs to prevent unnecessary placements and promote family-based care. Eligible children and parents include those who are candidates for foster care; pregnant and parenting youth in foster care; and parents, caregivers, and guardians of candidates for foster care. Evidence-based programs are evaluated through a national clearinghouse that offers three tiers of ratings: promising, supported, and well-supported; 50 percent of expenditures must be used for well-supported practices and can include mental health, substance abuse and prevention, and in-home parenting skills. FFPSA will be fully implemented in FY 2020, but Georgia still has an opportunity to define, beyond the federal definition, which children are at imminent risk of entering foster care unless they receive IV-E prevention services.

The Department of Early Care and Learning (DECAL) licenses and monitors all childcare providers in Georgia and administers the lottery-funded Georgia Pre-K program. DECAL recently developed the Social-Emotional Early Development Strategies (SEEDS) for Success, a helpline to assist parents, childcare providers, and the community with relevant mental health referrals for very young children.[7] DECAL provides an early learning multi-tiered system of support through 18 field-based staff, which includes 12 inclusion specialists and six behavior support specialists. These specialists provide support to children and teachers in the classroom setting. The specialists are not mental health professionals but can provide referrals for therapy; however, DECAL noted that very few agencies in Georgia provide therapy to children under the age of 5.

[7] 1 (833) 354-HELP, inclusion@decal.ga.gov

Michele Hill, Owner of KIDazzle Child Care, provided an example of how a DECAL inclusion specialist helped a classroom in her facility. Specifically, Ms. Hill spoke about a two-year old class at one of the centers she operates. The classroom had multiple children experiencing aggression and rage through tantrums and profanity. When Ms. Hill reached out to the center's quality consultant about the issue, she received a call from an inclusion specialist within hours and an on-site visit within days. The specialist suggested changing classroom instruction from learning the alphabet and numbers to learning to identify emotions, reading stories about behavior modification, and practicing breathing exercises; teachers were given classroom management strategies to implement. The class saw great improvement in the children's behavior and teachers felt supported and were looking forward to additional visits by the inclusion specialist.

PAYING FOR MENTAL HEALTH SERVICES FOR CHILDREN ZERO TO THREE

The study committee learned, from multiple presenters, that healthcare providers in Georgia do not receive Medicaid reimbursement for behavioral or mental health services for children under 4. When asked, Catherine Ivy, Director of Medicaid Waivers for Department of Community Health (DCH), indicated Georgia's current Medicaid State Plan does not cover behavioral health services for children under the age of 4; furthermore, Ms. Ivy indicated that in order to cover behavioral health services for children birth to 3, DCH would rely heavily on DBHDD to identify evidence-based practices and provide descriptions and procedure codes. An application to change the state plan would then be submitted to the Centers for Medicare and Medicaid Services (CMS) with a cost analysis for approval.

The study committee was provided a copy of DC: 05, a diagnostic classification of mental health and developmental disorders of infancy and early childhood developed by Zero to Three. The publication includes developmentally appropriate diagnostic codes and gives actions for treatment when coupled with ICD: 10, the classification of Mental and Behavioral Health Disorders. Because Georgia's Medicaid program doesn't reimburse for behavioral health services for children under 4, age appropriate diagnostic codes do not exist. Callan Wells, Health Policy Manager at Georgia Early Education Alliance for Ready Students (GEEARS), discussed the work done by the I-ECMH Mental Health Committee, a committee of the I-ECMH Georgia Coalition. The I-ECMH Mental Health Committee learned that other states, including Arkansas, clarified billing codes for social emotional health screenings, dyadic treatments, and parenting programs.

Additionally, Medicaid only covers the mother for three months after the birth of a child. Multiple presenters recommended Medicaid cover the mother for 12 months after birth to ensure mothers are healthy through the first year of the newborn's life, specifically as it relates to post-partum depression. In her presentation, Dr. Johnson described post-partum depression as one of the most traumatic stressors a baby could face.

WORKFORCE CHALLENGES

Multiple presenters stated Georgia has a workforce shortage of licensed mental health providers for children ages 0 to 3. While prevention and promotion programs do exist in Georgia, especially on the state level, there is a shortage of providers to refer children and families when treatment is necessary. Melissa Haberlen, Voices for Georgia's Children, stated Georgia has a severe shortage of child and adolescent psychiatrists; there are currently 7.5 psychiatrists per 100,000 children for a total of 186 in the entire state. In Georgia, 76 counties are without a licensed psychologist and 52 counties do not have a licensed social worker. Voices suggested embedding mandatory training and optional certifications into University System of Georgia (USG) and Technical College System of Georgia (TCSG) educator preparation programs, and requiring state agencies and provider organizations to train their existing workforce.

Dr. Fener-Sitkoff, also with Voices for Georgia's Children, explained a challenge in developing a workforce strategy for mental health clinicians for young children is that workforce data is not collected by the state, including the number of providers and where they are located. The state currently collects this data on physicians through Georgia Board of Health Care Workforce. Voices suggested a way to expand licensure is to have easily accessible, quality supervision opportunities for Master's-level professionals. This could be done through APEX to create supervision opportunities and encourage education programs to play a greater role in connecting graduates to supervision opportunities.

During the presentation on Parent Child Interaction Therapy (PCIT), Dr. Marianne Celano also addressed workforce concerns with licensed mental health professionals providing services to children 0 to 3. Certification in PCIT requires a Master's degree in a mental health field, licensure or working under the supervision of a licensed provider, 40 hours of face-to-face training with a PCIT trainer, successful completion of two cases, and mastery of specific PCIT skills. There are only five certified PCIT therapists in Georgia, and only one level I trainer which can train other clinicians at their own institution.

Chattahoochee Technical College offers an Infant/Toddler Child Care Specialist Certificate as an option in their Early Childhood Educator Program. Within that certificate, there are two courses that include 65 competencies for infant and toddler development, such as understanding infant brain development, assessment and screening of infants and toddlers, identifying social and emotional milestones, understanding the importance of reading social cues, and identifying emotional strengths. Workforce development issues to consider include a student's perceptions and career aspirations, salary and benefits, turnover, and advisement.

Dr. Anita Brown, from the Georgia Psychological Association (GPA), stated within GPA membership, only about six percent of psychologists identify themselves as working with infants and toddlers, 40 percent of psychologists identify working with children and adolescents. A barrier to provide actual treatment is the lack of Medicaid reimbursement for young children; specifically, preventative services cannot be provided without a formal DSM-V diagnostic label to preclude premature labeling.

In 2017, the Georgia Childcare Association heard from their workforce regarding the need for training around challenging behaviors and inclusion. Ellen Reynolds with the association explained that during a robust economy, there is a smaller applicant pool for early education because people can work retail jobs earning $11 to $15 an hour, without multiple background checks. The Department of Early Care and Learning has provided support to childcare providers through the Childcare Development Block Grant, which pays for Georgia and federal background checks. The required federal and Georgia background checks had a tremendous financial impact on providers, the aggregate cost was $250,000 a month in 2017. The Department of Early Care and Learning also retained incentives through the Race to the Top grant, which rewarded teachers as they progressed in their credentials and degrees. Also, the Georgia SEEDS helpline has assisted in triaging social and emotional support to childcare providers, teachers, and children and their families.

ALABAMA MODEL

Dallas Rabig, State Coordinator for Alabama Infant and Early Childhood Mental Health spoke to the study committee about the action steps Alabama has taken to address access to mental health services for children from birth to 5. Alabama's foundation for IECMH was built by their Project LAUNCH grant program, the same federal grant Georgia received in 2014. Like Georgia, Alabama's Project LAUNCH was a pilot program that focused on early intervention, home visiting, First Class Pre-K (Alabama's Universal Pre-K) and Early Care Settings. After the implementation of Project

LAUNCH, Alabama chose to make infant and early childhood mental health a state priority, and the first step was funding and sustaining an IECMH state coordinator position.

In 2017, First 5 Alabama was created, and they established a set of competencies and endorsed open conversation with Alabama Medicaid. In 2018, Alabama was selected to participate in Zero to Three's Infant and Early Childhood Mental Health Financing Policy Project to support the state's advancement of assessment, diagnosis, and treatment policies. Alabama's policy team included a representative from the state Medicaid Office. The goal of Alabama's project was to increase the number of mental health providers for children from birth to 5; improve Medicaid billing policy for children from birth to 5; and implement the use of DC:05 Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood, which would include a crosswalk to Alabama Medicaid codes and law.

Alabama emphasized the relationship with Medicaid was integral in developing an IECMH workforce plan. Alabama was able to identify gaps in access to care and change the way assessment and intervention are provided and billed. Alabama found that no mental health services were available from ages 0 to 3. In 2019, Alabama was awarded $10.6 million to develop a birth to 5 mental health system of care infrastructure, which included implementing a training plan for IECMH professionals and increasing the number of licensed clinicians trained in Child-Parent Psychotherapy. In FY 2020, a new state funding stream was established to build an IECMH system of care and in January 2020, eight additional IECMH consultants will be employed by the Department of Mental Health to focus on early intervention and first Class Pre-K as well as pilot perinatal mental health consultation.

RECOMMENDATIONS

Establish IECMH State-Level Leadership

Include funding in the FY 2021 budget for an infant and childhood mental health coordinator at the Department of Early Care and Learning tasked with the following responsibilities:

- Develop a public awareness campaign, in collaboration with DECAL and Zero to Three, to be launched by June 1, 2021. The campaign is to show the incredible amount of brain development that happens in the first year of life and how that impacts the life trajectory of the child.
- Create a cross-agency leadership team for IECMH, to include individuals from the Department of Early Care and Learning, Department of Community Health, Department of Public Health, Department of Behavioral Health and Developmental Disabilities, and the Division of Family and Children Services.
- Establish an agreed upon set of IECMH core competencies.
- Convene meetings with the state Medicaid officer to discuss Medicaid reimbursement for behavioral health services for children ages birth to 4.
- Work with obstetricians and hospitals to provide screening at touchpoints as early as prenatally and improve touchpoints for children who do not have access to well-visits.
- Seek and apply for early and infant childhood development grants, including those to expand the IECMH workforce.

Determine Medicaid Reimbursement

Direct leadership at both the Department of Community Health and Department of Behavioral Health and Developmental Disabilities to submit a detailed report to the speaker of the House of Representatives, no later than June 30, 2020, with the following information:

- Documentation of where behavioral health services are not covered for children ages birth to 4 in the Medicaid state plan.
    - Direct the Department of Community Health to digitize the Medicaid state plan in a manner that makes it an electronically searchable document.
- A plan to add language to existing billing codes to clarify appropriate behavioral health services for children ages birth to 4. DCH and DBHDD can look to Arkansas and other states for examples.
    - This plan should consider that health providers for young children use DC:05 for diagnosis.
- A plan for Medicaid to cover the mother for 12 months after the birth of the child.

Workforce Development

- The cross-agency leadership team will assist in the creation of a statewide IECMH workforce development plan to grow the labor pool of mental health professionals serving children birth to 4 and determine how to provide IECMH training to existing state agency employees.
- Direct the Georgia Board of Healthcare Workforce to collect a minimum data set survey on mental health professionals, such as psychologists, counselors, social workers, and marriage and family therapy, at points of licensure and renewal.
- Direct DECAL to embed IECMH as a primary support in the Quality Rated Program.
- Direct the Technical College System of Georgia and the University System of Georgia to immediately begin the process of embedding early childhood social and emotional development curriculum into all early childhood education Programs.

ACEs and Childhood Stress

Voices for Georgia's Children | GEEARS Georgia Early Education Alliance for Ready Students | American Academy of Pediatrics Dedicated to the Health of All Children™ Georgia Chapter | Prevent Child Abuse Georgia | Division of Family & Children Services

Adverse Childhood Experiences (ACEs), or early negative experiences, can lead to negative impacts later in life, such as **poor mental and physical health, lower academic achievements, and substance abuse**. In the research discussed here, ACEs refer to these eight experiences:[1]

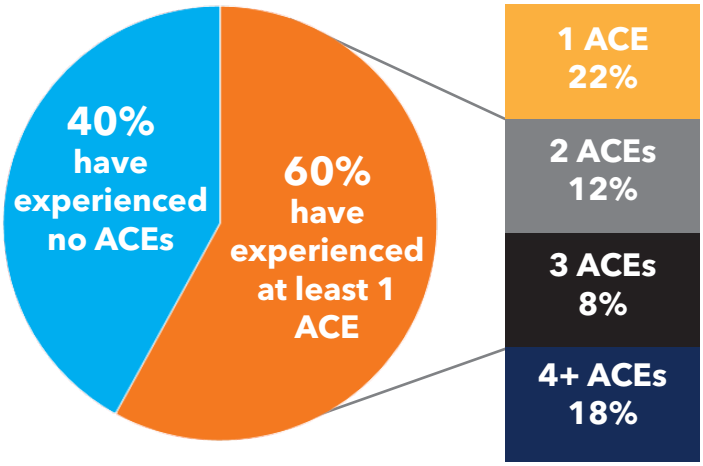
- Emotional abuse
- Physical abuse
- Sexual abuse
- Incarceration of a parent
- Mental illness in a household member
- Substance abuse within the household
- Violence between parents
- Separated or divorced parents

ACEs - along with experiencing community violence, racism, and other negative life events - can cause high levels of stress, or toxic stress, which can also have long-term effects on a child's development.

PREVALENCE OF ACEs IN GEORGIA[2]

Nearly 3 in 5 surveyed Georgians reported having experienced at least one ACE.

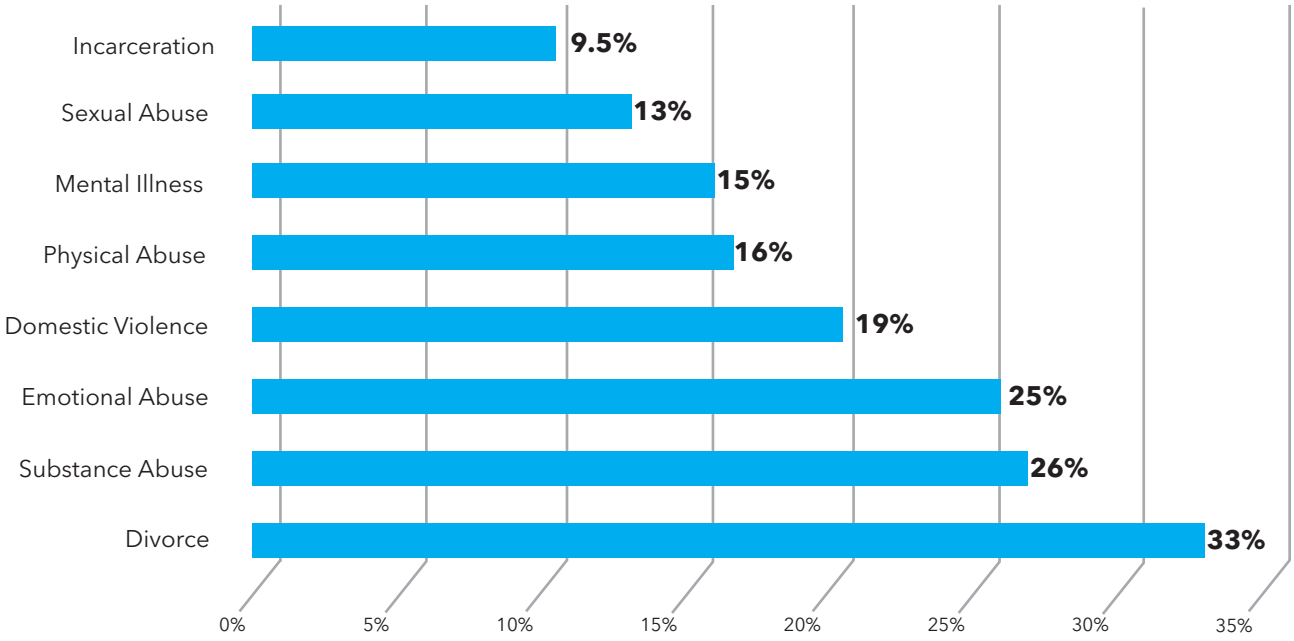
In 2016 and 2018, Georgia collected data from adults about ACEs they experienced as children, documenting the prevalence of the above eight types of ACEs. (Other types of ACEs not included in this research are experiencing neglect and having a family member attempt or die by suicide.)[3]



DATA ON DISPARITIES

While the likelihood of having four or more ACEs did not vary significantly by race or ethnicity in Georgia, White respondents were about **8 times** as likely to have experienced no ACEs as Black respondents, according to 2016 BRFSS data.

ACEs Among Adults 18 Years and Older, Georgia Behavioral Risk Factor Surveillance System, 2018



IMPACT OF ACEs

Children with ACEs are at increased risk of negative outcomes in multiple areas of their lives:[4, 5]

- Poor health, including mental health
- Substance abuse

- Depression
- Risky behavior
- Difficulty concentrating or making decisions

- Poor academic achievement
- Employment problems

POLICY RECOMMENDATIONS

These recommendations build protective factors around families. In order to adequately tackle ACEs and toxic stress, an adequate support system for each child should be at the center of any child policy platform.

Early Care and Learning

- Create an environment where the effects of toxic stress are buffered with appropriate supports to help children adapt and enhance cognitive and social development

Early Intervention

- Increase access to health care and home visiting support to promote healthy development and provide early diagnoses, appropriate care, and intervention when problems emerge

Parental Health

- Address parental mental and behavioral health to minimize, or even prevent a child's exposure to traumatic environments

Afterschool and Summer Learning Programs

- Increase funding and prevalence for quality afterschool and summer learning programs like the Boys and Girls Clubs and YMCAs to increase access and ensure affordability

Foster Youth Care

- Maximize implementation of the federal Family First Prevention Services Act
- Develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after they're transitioning out of the system

Juvenile Justice and School Discipline

- Provide environments that are safe and services that do not increase the level of trauma that youth and families experience
- Train Public Safety Officers who engage with children in child development and trauma awareness

Workforce and Systems Development

- Train caregivers and child-serving professionals on the effects of trauma and stress on children and youth to ensure they respond appropriately to behaviors and initiate effective interventions

Nutrition

- Increase funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Rev. 11/2020

Sources available here: https://tinyurl.com/ACEsChildhoodStress

Sources for ACEs and Childhood Stress

1 "Preventing Adverse Childhood Experiences Through Positive Connections and Policies," Georgia Essentials for Childhood, 2020, https://www.acesconnection.com/g/george-aces-connection/fileSendAction/fcType/0/fcOid/502912386532849732/filePointer/502912386532849745/fodoid/502912386532849742/Preventing%20ACEs%20through%20Positive%20Connections.pdf

2 "ACEs and Toxic Stress: Frequently Asked Questions," Harvard University Center on the Developing Child, accessed December 6, 2019, https://developingchild.harvard.edu/resources/aces-and-toxicstress-frequently-asked-questions/

3 "Preventing Adverse Childhood Experiences Through Positive Connections and Policies," Georgia Essentials for Childhood. 2020, https://www.acesconnection.com/g/george-aces-connection/fileSendAction/fcType/0/fcOid/502912386532849732/filePointer/502912386532849745/fodoid/502912386532849742/Preventing%20ACEs%20through%20Positive%20Connections.pdf

4 Ibid.

5 "ACEs and Toxic Stress: Frequently Asked Questions," Harvard University Center on the Developing Child, accessed December 6, 2019, https://developingchild.harvard.edu/resources/aces-and-toxicstress-frequently-asked-questions/

Preventing ADVERSE CHILDHOOD EXPERIENCES Through Positive Connections & Policies

Children are shaped by their earliest experiences and relationships. Creating safe, stable, nurturing relationships and environments are needed to support early brain development and promote lifelong learning and success. Conversely, negative early experiences, called Adverse Childhood Experiences (ACEs), cause high levels of stress, called toxic stress. Frequent and prolonged levels of toxic stress can dramatically change how the brain develops.

This report summarizes data collected in 2016 and 2018 through Georgia's ACEs module (11 questions) as a part of the Georgia Behavioral Risk Factor Surveillance System (GA-BRFSS)[1].

Adverse Childhood Experiences in Georgia

Respondents Reporting ACEs (n=11,581)

- Divorce 33%
- Substance Abuse 25.9%
- Emotional Abuse 25.2%
- Domestic Violence 18.6%
- Physical Abuse 16.3%
- Mental Illness 15.2%
- Sexual Abuse 12.9%
- Incarceration 9.5%

ACEs by Demographic Characteristics

- Females had a slightly higher prevalence of four or more (4+) ACEs compared to males
- Having 4+ ACEs did not significantly differ by race or ethnicity
- College graduates had a significantly lower prevalence of 4+ ACEs than adults with other educational levels.

Potential Outcomes

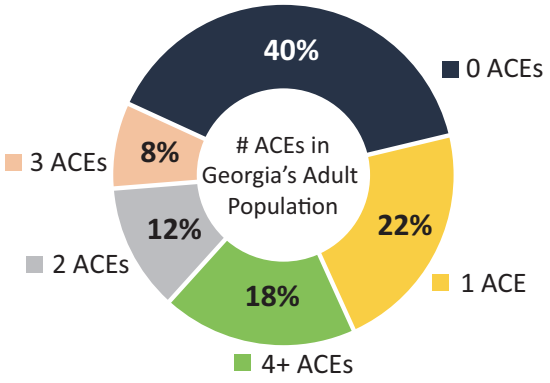
National data shows adults with 4+ ACEs compared to zero are:

- 6 times* more likely to have clinical depression
- 3.6 times* more likely to have serious job problems
- 2.2 times* more likely to have a heart attack

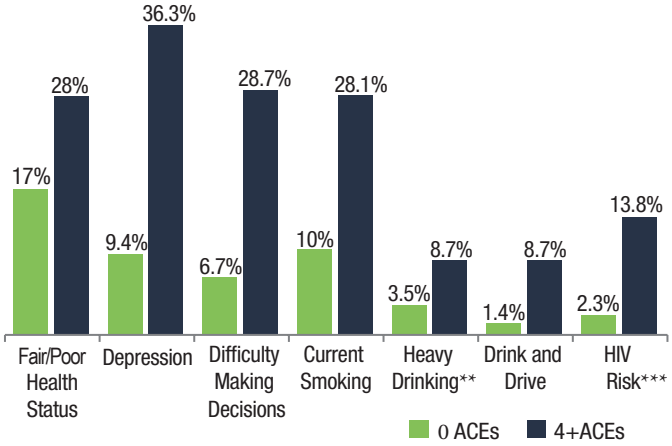
Georgia Essentials for Childhood is a statewide network of organizations and individuals working to build resilient communities, address and prevent adverse childhood experiences, improve community environments, and other forms of trauma, and to create communities where all children thrive in safe, stable, nurturing relationships and environments.

Abuse.PublicHealth.GSU.EDU/Essentials

3 in 5 Georgians Reported at Least One ACE



Health Behaviors and Outcomes for GA Adults Reporting 4+ ACEs Compared to 0 ACEs*



Adults with 4+ ACEs were more likely to:

- Have poor mental health for 14 days or more in the previous month
- Have been diagnosed with depression
- Have difficulty concentrating, remembering, or making decisions due to a physical, emotional, or mental condition

*All displayed results are significant

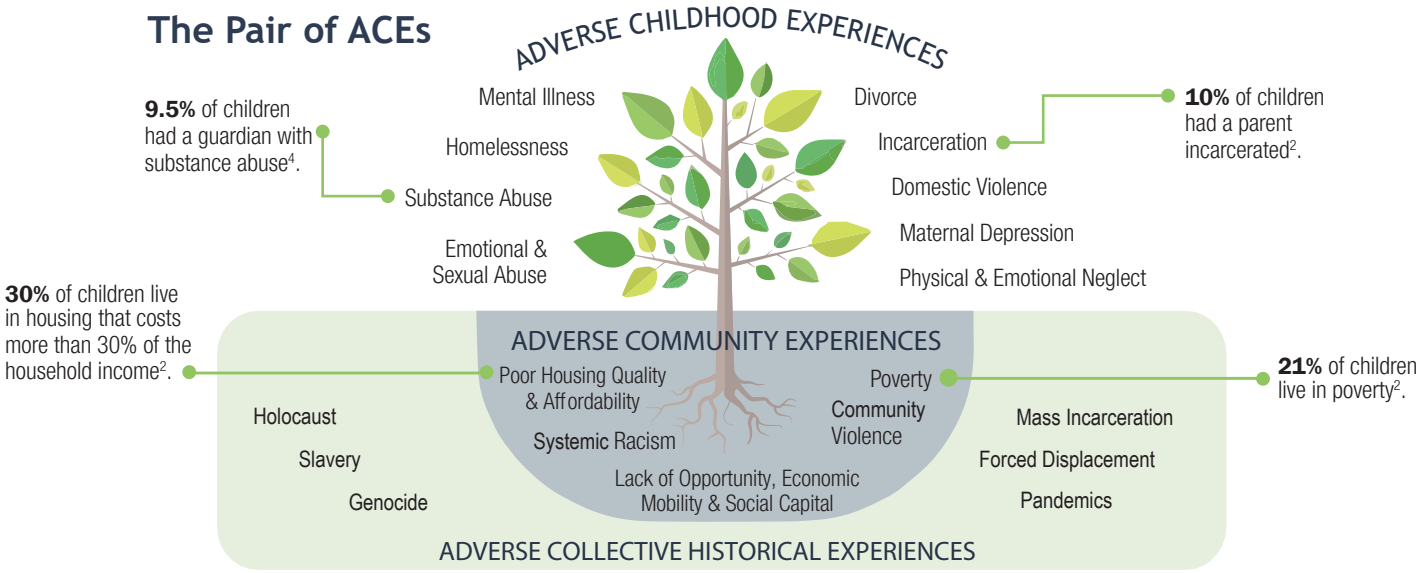
**Heavy Drinking- Male respondents who reported having more than 14 drinks per week, or female respondents who reported having more than 7 drinks per week.

***HIV Risk- Adults who reported that in the past year they had:
1) Injected any non-prescribed drug, 2) Treated for a sexually transmitted disease, or 3) Given or received money or drugs in exchange for sex

Preventing and Mitigating Impact on Families

Many children who experience ACEs have a parent or guardian who also experienced ACEs. The adverse effects of a parent's traumatic experiences as a child can exacerbate a family crisis. The official Adverse Childhood Experiences scale only captures a piece of the story. The Communities in which families and children live may also face adversity: widespread poverty, lack of opportunity, and lack of needed social services—including mental health. These social determinants of health are at the root of widespread adversity, inequities, and trauma. Thus, a comprehensive solution must address adversities experienced at both the individual and community level.

The Pair of ACEs Tree depicts the interconnectedness of Adverse Childhood Experiences of the family environment and Adverse Community Environments—the soil in which families' lives are rooted.



Positive Childhood Experiences

Science shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behavior, and health[5].

Examples include sharing family meals, caregivers participating in a child's activities, educators and mentors who are engaged and invested in their children. This can extend to the larger community, thus emphasizing that one caring adult can make all the difference.

Policy Implications

Providing supportive and positive conditions for early childhood is more effective and less costly than attempting to address the consequences of adversity later. Policies and programs that identify and support families, and communities who are most at risk for experiencing trauma and disparities as early as possible will reduce or avoid the need for more costly and less effective remediation.

High quality early childhood programs can yield a **$4-$9 return per $1 invested[6].**

By Focusing On	We Can
Policies directed toward early care and education, adult and child mental health, family economic supports, and many other areas...	Promote the safe, supportive environments and stable, caring relationships that children need to thrive.

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4. Data Resources Center for Child & Adolescent health https://www.childhealthdata.org/browse/survey/results?q=7210&r=12
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GEEARS
GEORGIA EARLY EDUCATION
ALLIANCE FOR READY STUDENTS

Family Supports

Family-Friendly Policies & Supports

Advancing Opportunity:

Parents' Solutions to Georgia's Child Care Challenges

METRO ATLANTA CHAMBER

GEEARS GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

RECOMMENDATIONS FOR POLICYMAKERS

Child care challenges can affect parents' participation in the workforce and have far-reaching effects for families, employers, and Georgia's economy. Starting in 2018, GEEARS: Georgia Early Education Alliance for Ready Students and the Metro Atlanta Chamber set out to better understand the prevalence, nature, and impact of child care challenges through a survey and series of focus groups with parents of young children. **The results are alarming.**

Child care challenges lead to at least

$1.75 BILLION IN LOSSES

in economic activity annually and an additional

$105 MILLION

in lost tax revenue.

OVER A QUARTER

of surveyed parents of children under 5 reported a

SIGNIFICANT DISRUPTION

to their or a family member's employment (quitting, not taking, or greatly changing a job) in the past year due to child care challenges.

Parents described a range of challenges that led to such disruptions, including general pressure to meet the demands of both career and child rearing, a lack of affordable and accessible child care options, and limited flexibility in the workplace. The survey and focus group findings underscore a need for stakeholders, specifically policymakers, employers, and higher education, **to work together** to address child care challenges.

Child care challenges affect both young children and their parents or caregivers. **Policy-based solutions to such challenges can have a two-generation impact that promote the educational success and economic stability of the whole family.** The recommendations that follow—vetted by parents themselves—are specific opportunities for **policymakers** to address such challenges and help assure Georgia's place as a top place to do business and raise a family.

"There is no better way to invest in the long-term health and future of this state than in our young kids. Creating environments for them to thrive, both with family and their larger communities, is critical to building a foundation for them to succeed as they grow and become productive members of society."

- Father, Atlanta

Child Care Affordability

Expand Childcare and Parent Services (CAPS)

Georgia's child care subsidy program, Childcare and Parent Services (CAPS), helps some low-income working families afford child care through scholarships and is primarily federally funded through the Child Care and Development Block Grant. Focus group participants agreed **that too few families qualify for CAPS** because income eligibility is too strict. Initial family eligibility for CAPS is set at or below 50% of the state median income based on family size. Parents must also participate in 24 hours/week of allowable activities, such as work or education.

Focus group participants agreed **that too few families qualify.** Due to limited funding, however, the Georgia Department of Early Care and Learning (DECAL) is unable to enroll all income-eligible families. **Only an estimated 14.8% of income-eligible, working families are served by CAPS in Georgia.**[1]

RECOMMENDATIONS

- **Expand the income limit for CAPS to 85% of the state median income.**
- **Increase state investment in CAPS by $20 million, which would allow for more than 3,000 new infants and toddlers to receive a CAPS scholarship.**

Strengthen and Expand Georgia's Pre-K

Parents were generally aware and supportive of Georgia's Pre-K, the lottery-funded, "universal" (i.e., not need-based) pre-kindergarten program for 4-year-olds. Georgia's Pre-K serves approximately 60% of Georgia's 4-year-olds[2] through a mixed delivery system, with classrooms in both private child care centers and public schools. In addition, parents overwhelmingly stated that **education starts at birth** and expressed the desire for a program similar to Georgia's Pre-K for younger children.

RECOMMENDATIONS

- **Strengthen Georgia's Pre-K by:**
  - Decreasing the maximum class size from 22 to 20, which was the maximum prior to funding cuts in 2011.
  - Supporting school districts and communities in enrolling at-risk children whose parents may be unaware of the program.
- **Continue Georgia's history of supporting education—from early childhood through postsecondary education (e.g., Georgia Lottery)—by using additional revenue sources as they become available (e.g., gambling) to support education, specifically for young children.**

"I would like to experience my tax dollars being used to broaden the Georgia lottery Pre-K program to include children from birth to 4-years-old. Every child has the right to fair education and a brighter future."

- Mother, Atlanta

Access to High-Quality Child Care

Support and Strengthen Quality

Administered by DECAL, ***Quality Rated*** is Georgia's voluntary quality rating and improvement system for child care programs designed to assess, improve, and communicate the level of quality of a child care program. The three-star rating system helps parents and families find high-quality child care through a free, online tool so they can make the most informed choice for their child. Of the 4,782 eligible, licensed child care programs in Georgia, 3,483 are participating in *Quality Rated* (as of November 2019).[3] By December 31st, 2020, all eligible child care providers that participate in CAPS must have received their star rating.

RECOMMENDATIONS

- **Continue to support *Quality Rated*, and encourage non-participating providers to become *Quality Rated.***
- **Ensure that parents and community leaders are aware of *Quality Rated* and utilize the free, online tool when searching for child care.**

Bolster the Child Care Workforce

Early care and education professionals, particularly infant and toddler teachers, **make significantly less than their counterparts** in similar professions, which leads to high turnover rates and lower program quality.[4] To retain and better support early childhood teachers, DECAL developed **DECAL Scholars,** which provides a range of scholarships, grants, educational counseling, financial help, and rewards to qualifying early childhood teachers.[5]

"I shouldn't have to worry about my child's well-being because I can't afford quality care."

- Mother, Columbus

RECOMMENDATIONS

- **Strengthen the capacity of the early learning workforce through ongoing professional development and skill building, particularly in high-need areas (e.g., trauma-informed care).**
- **Increase pay and financial incentives, such as DECAL Scholars, for early childhood professionals, particularly for those serving infants and toddlers or employed at a child care center that accepts CAPS.**

Tax Benefits for Families with Young Children

Focus group participants were supportive of improving existing tax benefits, such as the Child and Dependent Tax Credit (CDCTC), the Earned Income Tax Credit (EITC), and the Child Tax Credit (CTC), which can help offset the cost of child care.

Child and Dependent Care Tax Credit (CDCTC)

The federal Child and Dependent Care Tax Credit (CDCTC) and Georgia's CDCTC can **help eligible families offset their out-of-pocket expenses for child and dependent care** by lowering the amount of taxes a family owes. Georgia's CDCTC is 30% of the federal CDCTC a family has received[6] and is **non-refundable,** which means that the credit does not help low-income individuals who often need the most help affording child care.

RECOMMENDATION

- **Improve Georgia's CDCTC by:**
  - Increasing the percentage of the federal credit used to calculate the state credit, and making it refundable to benefit low-income families with little to no state income tax.

Earned Income Tax Credit (EITC)

The federal Earned Income Tax Credit (EITC) **rewards work and reduces poverty by decreasing taxes for low- and moderate-income individuals,** particularly for those with children. Georgia is one of 21 states that does not have a state EITC.[7]

RECOMMENDATIONS

- **Create a state EITC that supports low-income working Georgians and their families.**
- **Encourage eligible individuals, particularly young parents (of which only 35 percent in Georgia claimed EITC in 2017[8]), to take advantage of the federal EITC.**

Paid Family Leave

Despite widespread support, the United States has no national paid family leave law. Only an estimated 40% of Georgians are eligible for and can afford to take unpaid leave under the Family and Medical Leave Act,[9] the federal law requiring certain employers to provide 12 weeks of unpaid leave to eligible employees. In July 2019, Georgia House Speaker David Ralton announced a new paid family leave policy that will allow House employees to take three weeks of paid leave when welcoming a new child into their family,[10] representing a critical step forward for working families in Georgia.

RECOMMENDATION

- **Provide eight weeks of paid family leave to eligible state, city, and/or county employees, thereby setting an example for the private sector to follow suit.**

"Paid maternity and paternity leave is needed and it provides many benefits to families and the community. Being able to spend time with your kids helps create bonds [for] a lifetime."

- Father, Atlanta

System Coordination and Leadership

The challenges that families face are often interconnected, affecting both children and parents. Increased coordination and collaboration among government agencies that serve Georgia's young children and their parents can help maximize resources and better serve both children and parents.

RECOMMENDATIONS

- **Increase data sharing, coordination, and analysis to better understand how different programs and factors affect short- and long-term child outcomes.**
- **Leverage funding from philanthropic and private sectors in coordination with government-funded programs.**
- **Coordinate and streamline policies, programs, and funding across state agencies to provide more young children and families with the services they need to thrive.**
- **Take the lead in implementing family-friendly policies for state employees to serve as a model for other sectors to follow suit.**

Moving Forward

The impact of child care challenges is significant and felt by Georgia families, employers, higher education institutions, work training programs, and the state as a whole. By adopting a two-generation approach—considering the workforce of today and tomorrow—Georgia's policymakers can move the needle for the state's families and bolster the economy.

For more information, references, and to read the full report, go to www.opportunitieslost.org.

Home Visiting

EVIDENCE-BASED HOME VISITING IN GEORGIA

Voluntary, evidence-based home visiting connects parents and caregivers—including expectant parents of young children with a trained professional who supports them during the early stages of raising a family. Extra support during the first years of a child's life, when the **brain develops most rapidly**, plays a crucial role in ensuring that children experience the types of positive relationships that ultimately create strong neural pathways and shape future learning.

> **"I appreciate the chance to have someone come into my life when I was alone. I thought my daughter and I would not be together today, but because of people like Ms. Tonya and this program, I'm not only a better person but a great mom. I hope that many more moms have the chance to experience this program and have it be a gift to their life like it has been to mine."**
>
> **Cindy, Georgia mom**

Home visitors use an **evidence-based curriculum** to give caregivers tools to support **infant and child health, foster educational development and school readiness, maintain well-visit and immunization schedules, connect with community resources, and promote safe, stable environments and relationships** that are critical to children's lifelong physical and social-emotional wellbeing. Home visits can also reduce caregiver isolation, which has been exacerbated by the COVID-19 pandemic.

Built upon decades of scientific research, evidence-based home visiting has been shown to help **prevent prematurity, low birth weight, infant mortality, and child maltreatment** and can address the needs of children whose families experience poverty, interpersonal violence, and substance use disorders.

Georgia is currently one of only a handful of states that do not invest state dollars into home visiting, despite the overwhelming evidence behind the benefits for families and children. **As a result, Georgia's Home Visiting Programs currently serve fewer than 2,000 families per year in only 27 of 159 counties.**

WHAT DOES EVIDENCE-BASED HOME VISITING LOOK LIKE?

Evidence-based home visiting is a **voluntary** program. Parents and caregivers **choose** to participate.

Home visiting consists of four distinct components: one-on-one home visits, group meetings, developmental screenings for children, and a resource network.

Home visits are conducted by a professional trained in one of several evidence-based, nationally recognized models. Home visitors support parents and caregivers in a variety of areas, including **safety** (e.g., safe sleep, tobacco cessation, car safety), **parenting skills, nutrition, literacy, employment and education supports, and goal setting.** Home visitors can also conduct **child screenings and assessments** (e.g., ASQ) and help families maintain **regular health care appointments.** In addition to crucial resources, such as **car seats and books,** families may also receive **outside referrals,** such as to **public benefits (e.g., SNAP, Medicaid), Early Intervention, a pediatrician, or a child care program.**

The frequency of home visits depends on the needs of a family and the model used. A home visitor usually sees a parent **weekly or bi-weekly** for **hour-long visits**. Home visitors may stay with a family for as long as **5 years**. Home visiting is not just for pregnant women and children. **Fathers, grandparents, and other family members are often included in home visits.**

Georgia's Evidence-Based Home Visiting Programs are associated with positive outcomes that benefit infants, toddlers, and their families.

- 99% of families had **no reports of child maltreatment**
- 83% of enrolled children received their last recommended pediatric **well child visit on time**
- 76% of new mothers **completed their postpartum visits**
- 87% of mothers were **screened for depression**
- 80% of caregivers reported **always using safe sleeping practices**
- 84% of caregivers were **screened for intimate partner violence**
- 97% of caregivers reported **reading, telling stories, or singing to children**

STATE SPOTLIGHT

In 2020, **Alabama** allocated $1 million in general funds to an evidence-based home visiting model. In **Louisiana**, roughly $2.5 million of the state general fund is allocated to evidence-based home visiting. Additionally, TANF dollars, fees on duplicate copies of birth certificates, and tobacco settlement money are used to support evidence-based home visiting.

WHO ARE GEORGIA'S HOME VISITORS?

Georgia's home visitors are professionals situated **within a community**, who are certified in one of three approved evidence-based home visiting models.

The home visiting workforce is racially diverse, consisting of mostly women identifying as Black or African American (52.4%), White (31.7%), Asian (6.3%), Biracial/Multiracial (4.8%), and other (4.8%).

In addition to providing families with **tools to improve parenting skills, safety in the home, and literacy and school readiness**, home visitors can conduct **parent and child screenings and assessments**, help families **access health care, and support job and education goals for caregivers**.

WHO RECEIVES EVIDENCE-BASED HOME VISITING IN GEORGIA?

Evidence-based home visiting stands to benefit all caregivers of young children, but currently, due to limited funding, **it is prioritized for parents who have conditions or experiences that make the first years of a child's life even more stressful**. This includes parents who are low-income, first-time parents, under 21, unemployed, have an unstable housing situation, have received late or no prenatal care, have a history of substance use, depression, or mental illness, or are in the military. **Evidence-based home visiting is completely voluntary**.

Evidence-Based Home Visiting Models

In Georgia, there are three evidence-based home visiting models in use. All three models have been ranked as "well-supported," the highest-ranking on the Title IV-E Prevention Services Clearinghouse.

Nurse Family Partnership (NFP)

Utilizes nurses to promote mothers' self-efficacy, personal growth, parent-child attachment, and healthy parenting choices.

Parents as Teachers (PAT)

Focuses on enhancing parenting knowledge, attitudes, and behaviors, and promoting family well-being.

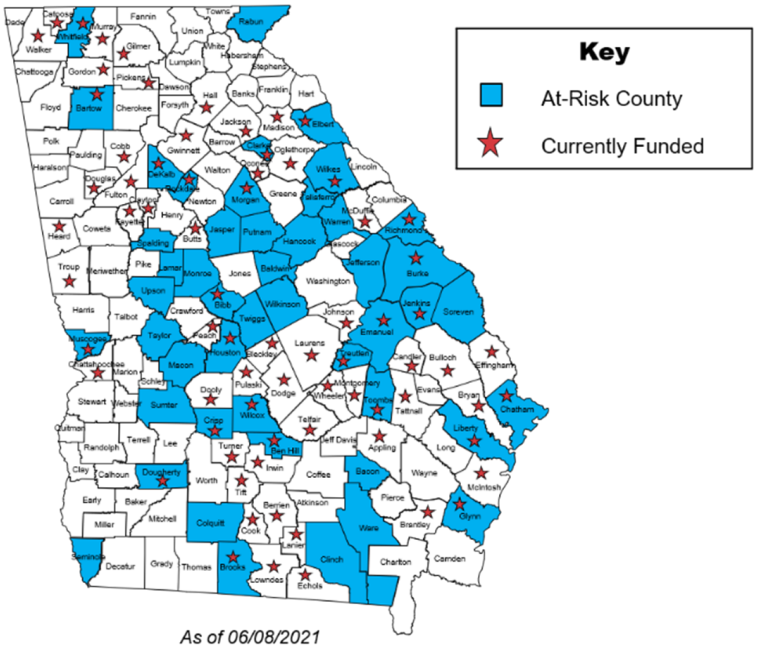
Healthy Families Georgia (HFG)

Focuses on enhancing early, nurturing relationships between children and their primary caregivers as the foundation for life-long, healthy development.

STATE SPOTLIGHT

High-quality home visiting programs offer **returns on investment ranging from $1.75 to $5.70 for every dollar spent** due to reduced costs of child protection, K-12 special education, grade retention, and criminal-legal expenses. Recognizing this, other states have made significant investments in home visiting.

- **Ohio** recently allotted an additional **$1.9 million** in general funds to their evidence-based home visiting budget, bringing the total annual investment to **$43,142,281**.
- **Arizona** allocates **$15 million** annually in general funds to evidence-based home visiting.
- In addition to an annual allotment of state general funds, **Texas**' legislature established the **Texas Home Visiting Trust Fund** to which individuals applying for a marriage license can donate.



*Only **27 of Georgia's 48 at-risk counties** as identified by the 2020 MIECHV Needs Assessment have evidence-based home visiting programs.*

Roughly 1,900 children were served by 23,000 home visits in 2019 – 2020. For context, there are an estimated 159,000 families with children under 5 living below the federal poverty level who might benefit from evidence-based home visiting.

RECOMMENDATION

Currently, evidence-based home visiting is funded through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECH-V), Title V, the Child Abuse Prevention and Treatment Act (CAPTA), and the Family First Prevention Services Act (FFPSA). **State agencies blend and braid funding to fund home visiting sites in communities using these federal dollars**. The Department of Public Health (DPH) administers evidence-based home visiting, and the University of Georgia provides technical assistance for home visiting sites. **Currently, there are no state funds allocated to evidence-based home visiting in Georgia - one of only a few states with that distinction.**

Georgia's legislature should consider investing $7 million to serve an additional 23 counties considered "high-risk" by the MIECH-V needs assessment. The "at-risk" domains include prematurity, low birth weight, infant mortality, poverty, substance abuse, and child maltreatment.

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GEEARS
GEORGIA EARLY EDUCATION ALLIANCE FOR READY STUDENTS

Georgia's Home Visiting Program

Voices for Georgia's Children

New parents may need support to strengthen their families as they transition to parenthood. **Evidence-Based Home Visiting**, under the Georgia Department of Public Health, gives at-risk pregnant women, new moms, and families with children 0-5 years old the skills they need to raise healthy children.[1]

GOALS OF HOME VISITING PROGRAMS

Increase healthy pregnancies

Improve parenting skills

Improve child health and development

Strengthen family connectedness

In 2018, more than 19,300 home visits were conducted for nearly 1,500 Georgia families.[2]

WHO IS ELIGIBLE FOR HOME VISITING?

To be eligible, parents must be in need of ongoing support and meet some of the following criteria:

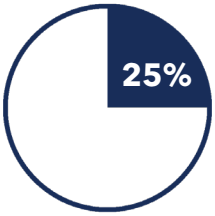
- Low-income
- First-time parent
- Younger than 21 years old
- Lack employment or stable housing
- Low educational attainment
- Lacking access to prenatal care
- Experienced child abuse or neglect
- History of, or ongoing, substance abuse or mental health challenges
- Is receiving or has received special education services
- Has veteran or active military members in the family

WHO RECEIVES THESE SERVICES?

26 the average age of primary caregivers upon enrollment

More than **70%** of parents served by the Georgia Home Visiting Program were **low-income** in 2018.

More than **1 in 10** parents were **teen parents**.



of services were provided in a **language other than English** in 2018

EFFECTIVENESS OF THE GEORGIA HOME VISITING PROGRAM

Outcomes for children after receiving home visiting services:

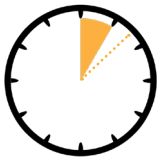
- **99%** had *no reports of maltreatment*
- **95%** *spent quality time* with a caregiver (e.g., read a story, sang songs)
- **78%** were *screened for developmental delays* at the appropriate time
- **67%** were referred to early interventions services for developmental delays *received services in a timely manner*

Outcomes for parents after receiving home visiting services:

- **76%** *received postpartum care*
- **80%** were *screened for depression*
- **80%** were *using safe sleep practices*
- **88%** were *screened for intimate partner violence*
- **93%** who used tobacco products were *referred to quitting services*
- **65%** *maintained health insurance* for at least 6 months of the year

ELEMENTS OF A HOME VISIT

Weekly to monthly visits, based on the families' needs



Visits last 1 to 1.5 hours

Answering questions about child development

Promoting engaged, positive parenting practices

Screening for developmental delays, parent depression, and domestic violence

Making referrals to community resources

Encouraging perinatal and well-child visits

Supporting parents' education and employment goals

GEORGIA HOME VISITING MODELS

Evidence-Based Home Visiting Model	Strategy/Objective
Early Head Start - Home Visiting	Promotes healthy prenatal outcomes, infant/toddler development, and strengthening families
Healthy Families Georgia	Enhances early, nurturing relationships between children and their parents/caregivers
Nurse-Family Partnership	Promotes healthy pregnancies for first-time mothers, and encourages healthy attachment and parenting choices
Parents as Teachers	Focuses on parenting knowledge, attitudes, and behaviors; promotes family well-being and healthy child development

Rev. 11/2020

Sources available here: https://tinyurl.com/GAHomeVisiting

Sources for Home Visiting

1 "Home Visiting Program," Georgia Department of Public Health, accessed on November 2, 2020, https://dph.georgia.gov/homevisiting.
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Paid Family & Medical Leave

Paid Family and Medical Leave

An Essential Support for Babies and Families

In crisis and in calm, America's future needs paid family and medical leave. The COVID-19 pandemic brought our country's caregiving crisis into sharp relief. In the absence of a national paid leave policy, many families were forced to put their economic security at risk as they took time from work to care for their families. Acknowledging this pressing need, Congress created emergency and temporary paid family and medical leave through the *Families First Coronavirus Response Act*. Without a permanent national policy, however, millions of families remain vulnerable to personal and public health crises that require them to choose between the income that sustains their families and caring for themselves or their loved ones.

For families with young children, the time right after a baby is born or adopted is a time of extraordinary growth, development, and connection. These early days and weeks are a time for parents to attend not only to physical needs – immunizations, breastfeeding and nutrition, and adjusting to a new schedule – but to build the crucial relationships that will help their babies thrive. Babies' earliest relationships literally shape the architecture of their developing brains, forming the foundation for their futures.[i] Positive, consistent relationships during babies' earliest days result in individuals who are better equipped for success in school and life—paving the way for bigger returns down the road, including a higher-quality workforce and strong economic growth.[ii] These relationships may seem basic, but they require care, consistency, and above all, time.

While the *Family and Medical Leave Act of 1993* provides important protections that have improved conditions for many families, too many American workers are not covered or cannot afford to take the unpaid leave it provides.[iii] Further, the majority of working parents do not have access to paid family or medical leave through their employers.[iv] The paid leave crisis is particularly marked for families of color, who overall have less access to paid leave and fewer financial resources to allow them to take leave, even when paid a percentage of their wages.[v] **If we want working families to succeed and boost our country's economic stability, Congress and the Administration must commit to creating a permanent national paid family and medical leave program that ensures all families can provide their babies with the care and stability necessary for a strong future.**

QUICK FACTS

- 85% of working people in the United States do not have access to paid family leave through their employers.[1]
- A 10-week extension in paid leave reduced the death rate in infants from 1-12 months old by 6%.[2]
- Fathers who take two or more weeks off after the birth of a child are more involved in infants' care than fathers who take no leave.[3]
- Children whose families have paid family leave have higher rates of immunizations and participation in well-child check-ups.[4]
- Workers in low-wage jobs are less likely to have paid family and medical leave.[5]
- Employers who have been affected by California's paid family leave requirements reported that the program had a neutral or positive effect on business. [6]
- 8 in 10 voters support a comprehensive national paid family and medical leave policy that covers all people who work.[7]

Policy Recommendation

Create a national paid family and medical leave program.
While some states and localities have taken the lead in adopting paid leave policies, the time parents have to bond with and care for their babies should not be dependent on income, workplace, zip code, or gender. The Administration and Congress should create a comprehensive national paid family and medical leave insurance program, such as the *Family and Medical Insurance Leave Act*, that embodies the following core principles:

- Accessibility for all working people;
- A meaningful length of leave—at least 12 weeks;
- Coverage for the full range of medical and family caregiving needs established in the *Family and Medical Leave Act*;
- Affordability and cost-effectiveness for workers, employers, and the government;
- Inclusivity in its definition of "family"; and
- Protection from employer retaliation for workers who take leave.

Research

A period of paid leave after the birth of a child contributes to the healthy development of infants and toddlers.

- A child's first relationships lay the foundation upon which future learning and relationships are built. Positive, consistent relationships during this period yield confident individuals who are better equipped for success in school and in life.[vi] Adequate time off from work gives parents and children the time that is necessary to make these connections, and their ability to do so sets the course for all future development.
- Paid leave yields higher rates and longer periods of breastfeeding,[vii] reducing childhood infections and maternal stress.[viii]
- Dedicated time at home with newborns, infants, and toddlers gives parents time to attend well-child medical visits and ensure that their children receive all necessary immunizations.[ix] These practices lower infant mortality and reduce the occurrence and length of childhood illnesses, which in turn reduce private and public health expenditures.[x]

Paid leave improves outcomes for the entire family, including parents and caregivers.

- Paid leave is associated with health benefits for new mothers, including declines in depressive symptoms and improvement in overall health.[xi]
- Families in Rhode Island using the state paid leave program were much more likely to report better health, lower stress, and a higher satisfaction in their ability to care for their new children and arrange child care.[xii]
- Paid leave may also help prevent child maltreatment, perhaps by reducing risk factors like parental stress and depression.[xiii]

The lack of a national paid leave policy disproportionately impacts Black and Latinx families.

- Overall, families of color are less likely to have access to paid leave, and, on average, have fewer financial assets to weather gaps in income to take leave even when paid a percentage of their wages. [xiv]
- Maternal mortality among Black women (40.8 per 100,000 live births) is more than three times higher than among white women (13.2 per 100,000 live births).[xv] Returning to work early interferes with the rest and follow-up medical care recommended for new mothers.
- Infant mortality for Black babies (11.1 per thousand births) is almost twice the national average (5.8 per thousand births).[xvi] Paid leave is shown to decrease infant mortality.

Paid leave policies benefit employers, taxpayers, and the economy, now and in the future.

- After instituting paid leave in California, companies and organizations overwhelmingly reported that the policy had a neutral or positive effect on their businesses.[xvii]
- As workers feel support for their families, they develop loyalty to their employers. Furthermore, they get the early care for their children that can prevent issues like infant mortality and longer term illnesses that pull them away from work.
- Positive, consistent relationships during a child's early years yield confident individuals who are better equipped for success in school and life,[xiii] paving the way for a higher quality workforce and strong economic growth.

For additional information, see go.zerotothree.org/PFML

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Nutrition

FRAC Food Research & Action Center

Profile of Infants and Toddlers in Georgia

Hunger, Poverty, Health, and the Federal Nutrition Programs

think babies™

THE PROBLEM

Far too many young children in Georgia experience food insecurity and poverty.

17.5% of children under age 18 live in a food-insecure household compared to **17.4%** nationally.[1]

28.7% of children 0-3 years old live in poverty compared to **23.7%** nationally.[2]

In addition, far too many young children do not have a healthy start in life.[3]

	High Weight-for-Length Among WIC Infants Ages 3–23 Months (2014)	Obesity Among WIC Children Ages 2–4 Years (2014)	Low Birthweight Rate (2017)
GEORGIA	10%	13%	10%
NATIONAL	12%	14%	8%

THE IMPACT[4]

- Poor health
- Iron deficiency anemia
- Developmental delays
- Hospitalizations
- Less prepared for school

THE SOLUTION[5]

The federal nutrition programs for young children — the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Child and Adult Care Food Program (CACFP) — support health, nutrition, and well-being during early childhood and beyond.

The programs IMPROVE ...

- Overall health
- Birth weight
- Infant feeding practices
- Breastfeeding initiation
- Dietary quality
- Cognitive development
- Educational attainment & income in adulthood

The programs REDUCE ...

- Poverty
- Food insecurity
- Hospitalizations
- Preterm birth
- Infant mortality
- Stunting
- Anemia & nutritional deficiency
- Overweight & obesity

THE DATA

In Georgia, many young children and their families benefit from the federal nutrition programs:[6]

- 61,010 infants, 101,203 children, and 55,482 women received nutrition counseling and nutritious foods through WIC in the average month. ($102.5 million in healthy WIC food benefits in FY2018.)
- 142,554 children received healthy meals and snacks on an average workday in child care participating in CACFP. (76.9 million CACFP meals and snacks were served in FY2018.)
- 191,000 children age 0-3 received SNAP food benefits to support good health and food security.

How does your state's participation in the federal nutrition programs compare to the U.S.?

WIC Coverage Rates[7]

	GEORGIA	NATIONAL
Eligible Infants	71%	77%
Eligible Children	40%	44%
All Eligible Participants	49%	53%

SNAP Participation Among Young Children Living in Low-Income Households[8]

GEORGIA	NATIONAL
67%	66%

Children Participating in CACFP: Five-Year Trends[9]

	GEORGIA			NATIONAL
	Children Participating FY 2018	Five-Year Percent Change FY 2013–FY 2018	State Ranking On Percent Change	Five-Year Percent Change
Homes	14,891	3%	10	-9%
Centers	127,662	6%	42	36%
Total	142,554	6%	33	26%

NOTE: State ranking scale from (1) for the state with the highest rate of growth to (51) for the lowest rate of growth (or highest rate of decline) in the number of children participating on an average workday.

Endnotes

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FRAC wishes to thank the Think Babies™ campaign for their generous support of this fact sheet. ZERO TO THREE created the Think Babies™ campaign to make the potential of every baby a national priority. Funding partners for Think Babies™ include the Robert Wood Johnson Foundation, which supports the campaign's public education aspects, and the Perigee Fund, which supports the campaign's public education and advocacy aspects. Learn more at www.thinkbabies.org.

Federal Child Food Programs in Georgia

Voices for Georgia's Children

When given access to adequate nutrition, the impact is clear: children are healthier and perform better in school.[1] However, children who are not provided adequate, healthy food often perform poorly in school and are more likely to experience mental health problems.[2] These children are also at greater risks for health issues later in life, like diabetes, high blood pressure, hypertension, heart disease, arthritis, and some types of cancer.[3]

CHILD HUNGER IN GEORGIA

Food insecurity affects

405,380

of Georgia's children under the age of 18.[4]

PROGRAMS DESIGNED TO SUPPORT HEALTHY AND ADEQUATE CHILD NUTRITION

Program	Description	Children Impacted in Georgia
CACFP Child and Adult Care Food Program	Reimburses for nutritious meals. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.[6]	153,933 average daily attendance[7]
NSLP National School Lunch Program	Provides nutritionally balanced, free or reduced-cost (based on a sliding scale) free lunches to children in public and nonprofit private schools, and residential child care institutions.[5]	1,174,602 total participation[8]
SBP School Breakfast Program	Provides cash subsidies to public or non-profit private schools and residential child care institutitions to provide meals that meet federal nutrition requirements. Meals are provided to eligible children for free or at a reduced cost.[9]	649,674 total participation[10]
NSLP/SBP Seamless Summer Option	Provides the same meal service that is available during the regular school year to hungry kids in the community during the summer. This program is provided through either the NSLP or SBP.[11]	101,394 average daily participation[12]
SFSP Summer Food Service Program	Reimburses for healthy meals and snacks served to children from low-income areas during summer months when school is not in session.[13]	80,055 average daily attendance[14]
SMP Special Milk Program	Provides milk in schools, childcare institutions and other eligible organizaitons which do not participate in other federal meal service programs. It is also available to children in half-day pre-kindergarten and kindergarten programs where school meal programs are not available.[15]	69,492 half-pints served[16]
SNAP Supplemental Nutrition Assistance Program	Provides a nutrition-designated electronic benefit card to supplement food budgets of individuals or families with low-income.[17]	327,000 households with children[18]
WIC Women, Infants, and Children	Provides supplemental food assistance, health care referrals, and nutrition education for low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age five.[19]	202,914 total participation[20]

All data represents average daily participation for FY 2019 except for SNAP and NSLP/SSO data. SNAP data is from FY 2018 and represents the number of households with children receiving SNAP. NSLP/SSO data is from 2017.

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