

Oregon Early Childhood Comprehensive Systems Plan

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1. Vision and Mission

This is our **vision**:

Children in Oregon are healthy, safe and thriving, in nurturing families and caring communities. They have the services, supports, resources and relationships they need to reach their full potential.

The vision is clear. Ways of realizing it are available. Obstacles clouding it are surmountable. Reasons for pursuing it are compelling. The importance of early childhood is undisputed. Potential societal and economic returns on early childhood investments are substantial. Public/private momentum for supporting early childhood development is unparalleled.

For over a decade, Oregon has sought to strengthen the well-being and learning readiness of young children through collaborative planning, systems development, service delivery and coordination. Despite the resulting array of early childhood services, collaborations, and system development improvements at both State and local levels, children's health and well-being still languish, and the early childhood system remains fragmented and incomplete.

One hundred and twenty four babies are born in Oregon every day. They are less likely to suffer from low birth weight, and more likely to be breast fed, than babies born anywhere else in the country. Every 57 minutes, however, a child in Oregon is abused or neglected. Every hour, a child in Oregon is born into poverty. Every day, a child dies before his or her first birthday, and every two weeks, a child is killed by gunfire.¹ Adversely affected by several biennia of economic downturn and corresponding cuts in State supported services, Oregon's young children and their families face the challenges inherent in slow economic recovery, and they continue to experience rates of methamphetamine use, unemployment, hunger, and food insecurity that are among the highest in the nation.

Oregon received a grade of C- on its most recent *Status of Children Report Card*, issued in January 2006 by Children First for Oregon (a non-profit, non-partisan, research-based public policy and advocacy organization). This State level report card assesses children's well-being in relation to State benchmarks for family financial stability, health, early care and education, youth development and education, and safety². While Oregon's 2006 grade shows slight improvement over its 2005 rating of D+, this barely average overall performance, with grades of "F" in family financial stability and "D" in health for the second year in a row, indicates substantial unmet need in areas critical to the health and well-being, learning readiness, and ultimate school and life success of young children and their families.

As the authors of *From Neurons to Neighborhoods* exhort, "The time has come to stop blaming parents, communities, business, and government, and to shape a shared agenda to ensure both a rewarding childhood and a promising future for all children. ... The charge to society is to blend the skepticism of a scientist, the passion of an advocate, the pragmatism of a policy maker, the creativity of a practitioner, and the devotion of a parent – and to use existing knowledge to ensure both a decent quality of life for all of our children and a productive future for the nation."³

Oregon's Early Childhood Comprehensive System's plan represents such a blend. It both reflects and furthers Oregon's shared early childhood agenda. The culmination and synthesis of two years of stakeholder input, planning and action, the plan offers an overarching framework and a

comprehensive menu of steps and strategies that can help move the State's performance from minimally adequate to consistently excelling, and can move Oregon and its young children and families toward a preferred and possible future.

The mission of the ECCS Initiative is to help plan, implement and sustain, in collaboration with diverse partners, a comprehensive statewide early childhood system that addresses the universal needs of young children and their families and attends to the specific needs of young children and families who are vulnerable due to risks and identified conditions. The ECCS Initiative, through partnership efforts, strengthens and sustains infrastructure and service capacity to support systems, agencies, communities and parents in promoting the health, development, learning readiness and well-being of young children within the context of their families, cultures, and communities.

2. Evidence and Roles of Multi-Agency State-Level Partnerships

Multiple State-level partnerships currently support Oregon's early childhood system and include:

- **Partners for Children and Families (PCF)**

Comprised of both State and local partners, PCF's role is to serve as the collaboration that fulfills statutory requirements for State agencies serving children and families to: 1) Increase efficiency and effectiveness by developing a collaborative partnership; 2) Set guidelines for planning, coordination and delivery of services to children and families; and 3) Engage citizens in local decision-making to support the well-being of children and families. Its population purview is children aged 0-18 and their families. Oregon's MCH Title V Director and ECCS Project Manager are among the active members of this collaboration.

PCF supports early childhood system development through assuring and overseeing comprehensive community planning and through the activities of its sub-committee, the State Early Childhood Team. The PCF Steering Committee includes members from the following entities: Association of Oregon Community Mental Health Program Directors; the Department of Community Colleges and Workforce Development; the Department of Human Services (Child Welfare, Mental Health and Addiction Services, Family Health, Self-Sufficiency), Employment Department, Child Care Division; Governor's Council on Alcohol and Drug Abuse Programs; Oregon Criminal Justice Commission/ Juvenile Crime Prevention Advisory Committee; Oregon Department of Education; Oregon Housing and Community Services; Oregon Juvenile Directors Association; Oregon Progress Board; Oregon Youth Authority; and State and Local Commissions on Children and Families.

- **The State Early Childhood Team (ECT)**

This sub-committee of Partners for Children and Families is an actively collaborating interagency workgroup designed to provide leadership and support to State and local early childhood planning, policy, systems and resource development partnerships and service integration efforts. The ECT's role is to assist Partners for Children and Families in fulfilling legislative mandates related to developing and sustaining a voluntary statewide early childhood system in Oregon. The State ECT serves as an advisory group to the ECCS Initiative and monitors it as one of five State sentinel projects. The ECCS Project Manager and the MCH Title V Director both participate in the State Early Childhood Team.

Members include the four State agencies mandated to jointly lead early childhood systems development (the Department of Education, Department of Human Services, Employment Department/Child Care Division, and the Oregon Commission on Children and Families), represented by Early Childhood Education Programs, the Head Start Collaboration Project, Early Intervention / Early Childhood Special Education, the Office of Mental Health and Addiction Services, and the Office of Family Health. Both the Title V Director and the ECCS Project Manager from the Office of Family Health serve on the State ECT. Additional partners include the Oregon Center for Career Development in Child Care and Education; the Oregon Commission for Child Care; the Oregon Child Care Resource and Referral Network, the Oregon Head Start Association, the Oregon Child Development Coalition, the Institute on Violence and Destructive Behavior, Yamhill County Mental Health Family and Youth Program, and a representative from the State Interagency Coordinating Council.

- **The State Early Childhood Steering Committee**

Oregon Statute (ORS 417.728) directs four State agencies to jointly lead, with other state and local early childhood partners, efforts to establish and maintain a voluntary statewide early childhood system in Oregon. These agencies, The State Commission on Children and Families, the Department of Education, the Employment Department/Child Care Division, and the Department of Human Services, now form the core of a year-old executive-level State Early Childhood Steering Committee. The MCH Title V Director, represents the Oregon Department of Human Services on this Steering Committee, which advises State agency directors on early childhood systems issues and provides direction to the State Early Childhood Team.

- **Additional Partnerships and Initiatives**

Oregon's early childhood system also benefits from the work of other system-wide as well as component-specific, agency-specific, program-specific, State, local and regional multi-partner efforts and initiatives, including but not limited to: the Healthy Kids Learn Better Initiative; the Ready Schools Initiative; the Ready for School Initiative; Strengthening Oregon's Community Services (SOCS)/Early and Continuous Screening of Young Children Collaborative; F.E.A.T. (Family Early Advocacy and Treatment); the Chalkboard Project; the governor-appointed 15-member State Commission on Children and Families (the parent umbrella for PCF, described above); Childhood Care and Education Coordinating Council; State Interagency Coordinating Council; Children's Mental Health Advisory Board; Department of Human Services Family Support Council; local Commissions on Children and Families; local Interagency Coordinating Councils; the Northwest Early Childhood Institute; the Children's Institute; Stand for Children; and Children First for Oregon.

3. Best Practices and Guiding Principles

The multi-level, multi-disciplinary array of research-based principles and best practices that guide the ECCS Initiative, include:

Early Childhood Development and Policy and Practice Principles outlined in *From Neurons to Neighborhoods*):

- All children are born wired for feelings and ready to learn.
- Early environments matter and nurturing relationships are essential.
- Society is changing and the needs of young children are not being addressed.
- Interactions among early childhood science, policy, and practice are problematic and demand dramatic rethinking.

- Human development is shaped by a dynamic and continuous interaction between biology and experience.
- Culture influences every aspect of human development and is reflected in childrearing beliefs and practices designed to promote healthy adaptation.
- The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains of behavior.
- Children are active participants in their own development, reflecting the intrinsic human drive to explore and master one's environment.
- Human relationships are the building block of healthy development.
- The broad range of individual differences among young children often makes it difficult to distinguish normal variations and maturational delays from transient disorders and persistent impairments.
- Children's development unfolds along individual pathways whose trajectories are characterized by continuities and discontinuities, as well as by a series of significant transitions.
- Human development is shaped by the continuous interplay among sources of vulnerability and sources of resilience.
- The timing of early experiences can matter, but more often than not the developing child remains vulnerable to risks and open to protective influences throughout the early years of life and into adulthood.
- The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes.⁴

Principles of the Irreducible Needs of Children, which confirm children's needs for:

- Ongoing nurturing relationships
- Physical protection, safety and regulation;
- Experiences tailored to individual differences;
- Developmentally appropriate experiences;
- Limit-setting, structure and expectations;
- Stable, supportive communities and cultural continuity.⁵

Early Childhood Comprehensive Systems Principles as outlined in *Building Bridges*:

- Health and development can and should be optimized for all children.
- Families are a central focus of young children's health and development.
- All families can benefit from guidance and support.
- Child development is a shared public responsibility.
- "Developmentally informed" public policy and investments must be sustained.
- Strong and innovative leadership is needed.
- Systems need to be held accountable for outcomes.
- Our complex and changing society requires diverse approaches to service delivery.⁶

Comprehensive Planning Principles compiled and endorsed by Oregon child and family stakeholders in 1999 to guide comprehensive planning processes:

- Create a holistic and community-based approach;
- Assure family-centered processes;
- Establish and maintain effective partnerships

- Utilize a balanced (strengths, weaknesses, opportunities and threats) approach
- Include data
- Implement research-based accountability
- Promote innovation
- Reflect and incorporate diversity

Additionally, the ECCS Initiative adopted the best practice planning and systems development approaches outlined in:

- *Results Accountability for a State Early Childhood Comprehensive System*,⁷
- *A Strategic Planning Guide for State-level Early Childhood Systems-Building Initiatives*,⁸
- *Building an Early Learning System: The ABC's of Planning and Governance Structures*,⁹ and
- The Institute of Medicine's service delivery model, which promotes a continuum of promotion, prevention, intervention and follow-up services and addresses universal, selected and targeted populations.

Consistent with these models,

- Oregon's ECCS Plan addresses the universal population of young children and their families, while maintaining a focus on those who are vulnerable due to risks and identified needs.
- Oregon is incrementally creating a "system of systems,"¹⁰ consisting of intentional infrastructure and increasingly coordinated, interacting components (including health, social/emotional development and mental health, early care and education, parent education and family support) that work to improve shared outcomes for young children and families.
- Oregon continues to build on and coordinate existing early childhood partnerships and structures to further implement and improve its statewide early childhood system.
- Research informs, but does not limit, Oregon's strategic planning and systems implementation processes. Principles, values, community and partner priorities and plans, and examples of "what works" locally also inform Oregon's early childhood system development.

4. Maternal and Child Health Internal Scan

The Office of Family Health engaged in a process of Appreciative Inquiry to scan MCH involvement in Oregon's Early Childhood System. This strengths-based approach to organizational assessment and change engaged staff from all OFH sections in three levels of inquiry to discover, dream, and design how OFH does, can, and will promote maternal and child health through the early childhood system.

Through the process of *discovery*, OFH identified what is currently working - its existing strengths and contributions to the early childhood system. Through the process of *dreaming*, OFH envisioned what the ideal early childhood system would look like and what OFH's involvement and contributions would be when it is continually doing its best work. Through the process of *design*, OFH generated capacity ideas that build on its strengths, promote its best work, and facilitate achievement of the types and levels of early childhood system contributions it envisions. Through the future process of *delivery* (the fourth step in the appreciative inquiry approach), OFH will utilize the ECCS Plan framework to further align its work with the shared goals and objectives of the early childhood system.

The ECCS scan was intentionally linked to the 2005 MCH Title V 5-Year Needs Assessment process, to assure integrated approaches to discerning and addressing early childhood needs and capacity issues. Maternal and child health promotion within the early childhood system emerged as one of the Needs Assessment's six recommended priorities. The other five priority areas pertain to a broader population, but clearly parallel ECCS scan findings and plan objectives. They include: access to comprehensive, coordinated health care, screening, assessment and intervention; promotion of healthy lifestyles and chronic disease prevention; promotion of mental health and social emotional development; elimination of racial and ethnic disparities; and enhancement of leadership for policy development and advocacy.

Through the Appreciative Inquiry process, OFH identified the following as its strengths and contributions to the early childhood system:

Surveillance

- Collects, analyzes and disseminates data on child health status and needs to state and local partners.
- Conducts research and disseminates information on emerging issues and best practices in child health.

Assessment and Quality Assurance

- Provides technical assistance and expertise for needs assessment, program evaluation and planning.
- Conducts community and state level surveys and assessments to gauge current and emerging child health needs.
- Develops data systems to facilitate the collection and appropriate use of critical child health information.

Resource Development

- Provides a link for state and local partners to information about best practices and to resources to support them.
- Helps to identify new and sustainable funding opportunities.

Advocacy

- Advocates for policies and funding to support populations in need and the agencies that serve them.

Collaborative partnerships

- Builds, fosters, and participates in coalitions and partnerships with many public and private agencies working to support young children.
- Jointly leads the development of the early childhood system through involvement in multiple partnerships, including the State Early Childhood Steering Committee, Partners for Children and Families, and the State Early Childhood Team.

Referral and Linkages

- Provides information and referrals to the public and to agency partners to link them to health resources in communities around the State.

Service Delivery

- Develops and/or sponsors state and local level outreach and public education campaigns.
- Disseminates educational materials and supplies to local health departments and community agencies (brochures, vaccines, etc.)
- Funds, administers, and monitors key Maternal and Child Health programs which link with the infrastructure and five essential components of the early childhood system components as indicated in the OFH early childhood system involvement chart in Appendix B.

While OFH evidences involvement in the overall infrastructure as well as in each essential component of Oregon's early childhood system, the Office's contributions do not yet approach the ideal levels it envisions. At a dreaming-to-design strategy session, a group of over 80 staff prioritized the following potential capacity enhancements for OFH's early childhood system work:

Cross-cutting/system-wide capacity enhancements:

1. Increase family and youth involvement in OFH policy and program design, development implementation and evaluation;
2. Strengthen comprehensive data collection and analysis, focusing on data integration (e.g. FamilyNet), data sharing and filling data gaps (e.g. elementary age children);
3. Support partners, and promote coordination, by focusing on the prevention and health promotion end of the service continuum;
4. Promote universal developmental screening;
5. Improve communication and relationships within DHS and between DHS and other private and public early childhood partners.

Health Component capacity enhancements:

1. Promote increased use of information technology for Medical and Health Care Systems improvement: e.g., electronic medical record, e-exchange of data, child health profile for use by providers to facilitate multidisciplinary patient care, QI, and PH surveillance.
2. Increase our facilitation, liaison and collaboration with public/private stakeholders using web integration as a tool.
3. Work to increase access to care and reduce health disparities through strengthening our role in collecting, analyzing and disseminating access and health disparity data to stakeholders and decision-makers (including the voting public and legislators):
4. Approach Information and Referral as an access to care issue through SafeNet.
5. Create and advocate for stronger linkages and partnerships between existing health systems and other formal and informal systems of care, and advocate for partnering solutions.

Mental Health and Social/Emotional Development Component capacity enhancements:

1. Assure that the public health workforce and other early childhood service providers are educated about mental health and social/emotional development, and trained to refer to mental health services.
2. Integrate prevention and screening/early identification of mental health risk conditions into public health settings;
3. Work with partners to assure that children and parents have access to prevention, screening, diagnosis and treatment for mental health/social emotional development issues.

4. Advocate for the child and family mental health service system to have increased capacity to address both prevention and treatment.

Early Care and Education Component capacity enhancements:

1. Develop additional health consultation capacity to childcare providers and other partners, including development of a health consultation marketing plan;
2. Use the coordinated school health model as a base for expanded partnerships;
3. Coordinate the regulatory and educational functions of public health with the Childcare Division.

Parent Education and Family Support Component capacity enhancements:

1. Commit to work more actively with Child Welfare through making our information more accessible to them, inviting more Child Welfare partners to our presentations and trainings, increasing involvement in multidisciplinary groups, and making better use of technology;
2. Work with partners on a comprehensive, integrated approach to home visiting that starts before birth
3. Build on our current DHS partnerships to synchronize policies and programs, using a client-centered philosophy; Provide education and resources on child health and development to social service workers and foster home providers;
4. Increase local capacity to partner with social services and parent education through technical assistance, consultation and needs assessment.

5. Current Financing of Early Childhood Services Supported by the Title V Program

The Office of Family Health's annual budget for Fiscal Year 2006 is \$84.6 million, inclusive of funding for WIC, immunization, family planning, perinatal, child and adolescent health, women's health, Maternal and Child Health administration, and children and youth with special health care needs (CSHCN)*. Please refer to the capacity chart in Appendix B of this document for a listing of the numerous programs, services and initiatives supported through the OFH budget. Please see Appendix C, for a chart detailing OFH expenditures by population.

Funding related to children aged 0 –18 and their families represents 62% of the OFH budget, totaling approximately \$53 million. Early childhood expenditures total 49% of the budget, or approximately \$43 million. An additional \$4.75 million in funding for pregnant women is also an early childhood resource since the prenatal population is served. Child-related financing thus totals \$57.75 million, with an estimated \$47.75 million allocated for the early childhood population, which includes pregnant women and mothers.

Major Funding Streams Supporting the Work of the Office of Family Health

Major funding streams contributing to the OFH budget, depicted in the chart below, include:

- Federal Title V (MCH) Block Grant Funds (* -30% of the Title V Block Grant is transferred via Interagency Agreement to the Oregon Center for Children and Youth with Special Health Needs, which is Oregon's Title V CSHCN agency, housed in the Child Development and Rehabilitation Center at Oregon Health Sciences University).
- Other Federal Funds (from the US Department of Agriculture, the Health Resources and Services Administration / Maternal and Child Health Bureau, Center for Medicaid and Medicare Services, and the Centers for Disease Control),

- State General Funds,
- Local agency revenues, and
- Other Funds (which include public health lab fees, non-federal grant funds, and non-State/non-federal funds for children and youth with special health needs).

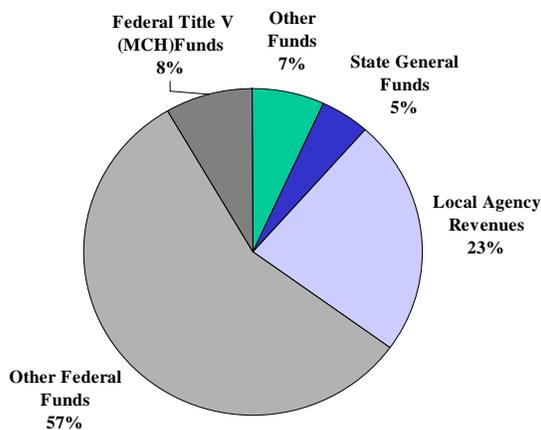


Figure 1: MCH Funding Streams and Percentages

Funding Streams Supporting OFH Target Populations

As the chart below illustrates, a portion of each major OFH funding stream supports services to the early childhood population. Please refer to Figure 1 in Appendix C for percentages.

Population	Federal MCH (Title V) Funds	Other Federal Funds	State General Funds	Local Agency Revenues	Other Funds	Total Funding (in millions)
Pregnant Women	X	X	X	X	X	\$ 4.75
Young Children	X	X	X	X	X	\$ 42.61
Adolescents	X		X			\$ 0.63
Children all ages	X	X	X	X	X	\$ 5.97
CSHCN	X	X	X		X	\$ 3.90
Women	X	X	X		X	\$ 25.43
Administration	X	X	X		X	\$ 1.30
TOTAL						\$ 84.59

6a. External Environmental Scan

The Status of Oregon’s Children

The conditions and circumstances of Oregon’s children, as summarized in the introductory section and in the profile chart in Appendix A, attest to the need, and potential, for improving the system of services and supports for young children and their families.

Status of the Overall Early Childhood System

Results of the early childhood comprehensive systems scan indicate that Oregon's current system as a whole, as well as each component within it, needs enhanced service and support capacity and stronger infrastructure to uphold, coordinate, and advance it. Because responsibility for the early childhood system rests statutorily with four distinct State agencies, and because each component is loosely comprised of multiple partners with different mandates, missions, needs, and resources, it is imperative to strengthen shared leadership and accountability, better align priorities, policies and resources, and improve understanding and utilization of each partner's important roles and strengths.

Multiple sources confirm that Oregon's young children and families would benefit from an early childhood "system of systems" that integrates the State's strengths with the best of what is known about supporting and sustaining child and family well-being. Two major needs identified for Oregon's overall system capacity are; 1) the development of a more comprehensive, coordinated continuum of services that address universal, selected and targeted needs, and; 2) a system of universal voluntary early screening, referral and follow-up. Called for by state statute, stakeholder input, and best practice as essential elements of an early childhood system, these two overarching facets, despite developmental efforts, continue to elude statewide implementation.

System Strengths

Oregon currently evidences legislative, executive, administrative, community and business / philanthropic synergy to improve early childhood outcomes, and to collaboratively address the challenging conditions and circumstances young children and families face.

Early childhood system development is mandated in State statute, and Oregon has well-defined State and local infrastructure for early childhood planning, interagency coordination, system development and implementation. Recent enhancements to this structure, including chartering of the State Early Childhood Team, creation of an executive level Early Childhood Steering Committee to advise agency directors, and increased connections between the State and local Early Childhood Teams, indicate Oregon's readiness and commitment to expanding its strategic and systemic approach to early childhood system development.

The Governor's Children's Charter prioritizes children's health, safety and readiness to learn. Enhanced gubernatorial commitment to children is evident in the February 2006 introduction of two new initiatives: the Governor's "Healthy Kids Plan," to achieve healthcare access for all Oregon children; and The Governor's "Education Enterprise," to establish new ways of formulating education policy and prioritizing education funding.

The needs of Oregon's early childhood population are also an increasing focus of a growing number of business, philanthropic, and civic leaders and organizations. Partnerships in the Ready for School campaign, the Chalkboard Project, the learning agendas of Grantmakers of Oregon and Southwest Washington, and in-depth study of early childhood by the City Club of Portland are examples of private sector interest and growing public-private partnerships and investments in early childhood.

Results of the *Oregon Early Childhood System Key Leaders' Perspective Survey*, conducted in 2005 by NPC Research, identify progress in collaboration, communication, commitment, and coordination as current strengths of Oregon's early childhood system.¹¹

According to the *2004 Summary of County Plan Updates* prepared by the Partners for Children and Families, thirty-two counties reported that comprehensive planning at the community level has resulted in improved coordination of services. Twenty-seven counties reported that planning has resulted in changes in how services are delivered.

Counties are required by statute to develop comprehensive plans for children aged 0-18 to guide delivery of some local services to children aged 0-18. Survey results indicate that early childhood plans have been integrated into these County 0 –18 plans.¹² Early childhood strategies were the most frequently reported additions to County comprehensive plans,¹³ suggesting Oregon’s ongoing and enhanced commitment to young children and families even during times of economic downturn and slow recovery.¹⁴

Other mandated local level plans and planning processes that address populations of which early childhood may be a part (local health department plans, community mental health plans, managed mental health organization needs assessments) are often coordinated on the process level, and the resulting documents incorporated into the 0-18 plan by appendix or reference. *The 2003 Early Childhood System Evaluation* completed by RMC Research indicated, “there is a high level of confidence in the effectiveness of local early childhood teams. Levels of collaboration across several groups appear to be extremely high.”¹⁵ Results of a 2005 survey of local Early Childhood Teams, conducted by the State Early Childhood Team, identified continued strengths in community level collaboration. Collaboration and coordination also emerged as the most frequently identified technical assistance and training needs¹⁶

The collaborative, interagency work of the Early Childhood Steering Committee and the State Early Childhood Team are bringing more focus and direction to Oregon’s early childhood agenda. These groups have key roles in implementation of the statewide early childhood plan.

Development of the FamilyNet Data System Family and Child Module continues, despite resource constraints and related time delays. This nationally recognized integrated data system model will serve as a primary data resource for Oregon’s early childhood system of services and supports.

System Challenges

Oregon’s current early childhood system is hampered by underdeveloped system infrastructure, compartmentalization, lack of shared accountability for child outcomes, and insufficient service and support capacity in the critical components of health, social / emotional development and mental health, early care and education, parent education, and family support. Limited public awareness and will regarding early childhood needs, unclear system priorities, lack of adequate and sustainable funding and resources; limited performance measurement and shared outcome data collection, analysis and dissemination capacity; unmet training and technical assistance needs; geographic, cultural and socioeconomic disparities; service gaps; access and availability limitations; and insufficient coordination and communication plague the current system.

Results of NPC Research’s 2005 state-level early childhood stakeholder survey (*The Early Childhood System in Oregon: Key Leaders’ Perspectives on Accomplishments, Challenges, and Needs*, January 2005), identified the early childhood system’s need for more “shared focus, goals and a plan.” Clear and consistent leadership, improved communication at and between all levels of the system, inclusion of non-traditional partners in planning and service coordination,

investment in technological infrastructure, and additional resources also emerged as primary early childhood system needs.

Comprehensive Community Plan Updates, completed by all 36 Oregon counties' local Commissions for Children and Families in June 2004, identified successes, challenges and gaps related to the implementation of legislatively-mandated County plans developed to achieve specific high level outcomes for children age 0-18 and their families. Mental health services for children and their families, living wage jobs, family support for high risk families, healthcare access, hard-to-find childcare, affordable child care, transportation and workforce training emerged as critical gaps in County services.

Data infrastructure and system performance measurement limitations impair Oregon's ability to ascertain progress toward achieving both local priorities and State-level shared outcomes for children and families. Capacity for data system development and integration, and data collection and analysis, is limited by funding and resource constraints. While early childhood partners mutually identified desired outcomes and measurement roles several years ago, until FamilyNet is in place, there is no current system to support data collection or analysis of the Early Childhood System's shared outcome measures.

The Oregon Progress Board's October 2005 assessment of the local comprehensive planning and measurement processes overseen by the Partners for Children and Families concluded that "local partners have probably made some progress in achieving intermediate outcome targets (although data limitations make it impossible to definitively judge success)."¹⁷ While almost 80% of mandated partners and 50% of voluntary partners indicated that local plans had improved services to children and families, only 39% of plan priorities had associated data collection plans, and only 25% included data.¹⁸ These findings led the Progress Board to make five recommendations regarding performance measurement for comprehensive community planning.

An evaluation of Oregon's early childhood system, completed by RMC Research in 2003, indicated that "implementation of... [a State statute mandating creation of a voluntary early childhood system of services and supports]... has not, however, been without challenges. County early childhood team members identified restrictions on the use of funds, insufficient staff and time to facilitate coordination of system improvement efforts, and differing eligibility criteria across programs to be among the more prevalent challenges."¹⁹

In addition to the previously mentioned gaps in County services, the 2004 County Comprehensive Plan Updates noted early-childhood specific gaps in the areas of home visiting, childcare quality, early childhood socialization opportunities, parenting education, early literacy, and transition supports to children entering kindergarten.

Workforce issues also limit the effectiveness of the current early childhood system. Shortages of key providers (including mental health professionals, pediatric dental care providers, child psychiatrists (especially in rural areas), and, occasionally, speech pathologists). These include: high caseloads (in WIC, self-sufficiency and child welfare); poverty-level wages and minimal or no benefits for segments of the early care and education workforce; and limited professional preparation and development.²⁰

Scope and scale limitations are also evident throughout the system. Some services and supports are not available statewide, and others are able to serve only a percentage of eligible clients.

Oregon PreKindergarten (HeadStart), for example, is State-funded to serve 59% of eligible clients. Healthy Start, a home visiting program for first born children at risk of abuse and neglect, previously funded to serve 80% of its target population, is now funded to serve 47% of first-born children. The Child Care Health Consultation Demonstration Program (HCCO), operates in only five counties. Oregon CARES (Compensation and Retention Equals Stability), which provides professional development scholarships and stipends for childcare providers, is a pilot only, and is available in only seven counties. The cost of bringing services, supports and infrastructure to scale statewide exceed current resources, and shared priorities for scaling have not been established.

Status of Essential Early Childhood System Components

There is significant need for infrastructure development, shared accountability, priority and policy alignment, coordination, communication, and increased capacity within each system component, just as there is a need to strengthen these elements across them. Development of a coordinated continuum that meets universal, selected and targeted needs requires simultaneous focus on infrastructure and on service and support capacity.

Universal, continuous early screening and referral needs to be available to assure the earliest intervention and best possible outcomes for young children and their families. While previous efforts of State agencies to develop and implement a common psychosocial risk-screening tool across all settings proved unsuccessful,²¹ several current efforts hold new promise for contributing to a statewide system of universal screening. A behavioral/pediatric health integration project in rural Lake County that includes a screening component (using the PEDS and ASQ-SE); continued research and development of a behavioral health screening tool through the Northwest Early Childhood Institute; and the Early and Continuous Screening of Young Children Learning Collaborative [sponsored by the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) through a Maternal and Child Health Bureau integrated services grant], are among current initiatives poised to strengthen the infrastructure necessary to support screening and referral within and across all components of the early childhood system.

At the local level, the status of components differs by county and sometimes by region due to scope and scale limitations of statewide resources, geographic disparities, preference for local control, and variable local needs, resources and priorities.

In 2004, ECCS staff compiled a local mapping of early childhood services by component and county from information available in local early childhood plans. While the programmatic mapping was a time limited snap shot, the results demonstrated the presence and relative strength of each component in every county, as well as the diversity of approaches and activities operative in the State.

Results of a 2005 survey of local early childhood teams indicated that the majority of Oregon's 36 teams continue to address all five early childhood system components, as shown in the Chart 1 in Appendix D. Activities related to healthcare access were the least frequently reported: while twenty five local early childhood teams reported involvement, eleven indicated no current activities related to access to health insurance or a medical home.

Local early childhood teams also identified priorities for the 2005-2007 in this survey. All 5 components emerged as priorities, as summarized in Chart 2 in Appendix D. Teams in four counties identified activities related to access to health insurance and a medical home as

priorities for the 2005-2007 biennium. These results must be interpreted with caution due to methodology constraints and variability in local needs and resources. Expanding the health focus and connections of local early childhood teams and communities, however, appears to be an area for substantial growth and attention. The high prioritization of parent education and family support activities by most communities reflects Oregon's need and readiness to strengthen these essential components.

Health

Oregon received a grade of "D" in health on its most recent Status of Children Report Card²². While a substantial decrease in teen pregnancies helped elevate the State's grade from D- to D over the past year, a significant increase in the number of uninsured children proved a countervailing force. The previously described conditions and circumstances of children in Oregon, combined with multiple partners' heightened awareness of the correlation between health, learning readiness, and success in school and life, has led to increased public and private alignment around improving the health of Oregon's children. The Governor's office, public agencies, public and private healthcare providers and organizations (including the Oregon Pediatric Society), child, family and health advocacy groups, and private sector partners evidence strong concerns about children's health.

Overarching needs identified through the ECCS scan include:

- Access to health insurance with adequate benefits for young children and their parents.

Over 117,000 children in Oregon have no health insurance. Almost half of these uninsured children are estimated to be eligible for but not enrolled in existing public coverage plans²³. Previous efforts, including outreach, raising of asset limits for SCHIP eligibility, and offering a dependent-only Children's Group Insurance option for small businesses, have not sufficiently reduced the number of uninsured children. The Governor's new initiative, the Healthy Kids Plan, builds on lessons learned from previous efforts and will engage state agencies and community partners in developing a comprehensive approach to enrollment, retention, benefit options, and service delivery.

Health insurance for parents is also an essential need and predicts children's use of healthcare²⁴ as well as their insurance status. A recent survey conducted by the Oregon Office for Health Policy and Research indicated that 81 percent of children who are uninsured in Oregon also have uninsured parents, and concluded that children are more likely to remain uninsured if their parents are uninsured.²⁵

Insurance benefits do not adequately or consistently cover the services young children and their families need. Benefit deficits include insufficient coverage for screening, well-child checkups and other preventive services; limited coverage of durable medical equipment and occupational and physical therapy for children with special healthcare needs; inadequate vision benefits; and insufficient pediatric dental coverage. Due to Oregon's mental health parity bill approved in the last legislative session, improvements in mental health and substance abuse treatment benefits available through private insurance are anticipated, but are not yet implemented.

- Reduction of cost barriers that limit healthcare access and utilization.

While Oregon does not require premiums or co-payments for children covered by the Oregon Health Plan (Medicaid), healthcare cost barriers exist for other young children and families. Cost

is the most frequently mentioned barrier to accessing care, cited in *Children's Access to Care Survey* conducted by the Oregon Office for Health Policy and Research. In response to questions about foregone necessary care, 46.0% of parents reported an inability to pay for the visit; 20.7% reported that their health plan would not pay for the treatment; and 17.4% of parents reported that they owed money to the provider²⁶

- Comprehensive and coordinated healthcare that includes medical, dental, vision, specialty, mental and behavioral health services.

Results of the most recent *National Survey of Children's Health* indicates that Oregon falls slightly below the national average in the percentage of children who have a personal doctor or nurse and receive accessible, comprehensive, culturally sensitive, and coordinated healthcare²⁷. While progress in the development of “medical homes” for children with special healthcare needs was evident during a three-year grant-funded Oregon Medical Home Improvement Project, momentum has not been sustained since the grant terminated,²⁸ and success in expanding medical homes to the universal early childhood population has been limited. Additional needs identified in relation to promotion of medical homes included: improving understanding and development of medical homes as partnerships; coordination and expansion of existing efforts, building on the medical home elements healthcare providers currently offer; framing medical home as quality improvement.

Additional health component needs included:

- More early childhood healthcare providers who accept clients covered by the Oregon Health Plan (Medicaid);
- More pediatric dentists and early childhood oral healthcare services;
- A reduction of administrative barriers to eligibility and enrollment in public health insurance programs, including streamlined application procedures and a review of eligibility and presumptive eligibility requirements and recertification timelines;
- Improved healthcare access and availability in rural areas;
- Routine, standardized developmental and psychosocial risk screening, referral and follow-up;
- Expanded healthcare provider awareness of existing referral resources;
- Stronger linkages and communication between healthcare providers, early intervention services, schools, mental health and other community services;
- Expanded health consultation to early care and education and other early childhood providers; and
- Improved physical activity and nutrition for young children and their families.

Social/Emotional Development and Mental Health

A lack of social/emotional development and mental health promotion and prevention services, and a paucity of early childhood mental health treatment services and trained providers for infants and young children experiencing identified mental health risks and conditions, emerged as major concerns in the early childhood social/emotional development / mental health arena. Widely recognized clinical and developmental insensitivities of the mental health diagnostic classification system used for service eligibility and reimbursement were also identified as barriers to meeting the mental health needs of young children and their families²⁹. Systemic mental health system problems identified by the Governor's Mental Health Task Force in 2004 included significant under-funding, fragmentation of funding, service delivery and accountability; insufficient integration of mental health with medical care, public health

initiatives, and other social services; workforce shortages; and insufficient community resources (including supported housing) for people with mental health conditions.³⁰ Children's mental health system concerns articulated in the State Office of Mental Health and Addiction Services' 2005 Block Grant Application included lingering effects of previous budget cuts despite partial restoration; a need for improved coordination and collaboration with early care and education (including the Department of Education, Head Start and Early Intervention), child welfare, and healthcare providers; a need to increase family involvement in all areas of children's mental health; a need for improved cultural competence in the provision of mental health services to children and their families; and a need for increased flexible funding for individualized service planning.

Current strengths of the mental health component include: multi-disciplinary interest in promoting social-emotional development; workforce development enhancements including the Infant/Toddler Mental Health Graduate Certificate Program at Portland State University; prevention, education and outreach requirements for and activities of managed mental health organizations participating in the Oregon Health Plan; forthcoming implementation of mental health parity legislation; pilot and demonstration projects that integrate social/emotional development, psychosocial and developmental risk screening, and/or behavioral health with other early childhood services; increasing focus on evidence-based practices; initiation of a Children's Mental Health advisory board with significant family and partner participation; and roll-out of a Children's Systems Change initiative to increase the availability and quality of an integrated community-based system of care.

Scan results for this component identified needs for:

- Enhanced support for parents and caregivers in promoting children's social-emotional development;
- Early psychosocial and developmental screening and prompt referral to indicated services;
- Increased promotion of social-emotional development in all the services and supports that surround young children and their families;
- Clear content and competency standards for the promotion of social-emotional development and the provision of early childhood mental health services;
- Cross-training of the early childhood workforce in social/emotional development and mental/behavioral health issues;
- Improved availability of promotion and prevention services;
- A more clinically and developmentally appropriate, and reimbursable, diagnostic system for young children and their families;
- Inclusion of early childhood mental health services in the basic benefit package developed to implement mental health parity;
- Increased availability of mental health services, including mental health consultation, in early care and education and other early childhood settings;
- Improved provision of early childhood mental health services in community-based settings;
- Improved mental health services to underserved and at-risk populations, including but not limited to young children involved in the child welfare system, experiencing homelessness, domestic violence, parental incarceration, parental mental health or substance abuse conditions, and those living in rural areas; and
- Enhanced coordination between mental health and other early childhood system components and providers, including early care and education, health and public health, and family support;

- Expanded availability of behavioral health services to parents of young children, including parental depression screening and treatment, and substance abuse screening and treatment.

Early Care and Education

Although early care and education earned a “B” on the most recent *Status of Children in Oregon Report Card*, this grade must be considered in full context and with some caution. Improvements in 3rd grade reading and math proficiency helped elevate this component’s grade, while other crucial early childhood benchmarks remain unmet, including affordable child care, available child care, and the percentage of children entering kindergarten ready to learn. Eighty per cent of Oregon kindergarteners enter school ready to learn. This laudable and improving percentage, however, falls short of the State’s 2005 benchmark of 85%, and the benchmark itself leaves 15% of Oregon’s young children behind.

Strengths identified in this arena include the ongoing collaborative and systems improvement efforts of the Childhood Care and Education Council and its numerous sub-committees, the Child Care Resource and Referral Network, the Oregon Association for the Education of Young Children, the Head Start Collaboration Project, and the State Interagency Coordinating Council; the ongoing work and logic model development of the Child Care Research Partnership; the transition enhancement efforts of the Ready Schools Initiative; business and philanthropic commitment to the Ready for School Initiative; development of the out-of-school-time care network; revisions in Oregon Registry steps and processes; increased mentorship opportunities; tiered reimbursement and quality improvement pilots; articulation agreements; completion of the child care economic impact study; near completion of the Early Learning Foundations; development of an early childhood assessment system and tool designed for use across multiple early care and education settings and that links with the K-12 system; and State policy priorities of expanding access, enhancing school readiness, reducing achievement gaps, promoting family and community involvement, and improving quality. The Education Commission of the United States (ECS), in its 2004 consideration of how Oregon’s education policies and programs align with a “P-16” (integrated pre-school through college) education framework, concluded that “Oregon’s record of accomplishments toward a seamless education system positions the state as a leader in P-16 education... While Oregon’s reforms are not yet at a point at which they can be deemed a success or failure, the state’s commitment to P-16 education and progress towards implementing P-16 policies and reforms provide important lessons regarding broad issues such as policy alignment, innovation, consensus building and negotiating territory issues. While work remains to be done, much as been accomplished.”³¹

Nearly 32% of Oregon children ages 0-9 are in some form of paid early care, and 5.7% of Oregon children are enrolled in preschool³². There is growing recognition of the triad of important roles child care fulfills in Oregon. In addition to facilitating parents’ workforce participation, and providing a source of non-parental early care that can nurture children’s development and prepare them for school and life, childcare also constitutes an industry that contributes significantly to the State’s economy. The childcare industry employs approximately 14,420 Oregonians in 7,900 small businesses; generates over \$600 million in gross annual revenues; helps enable 90,297 parents, who earn \$2.6 annually, to work; and supports other industries that further stimulate economic activity in the State.³³

Considered affordable if it costs less than 10% of a family’s income, early care is not affordable for over half of Oregon’s low-income families.³⁴ Affordability eludes families in other income

brackets as well. Thirty-nine per cent of Oregon families spend more than 10% of their family income on childcare. Recent as well as historical comparisons of public college tuition and early care and education costs indicate that the average annual cost of center-based early care and education exceeds the average annual cost of public college tuition. Tax credits for eligible families, and subsidies paid to providers for qualifying children, while available, appear underutilized. Despite state and federal tax incentives, less than 4% of Oregon employers offer child care benefits to their employees.³⁵ With the lowest childcare subsidy rate in the nation, and the highest parent co-payments, Oregon's Employment Related Day Care (EDRC) subsidy program serves only 20% of eligible children. Additionally, the *2004 Oregon Child Care Market Rate Study* confirms a growing gap between the current market prices of care in Oregon, and the subsidy rates paid by the State. To assure that families eligible for childcare subsidies can find and pay for care, Congress recommended setting subsidy rates at 75% of the market rate. Currently, enhanced subsidy rates (a 7% higher rate available to providers who meet specific training standards and other requirements) are adequate to purchase approximately a fifth of market child care slots statewide, and are not adequate to purchase any market-rate childcare in approximately half of the zip code areas in the State.³⁶

The number of available childcare slots has continued to decrease,³⁷ while unmet needs remain for more infant and toddler care, school-age care, extended hour and non-traditional schedule care, care in rural areas, and inclusive care for children with special needs³⁸

Additional needs identified through the ECCS scan include improvements in the quality of care; enhanced family and public awareness of quality needs and characteristics; expanded regulation; diminution of exempt (unlicensed, unregulated) care; improved identification of, training for, and linkages with family, friend and neighbor care providers, enhanced career development opportunities; expanded health and safety training; higher provider compensation rates and benefits; increased health consultation and stronger social emotional development and mental health supports in early care and education settings; and stronger transition supports and linkages between early care and education providers. Strengths and gains are evident in many of these areas, but require significantly expanded scope and scale to assure sufficient contribution toward positive outcomes for young children and families.

Areas of strength and concern were also evident in pre-kindergarten / Head Start, kindergarten, early intervention, early childhood special education, and early elementary and out-of-school-time care and education. Publicly funded early education programs evidence under-funding and related under-enrollment. Due to State financing levels and funding cuts, Oregon's Head Start Pre-kindergarten program serves only 59% of eligible children³⁹. Early Head Start serves less than 3% of eligible children⁴⁰. Oregon ranks 31st in per-pupil public school spending, about \$550 per child below the national average.⁴¹ The State's economic crisis resulted in "unprecedented program, staff and school-day cuts"⁴² A group of school districts and families recently filed suit against the State, claiming that chronic school under funding violates the State Constitution. A constitutional amendment approved by voters in 2000 requires that legislators set aside sufficient funds to meet the smaller class size, technological infrastructure upgrades, and enhanced teacher training goals enumerated in Oregon's Quality Education Model, or publicly explain why they have not done so. The Oregon model projects that \$2 billion more than the current (2005-2007) set-aside is required to meet these goals.⁴³

Spending on special instruction in Oregon has outpaced spending on regular instruction.⁴⁴ In the early intervention/early childhood special education arena, the number of children receiving

early intervention services, through increasing, remains lower than the national target. Timely completion of initial evaluations, and the increased provision of early intervention services in natural environments, have also been identified as areas for improvement.

Family Support and Parent Education

Oregon's 2005 Child Safety grade of C- and Family Financial Stability grade of F point out the need for significant improvement in the family support arena⁴⁵. The number of children abused and neglected increased 14% over the previous year, with increases in all types of maltreatment – neglect, physical abuse, sexual abuse, mental injury, and threat of harm.^{46, 47} The four main family variables identified in founded cases of abuse and neglect include parental substance abuse, parental law enforcement involvement, head-of-household unemployment, and domestic violence.⁴⁸

Child poverty in Oregon increased to 19.1% in 2005, and the number of children living in extreme poverty increased by 8% over the preceding year, from 148,000 to 160,000 children.⁴⁹ Although unemployment has very recently declined to 5.6% from a high of 8.5% in July 2003 and 7.5% in July 2005, Oregon's unemployment rate is the 9th highest in the nation.⁵⁰ Oregon's food insecurity rate is 117% of the national average, with more than one in five children at risk. Affordable housing eludes many families, including 78% of low-income rental households.⁵¹

Approximately one-third of abused and neglected children entering foster care in 2004 had received Temporary Assistance to Needy Family (TANF) support within the twelve months preceding their foster placement.⁵² The Governor has created a TANF Children's Initiative to help prevent vulnerable families receiving TANF from entering the foster care system.

Family Support and Parent Education are the most loosely constructed “components” of Oregon's early childhood system, as aspects of these services and supports may be found in all other components, are offered by a diverse array of sponsors and disciplines in a wide variety of settings with vastly different purposes, approaches, perspectives, funding streams and target populations. Many Oregon stakeholders, including the State Early Childhood Team, considered parent education to be a specific type of family support rather than a stand-alone component, and advised that family support, broadly defined, must be provided within and across all system components.

Self-sufficiency and child welfare are among the more structured and visible aspects of the family support component of Oregon's “system of systems.” Improvements in the child welfare arena have been noted in accountability and timely response.⁵³ State agency reorganization led to administrative and service delivery consolidation of these programs several biennia ago, and work toward full integration at both the State and local level continues. Several model integration sites for state-funded services exist, but are not available statewide, and typically do not serve, or draw, a universal population of young children and their families.

While parent focus group participants endorsed “one-stop shops” for information and resources, provider focus group participants evidenced more variability in their ideas about resource organization⁵⁴. The Family Resource Center model, previously operative in more counties, has evidenced limited and diminishing success in Oregon, constrained in recent years by funding disappropriations and reduced staffing resources. The current Community Schools initiative may hold promise for incorporating and expanding a family resource center model in school-based settings. Scan results indicated gaps in family-friendly policies and mechanisms for social;

relational, housing and financial stability; needs for streamlined family and provider-accessible information and referral, application and eligibility determination mechanisms; needs for strengthening supports for particular populations, including fathers, grandparents, children whose parents are incarcerated, and children experiencing domestic violence, parental behavioral health conditions, abuse and neglect, and foster care or other out-of-home placement.

There is wide variation in the availability, consistency, quality, and content of parent education offerings across the State, with no clear lead partners or network, and no consistent standards, oversight, or clearinghouse. Demand also varies, and tends to cluster around particular life stages and events. Promising, exemplary and replicable parent education services, curricula, and local infrastructures were noted, including a community college and extension service program that offers both universal parenting education classes and classes for court-mandated parents. Home visiting is a family support and parent education methodology that is articulated in State statute, but is not funded to serve all eligible children and families, and the configuration of home visiting services in the State does not yet constitute a coordinated continuum. Anticipatory guidance from pediatric healthcare providers is a powerful and parent-preferred venue for parent education, but does not routinely occur to the extent families report that they want.^{55 56}

6b. Maternal and Child Health Relationships

The Office of Family Health enjoys both formal and informal relationships with numerous early childhood stakeholders and system components. Its office-wide partnership matrix includes linkages with 266 partners. Strong early childhood relationships are evidenced by:

- Continually enhancing a strong partnership with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), the agency that administers the Title V program for Children and Youth with Special Healthcare Needs. This is accomplished through interagency agreement, joint management planning and communication; coordinated Title V Needs Assessment; grant development collaboration and support; reciprocal committee representation; and County-level funding and service integration.
- Jointly leading, through the Title V Director's participation, the State Early Childhood Steering Committee. As described in the multi-agency state level partnerships section of this document, this year-old executive-level team advises State agency directors on early childhood systems issues and provides direction to the State Early Childhood Team, between the Oregon Department of Education, the Employment Department's Child Care Division, the Oregon Department of Human Services, and the Oregon Commission on Children and Families.
- Participating actively on the State Early Childhood Team. OFH (ECCS) staff were instrumental in developing this Team's charter which articulates its roles and functions in developing and sustaining the statewide early childhood system.
- Engaging regularly with Partners for Children and Families (PCF) to assure and oversee coordinated, comprehensive community planning and systems development for children age 0-18 and their families. PCF is the parent organization of the State Early Childhood Team. Its membership reflects participation from representatives of all five essential early childhood system components as well as components of the larger system of services and supports for older children and their families, of which the early childhood system is a part.

- Contributing consistently as an active member of partner-sponsored advisory groups and initiatives, including but not limited to the Childhood Care and Education Coordinating Council; the State Interagency Coordinating Council; the ChildFind Committee; Oregon Office for Children and Youth with Special Health Needs (OCCYSHN)-sponsored initiatives including the Early and Continuous Screening Learning Collaborative; Portland State University Infant/Toddler Mental Health Certificate Program Advisory Board; the Northwest Early Childhood Institute’s Scientific Affairs Committee; the Healthy Kids Learn Better Mental Health Workgroup; the State Incentive Enhancement for Early Childhood Prevention Grant Advisory Board; the Hunger Relief Task Force; the Nutrition Council of Oregon; and the Early Childhood Cavities Prevention Coalition.
- Participating in ad hoc and time-limited workgroups relevant to the early childhood system, which currently include: the Partners for Children and Families (PCF) State Plan (for ages 0-18) Workgroup; the PCF Mental Health High Level Outcomes Workgroup; the HeadStart Collaboration Project’s “Promoting Social-Emotional Development in Child Care Settings” grant advisory board; the Ready Schools Initiative; and the Family Early Advocacy and Treatment Interagency Perinatal Working Group.
- Partnering with state and local, private and other public health entities including the Council of Local Health Officials (CLHO); the Oregon Pediatric Society; the Association of Public Health Nurse Supervisors (AOPHNS); local public health departments; and sister State agencies and offices including the Office of Medical Assistance Programs, the Office of Multicultural Health; the Office of Disease Prevention and Epidemiology; the Office of Public Health Preparedness; and the Office of Community Health and Health Planning.
- Including multiple public and private stakeholders as members of OFH advisory and work groups related to child care health consultation, oral health, early hearing detection and intervention, genetics, children with heritable conditions, fetal alcohol prevention, integrated client database (FamilyNet) development, and early childhood comprehensive (ECCS) systems planning. In addition to connections with the aforementioned OFH partners, ECCS activities have also included collaborative relationships with the Oregon Family Support Network, the National Alliance for the Mentally Ill Portland; Family Voices (parent advocacy group comprised of parents of children with special healthcare needs); the Children’s Institute; the Portland Hearing and Speech Institute; the Oregon Association of Treatment Centers; Community Mental Health Programs; PSU Research and Training Center; United Way of the Columbia-Willamette; and community pediatricians and healthcare providers.

6c. Biennial Financing of Children’s Services in Oregon State Agencies

Oregon does not currently produce an official Children’s Budget. The ECCS Initiative developed a beginning process and picture by distilling information from the State’s 2005-2007 Legislatively Approved Budget, and by surveying State Agency fiscal managers in cases where the percentage of agency funds dedicated to children could not be ascertained directly from the Legislatively Approved Budget. The resulting provisional biennial snapshots, due to data and reporting limitations, depict allocations for children aged 0-18 and could not isolate early childhood population expenditures. Similar constraints precluded determination of the percentage of specific funding streams dedicated only to children across all agencies.

While underlying assumptions and methodologies varied across agencies, several overarching parameters guided the process of developing a Children’s Budget picture. Funds were included if they served primarily children prenatal to 18; served adults only because of a child in the family; or served both children and adults but could separately identify the portion of services dedicated to children. Funding for programs that benefited children indirectly (i.e., adult job training), and funding that does not flow through the state budget, were excluded. If the percentage of agencies’ budgets dedicated to services for children could not be directly determined from the Legislatively Approved Budget, an estimate of 100% was used for agencies whose work was exclusively related to services for children, and percentage estimates provided by agency fiscal managers were used in all other cases. Dollar estimates were then calculated by applying the reported percentages to the Legislatively Approved Budget figures for each child-serving agency. Based on this methodology, the following budget pictures emerged:

- Approximately one quarter of the State’s total budget is dedicated to serving children.
- Approximately \$10.1 billion of the State’s total \$42.367 billion budget is dedicated to serving children.
- The \$10.1 billion allocated for children’s services is housed in seven separate State agencies.
- The percentages of agency budgets that children’s allocations represent ranges from 10% to 100%.
- All agencies evidence a blend of federal, state and other funding sources, with percentages varying widely across agencies.

The distribution of State agency funds dedicated to children are depicted below. Graphs of statewide and agency-specific budget percentages, and an overview of children’s allocations within the Oregon Department of Human Services, are included in Appendix C.

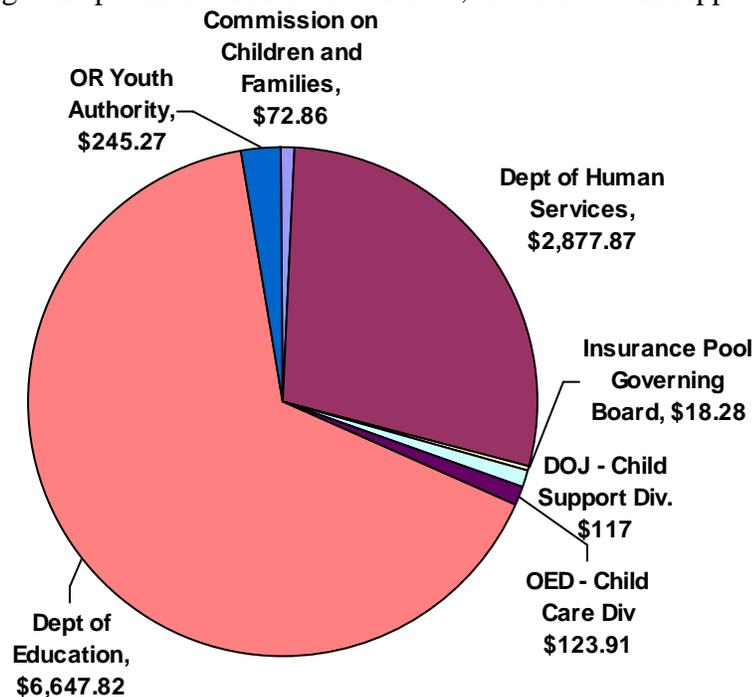


Figure 2: State Agency Funds Dedicated to Children (in Millions)

7a. Implementation Challenges and Opportunities

Systems development and plan implementation are complicated by the challenges enumerated in the environmental scan. The goals, objectives, strategies, and implementation steps of the plan are designed to mitigate the challenges and maximize the opportunities Oregon's early childhood system currently faces.

Securing adequate and sustainable funding and aligned resources for the early childhood system presents a major challenge. Growing recognition of the importance of early childhood, is not yet matched by sufficient levels of funding or resource commitment. A significant proportion of State general funds dedicated to early childhood system development were disappropriated in 2001 in the midst of economic downturn and a corresponding State budget crisis. Partial allocations leave some statewide programs, such as Oregon PreKindergarten (Head Start) underfunded and unable to serve all eligible children. Legislative appropriations remain insufficient to meet statewide, system-wide infrastructure and service capacity needs.

An initial challenge will be to assure sufficient horizontal and vertical visibility and implementation of the plan. State infrastructure constraints and competing priorities have compromised consistent visibility of and focus on the early childhood arena and the ECCS Initiative. Reaching a broader group of business and philanthropic leaders, and engaging additional non-traditional partners and those experiencing health, cultural and socioeconomic disparities across the State, also constitutes a challenge. Overlaying plan implementation on to the existing roles and responsibilities of multiple public partners without additional resources or compensatory workload adjustments presents another challenge. A new State legislative session and gubernatorial election year fall in the middle of the systems development timeline, which challenge continuity, but also present new opportunities for leadership, partnership, policy development, and legislative action.

Another major challenge resides in developing sufficient leadership, infrastructure, and capacity to transform parent education and family support into clearly identifiable and viable system components.

While challenges remain, opportunities also abound. Early childhood system development is mandated in State statute, and Oregon has well-defined State and local infrastructure to support early childhood planning and implementation. Recent enhancements to this structure -- including a charter to support implementation of the early childhood statute, further expansion and development of the year-old executive level Early Childhood Steering Committee that advises agency directors, and enhanced State and local coordination and communication -- further strengthen system development opportunities. Restructuring within the Oregon Department of Human Services in the past year, which included restoration of a public health director position, strengthens public health presence and leadership at the State level.

The Governor's Charter prioritizes children's health, safety and readiness to learn, and has recently been supplemented by announcement of a children's healthcare initiative. These opportunities indicate the public system's readiness and commitment to expanding its strategic and systemic approach to early childhood system development. Opportunities for increased private sector involvement, and growing public/private partnerships with business, philanthropic and community leaders, are also emerging. The 2005 Report to the Governor and Legislature on

the Early Childhood System claims, “The public and private sectors are unusually aligned at this time around building a commitment and action to improve early childhood outcomes; there is unprecedented opportunity to leverage public resources with private resources in the field of early childhood... State agencies indicate a renewed commitment to work across department lines to address child outcomes.¹ Partners have been enthusiastic about the Implementation of the ECCS Plan can help Oregon seize the opportunities inherent in this legislative, executive, community, family, and public/private synergy.

7b. Maternal and Child Health Role in the Early Childhood System

In addition to sustaining and strengthening its current leadership and partnerships in the early childhood system, the Office of Family Health (OFH) will continue to champion and drive the ECCS Plan and its implementation. OFH anticipates taking a lead implementation role within the Department of Human Services and with partners, integrating the plan more fully into its Title V goals, influencing plan dissemination to Counties in conjunction with other statewide partners, continuing the development of FamilyNet, and overseeing the evaluation of plan implementation and related system development outcomes.

8. and 9. Implementation Plan, Priorities, Goals, Objectives, and Strategies Overview

The priorities, goals, objectives, strategies and implementation steps that together comprise the crux of Oregon’s ECCS plan were developed through an iterative process that engaged multiple and diverse stakeholders, honored the work and input of both ongoing and ad hoc groups, synthesized promising and evidence-based system development information and statewide scan results, and built on the strengths and lessons of Oregon’s current early childhood system.

To promote shared leadership and cross-system responsibility for development of the early childhood system, State-level collaborations, rather than individual entities, are taking lead roles in implementing the ECCS Plan, as indicated below. Partners, sometimes singly but most often collectively, are championing different strategies, and have taken responsibility for specific initial implementation steps. The State Early Childhood Steering Committee will work with community partners to prioritize goals and implementation steps, and to hold partners accountable. Please refer to Section 2 for a description of the roles and members of the two collaboratives identified as leads for plan implementation. The implementation role of the Office of Family Health is described in Section 7. Current and prospective partners are a primary resource for implementation and are listed on Page 49 of this document. Implementation is anticipated to proceed within current financial and resource parameters, while simultaneously promoting the identification and leveraging of additional resources to strengthen system development.

Component	Lead
Infrastructure	State Early Childhood Steering Committee
Health	State Early Childhood Steering Committee and Early Childhood Team
Social/Emotional Development & Mental Health	State Early Childhood Steering Committee and Early Childhood Team
Early Care and Education	State Early Childhood Steering Committee and Early Childhood Team
Parent Education	State Early Childhood Steering Committee and Early Childhood Team
Family Support	State Early Childhood Steering Committee and Early Childhood Team

Priorities, Goals and Objectives for Oregon’s Comprehensive Early Childhood System

Two basic priorities emerged from the strategic planning process: infrastructure development, and service and support capacity. Essential elements of these priorities were identified as shared goals, and objectives were generated for each of them. General strategies, and specific implementation steps, support attainment of these goals and objectives. The implementation plan steps have been extracted into a separate section for this document, but are tied directly to the highlighted strategies for each priority goal and objective area.

PRIORITY 1: INFRASTRUCTURE DEVELOPMENT		
#	Goals	Shared Objectives
I-1	Collaborative Leadership	<ul style="list-style-type: none"> Strengthen collaborative leadership at State and local levels to guide development and refinement of the early childhood system. Expand and maintain public/private partnerships to support the early childhood system.
I-2	Public Awareness, Will and Action	<ul style="list-style-type: none"> Enhance public awareness of the importance of early childhood. Promote sustained public & political will to support a comprehensive system of coordinated, effective, high quality early childhood services and supports.
I-3	Sustainable Investments	<ul style="list-style-type: none"> Champion adequate and sustainable funding for the early childhood system’s infrastructure, services and supports.
I-4	Policy & Resource Alignment	<ul style="list-style-type: none"> Elevate early childhood as a statewide policy and resource priority Encourage alignment of state and local priorities, policies and resources within and across components of the early childhood system.
I-5	Cultural Proficiency	<ul style="list-style-type: none"> Enhance statewide capacity to provide culturally and linguistically proficient services and supports that meet the needs of Oregon’s increasingly diverse and changing population of young children and families.
I-6	Family Partnerships	<ul style="list-style-type: none"> Expand and maintain family and consumer partnerships in the design, delivery, evaluation and governance of all aspects of the early childhood system
I-7	Shared Accountability for Quality and Outcomes	<ul style="list-style-type: none"> Support a consistent performance measurement framework for the early childhood system. Share consistent quality standards across the early childhood system. Promote increased system-wide use of evidence-based practices.
I-8	Workforce Capacity	<ul style="list-style-type: none"> Promote the development and retention of a professional, culturally proficient and developmentally informed workforce across all early childhood services and supports.

PRIORITY 2: SERVICE & SUPPORT CAPACITY		
#	Goals	Shared Objectives
S-1	Universal screening, identification and follow-up	<ul style="list-style-type: none"> Support early universal developmental and psychosocial screening, and prompt referral to indicated services.
S-2	Comprehensive Continuum	<ul style="list-style-type: none"> Enhance the provision of a comprehensive, coordinated continuum of high quality, effective and affordable early childhood services and supports.
S-3	Health	<ul style="list-style-type: none"> Support universal comprehensive insurance and healthcare for expectant parents, young children and their families to cover the medical, dental, vision, hearing, mental/behavioral, and specialty healthcare services they need. Promote “medical homes” (sources of continuous, comprehensive, coordinated, family-centered and compassionate care) to meet the healthcare needs of all young children and their families.
S-4	Social/Emotional Development and Mental Health	<ul style="list-style-type: none"> Promote social-emotional development and mental health in all early childhood settings. Strengthen system capacity to provide social/emotional and mental/behavioral health services and supports to young children and their families in natural and familiar community-based settings.
S-5	Early care and education	<ul style="list-style-type: none"> Promote children’s social, emotional, and physical health and development in early care and education settings. Enhance the availability of high-quality, developmentally appropriate, affordable, accessible, and inclusive early care and education services. Enhance the capacity of early care and education to facilitate access to comprehensive services and supports for young children and their families.
S-6	Family Support	<ul style="list-style-type: none"> Strengthen and expand policies, services and supports that enhance family stability, safety, self-sufficiency and relationships.
S-7	Parent Education	<ul style="list-style-type: none"> Promote learning and leadership opportunities that enhance parents’ confidence and competence as primary nurturers, first teachers, and partners in early childhood services and supports. Elevate quality parent education as an integral and universal part of the early childhood system.

Strategies for Achieving Plan Goals and Objectives

Stakeholders created a robust yet flexible menu of strategies for both current and future implementation, to assure an early childhood system responsive to all young children and their families. Strategies are generally listed in an order consistent with the Institute of Medicine’s service continuum model, beginning with strategies for promotion and prevention, and ending with strategies for treatment and follow-up. Strategies selected for initial implementation are **highlighted in bold**. The initial implementation plan developed for the highlighted strategies is presented in the next section. As plan dissemination and implementation proceed, strategies can be completed, added and/or modified in response to changing conditions and circumstances.

Many strategies support multiple goals and objectives but are listed just once in this document in order to minimize duplication. Strategies for Universal Screening, and for the Comprehensive Continuum goals and objectives, are not listed separately. Instead they are imbedded in the Infrastructure and component-specific Service and Support strategies. Physical activity and

nutrition, for example, are listed as a health component strategy, but are also strategies pertinent to family support and parent education.

Strategies for Priority I Goals and Objectives: Infrastructure Development

I-1 Collaborative Leadership Strategies

- 1) **Enhance current early childhood partner collaboration.**
- 2) **Strengthen the governance structure of the early childhood system through shared leadership at all levels.**
- 3) **Identify and support additional early childhood champions.**
- 4) **Enhance collaborative business, philanthropic, advocacy, private agency, faith-based, citizen and parent/family involvement in the early childhood system.**
- 5) **Continue and strengthen collaboration between lead State early childhood agencies and additional early childhood partners.**
- 6) **Create and implement collaborative leadership development and training opportunities.**

I-2 Public Awareness, Will and Action Strategies

- 1) **Develop a communication plan for Oregon’s Early Childhood agenda that conveys consistent messages about early childhood and the early childhood system of services and supports.**
- 2) Launch a strategic public awareness/engagement campaign consistent with the communications plan.
- 3) Link awareness campaign with outreach and funding efforts.
- 4) Develop mechanisms to map, track and visually depict the early childhood system to facilitate stakeholder engagement and systems development.

I-3 Sustainable Investments Strategies

- 1) Determine the level of financial resources needed to sustain a comprehensive, quality early childhood system.
- 2) Develop and implement methods to determine and convey levels of unmet early childhood service and funding needs.
- 3) **Complete and maintain an inventory of early childhood funding and funding streams to guide efforts to maximize, leverage and coordinate financing.**
- 4) **Identify potential new funding streams and financing strategies.**
- 5) Promote routine biennial preparation and review of a state level Children’s Budget.
- 6) Use economic impact and cost-benefit analyses to promote public and private investments in early childhood.

I-4 Priority and Resource Alignment Strategies

- 1) Build broad stakeholder consensus on early childhood system priorities.
- 2) Assure that policies, services and supports are consistent with shared early childhood system priorities, objectives and outcomes.
- 3) Develop shared definitions and common language among key early childhood stakeholders.
- 4) Review (audit) State policies to mutually examine their impact on early childhood well-being and their consistency with early childhood system priorities.
- 5) Identify and address missing and misaligned policies and resources.
- 6) Include early childhood and family impact analyses in pertinent new policy development efforts.

- 7) Analyze relevant legislative bills for their impact on the well-being of young children and their families.
- 8) Enhance and maintain interagency awareness and understanding of the structures, functions, mandates, and services of early childhood partners.**
- 9) Encourage ongoing review and coordination of all key State plans to identify common goals and objectives.

I-5 Cultural Proficiency Strategies

- 1) Promote policies, practices, and services to eliminate resource, service, and health disparities, and achieve equal access for young children and their families.
- 2) Integrate cultural proficiency standards into all aspects and components of the early childhood system, including governance, administration, service delivery, recruitment, training, professional development and evaluation.
- 3) Systematically review demographic trends to insure ongoing responsiveness to cultural, linguistic and other diversity needs.
- 4) Expand the early childhood focus and involvement of state level cultural diversity committees, plans and initiatives.**
- 5) Promote the periodic administration and analysis of cultural self-assessments at provider, program, organizational and systems levels.**
- 6) Recruit and retain an early childhood workforce that reflects the diversity of the population it serves.
- 7) Enhance the cross-cultural effectiveness of people who work with young children and their families.**
- 8) Enhance the availability and utilization of qualified interpreters and translators.
- 9) Enhance the availability and utilization of cultural specialists, cultural consultants, and traditional healers.
- 10) Engage family consultants who reflect the diversity of the early childhood population.
- 11) Develop and implement common performance measures and indicators of cultural, linguistic and other diversity proficiency in the early childhood system.
- 12) Develop mechanisms to identify, track and disseminate information about culturally proficient services and supports.

I-6 Family Partnership Strategies

- 1) Identify and implement additional family involvement opportunities in all levels and components of the early childhood system.**
- 2) Create and sustain positions for parent consultants/family liaisons in State and local early childhood services and in system governance and oversight structures.
- 3) Develop mechanisms to compensate families for involvement.
- 4) Develop and implement family orientation and training protocols and processes.**
- 5) Provide technical assistance, consultation, and training to early childhood system partners to improve recruitment, orientation, training, and retention of families as partners.
- 6) Invite and support families to participate in designing, presenting, and attending early childhood trainings.**
- 7) Incorporate and implement family involvement requirements in quality standards, regulations, contracts and policies.**
- 8) Sponsor periodic community forums to inform and seek input from families.**
- 9) Routinely utilize consumer satisfaction surveys to guide improvements in early childhood services and supports.**

- 10) **Engage family and consumer organizations and coalitions in identifying and implementing strategies to strengthen early childhood system infrastructure, services and supports.**

I-7 Shared Accountability for Quality and Outcomes Strategies

- 1) Review, confirm, and prioritize shared outcomes for the early childhood system.
- 2) **Create shared outcome measures to evaluate overall infrastructure and system development progress.**
- 3) Develop coordinated State and local capacity and mechanisms to collect, analyze, report on, and utilize early childhood outcome data within and across components and levels of the early childhood system.
- 4) Determine baselines, targets and data sources for shared outcomes.
- 5) Consider incorporating National School Readiness Indicators Project indicators into Oregon's early childhood measurement system.
- 6) **Develop mechanisms to identify, disseminate, and track the use of evidence-based practices throughout the early childhood system.**
- 7) **Promote fidelity to evidence-based practices.**
- 8) Evaluate the impact of cross-training and professional development efforts.

I-8 Workforce Capacity Strategies

- 1) **Identify core knowledge and skill competencies needed by all providers who touch the lives of young children and families.**
- 2) Incorporate core competency training into cross-system, component-specific and specialty discipline pre-service, professional development and continuing education offerings.
- 3) **Strengthen and expand early childhood training opportunities across disciplines, based on mapping of needs and opportunities.**
- 4) Promote the implementation of minimum qualifications and standards for early childhood providers whose disciplines do not currently offer licensing or credentialing.
- 5) Develop a cross-agency early childhood training plan.
- 6) **Promote supports and incentives to encourage professional development (including but not limited to articulation, transfers, tiered reimbursement, and tuition subsidies).**
- 7) Develop mechanisms to recruit and retain sufficient numbers of providers to meet community needs (including but not limited to early childhood dental and mental health providers).
- 8) Improve telemedicine capacity to compensate for rural provider shortages.
- 9) Develop mechanisms to identify and disseminate evidence-based practice information to providers throughout the system.
- 10) Support livable wages and adequate benefits for the early childhood workforce.

Strategies for Priority 2 Goals and Objectives: Service and Support Capacity

S-3 Health Strategies

- 1) **Strengthen early childhood system linkages with healthcare coverage initiatives.**
- 2) **Enhance outreach efforts to increase enrollment in public and private health insurance programs.**
- 3) Promote health insurance portability to assure continuity of care.
- 4) Maximize third party reimbursement for developmental screening, assessment, promotion and prevention services, and care coordination.

- 5) **Maximize understanding and use of current benefits and services to meet healthcare needs.**
- 6) **Promote a coordinated system of evidence-based, universal screening, referral and follow-up services across the multiple settings that serve young children and their families.**
- 7) **Promote the use of standardized developmental and psychosocial screening tools as routine components of well-child check ups and community services.**
- 8) Facilitate system-wide training in the use of standardized screening tools.
- 9) Develop and disseminate customized sample toolkits to facilitate standardized screening, anticipatory guidance, and fidelity to medical home principles in primary care and community service settings.
- 10) Train the early childhood workforce to screen and refer for health risks and conditions.
- 11) Increase the number of healthcare providers participating in the Oregon Health Plan.
- 12) Expand the number of pediatric dental care providers and availability of pediatric oral health services.
- 13) **Expand the role and presence of parents as consultants and decision-makers in healthcare and early childhood settings.**
- 14) **Enhance partnerships, service coordination and information exchange between community services and healthcare providers.**
- 15) **Promote the co-location of health care and early childhood services.**
- 16) **Promote statewide availability of social/emotional, health and mental health supports and consultation in early care and education and other early childhood settings.**
- 17) Promote physical activity and healthy nutrition in all early childhood settings.
- 18) Expand and sustain the availability of health services and supports in school-based settings.
- 19) Expand telemedicine capacity for physical and behavioral health in rural areas.
- 20) Promote the use of integrated electronic health records.
- 21) Improve ancillary services (e.g., transportation) to improve healthcare access and utilization.
- 22) Support incentives to recruit and retain healthcare providers for medically underserved populations and geographic regions.
- 23) Review existing eligibility and enrollment policies and procedures and promote those that improve healthcare affordability, accessibility, and availability.

S-4 Social/Emotional Development and Mental Health Strategies

- 1) Develop and implement a research-based social marketing campaign emphasizing the importance of early childhood social/emotional development and mental health.
- 2) Enhance public, provider, and family awareness of the neurodevelopmental and psychosocial risks and consequences of prenatal drug and alcohol exposure and parental substance abuse.
- 3) **Support core competencies across disciplines to promote healthy social/emotional development.**
- 4) Train the multidisciplinary early childhood workforce in the core competencies that promote social/emotional development and mental health.
- 5) Promote the use of standardized screening and assessment tools by providers trained to use them.
- 6) Develop, maintain, and disseminate a list of standardized early childhood social-emotional development and mental health screening tools.
- 7) Train the multidisciplinary early childhood workforce to screen and refer for early childhood mental health and family behavioral health issues.
- 8) Increase the number of behavioral health providers serving young children and families.

- 9) **Promote the development of core competencies needed for providing early childhood mental / behavioral health services.**
- 10) Develop and implement in-service training, continuing education, and reflective supervision opportunities to assist behavioral health providers in increasing capacity to serve young children.
- 11) Promote the routine inclusion of coursework in early childhood development and family behavioral health in high school, college, graduate, specialty programs and professional development curricula.
- 12) **Expand social/emotional, health and mental health supports and consultation in early care and education, primary care, parent education, family support, and other early childhood settings.**
- 13) **Enhance coordination between early childhood mental health and pediatric healthcare providers.**
- 14) **Develop statewide mechanisms to support communities in implementing universal screening, referral, and follow-up services for young children and their families.**
- 15) **Promote universal screening and early treatment for maternal (prenatal and postpartum) depression.**
- 16) **Promote third party coverage and reimbursement of clinically and developmentally appropriate early childhood mental health diagnosis and treatment services.**
- 17) Encourage identification of and intervention with children whose parents evidence behavioral health conditions.
- 18) Expand the availability of alcohol, tobacco and other drug (ATOD) information and referral, prevention and intervention services for prospective and expectant parents and families with young children.
- 19) Enhance the availability of mental health services to young children and their families who are experiencing homelessness, domestic violence, foster care placement, and/or other involvement in the child welfare system.

S-5 Early Care and Education Strategies

- 1) Promote quality early care and education as an economic development strategy.
- 2) **Promote quality improvement efforts and initiatives in early care and education.**
- 3) Enhance licensing, monitoring and regulation to improve service quality.
- 4) Stabilize and professionalize the early care and education workforce by expanding systems that promote adequate compensation and benefits.
- 5) Support a professional development system for early care and education providers that includes incentives for career preparation and ongoing professional development.
- 6) Support the development of provider networks to reduce isolation, connect to community resources, and improve quality.
- 7) Promote HeadStart Performance Standards as a model framework for a universal early care and education system.
- 8) Promote the effective development and implementation of comprehensive research-based early learning guidelines applicable across early care and education settings.
- 9) Enhance family involvement in early care and education settings.
- 10) **Support efforts to further integrate health and safety standards into early care and education settings.**
- 11) **Facilitate smooth and planned transitions between home, school, and all levels of early care and learning.**
- 12) Promote universal preschool opportunities.
- 13) Support the expansion of full- and extended-day kindergarten.

- 14) Support the increased availability of extended-day, and out-of-school-time early care and education services.
- 15) Develop mechanisms to increase child care capacity in underserved communities.
- 16) Support increased availability of early care and education for infants and toddlers.
- 17) Support increased early care and education capacity in rural communities.
- 18) Strengthen early care and education settings as venues for parent education and family
- 19) Strengthen linkages between healthcare and early care and education providers.**
- 20) Increase the enrollment of eligible children in Oregon Prekindergarten.
- 21) Sustain and expand the availability of social/emotional, health and mental health supports and consultation in early care and education settings.**
- 22) Enhance early care and education capacity to serve children who experience homelessness, domestic violence, foster home placement, and/or other involvement in the child welfare system.
- 23) Enhance early care and education resource and referral capacity for children with special healthcare needs.
- 24) Promote the inclusion of children with special needs in early care and education and out-of-school-time settings.**
- 25) Increase screening, identification, and enrollment of eligible children in early intervention services.**
- 26) Expand the provision of early intervention services in natural settings.**

S-6 Parent Education Strategies

- 1) Support the systematic provision of evidence-based information, materials, resources and learning opportunities that assist parents in understanding and meeting their children's social, emotional, developmental, cognitive, physical, and healthcare needs.**
- 2) Enhance the availability of parent education opportunities for families of all young children.
- 3) Expand parent education opportunities for fathers, grandparents, foster parents, teen parents, parents of children with special needs, and vulnerable populations.
- 4) Imbed parent education opportunities in natural and familiar community settings (including, but not limited to, libraries, park and recreation settings, community centers, faith communities, schools, and work places).
- 5) Strengthen community capacity to plan and promote the coordination of parent education with other early childhood services.**
- 6) Orient and train the early childhood workforce to understand and promote parent education activities.
- 7) Support referral to and provision of parent education in current early childhood service and support venues including but not limited to health and mental health care, early care and education, child welfare, self-sufficiency, home visiting, and other family support services.
- 8) Support the development and implementation of a timely, comprehensive, publicly accessible directory of parent education resources.
- 9) Strengthen information and referral capacity to assist parents in accessing parenting information and resources.
- 10) Promote dissemination of evidence-based parent education curricula, materials and programs to providers and parents.**
- 11) Develop standards for parent education and core competencies for parent educators.
- 12) Support training and professional development for parent educators.
- 13) Promote development of a statewide parent educator network.

- 14) Infuse parenting and child development content into non-traditional training settings such as babysitting training, high school classes, recreation and safety staff training, adult literacy and education programs.
- 15) Support peer mentoring, coaching, and advocacy opportunities for parents.
- 16) Host periodic community forums and conferences for parents to share information on parenting and child development.

S-7 Family Support Strategies

- 1) Create statewide infrastructure for promoting and coordinating family support policies and services.**
- 2) Promote and maintain wage, unemployment and tax structures that assure a stable and sufficient standard of living for families with young children.
- 3) Promote policies and services that support families in spending time together during critical periods and challenging events.
- 4) Support adequate parental leave and flexible schedule policies for families with young children.
- 5) Strengthen policies, services and supports that promote the active involvement of both parents in the lives of their children.**
- 6) Support the establishment of a statewide information and resource helpline for families.**
- 7) Promote a universal application process to facilitate streamlined and simultaneous enrollment in multiple services.**
- 8) Promote parent-to-parent outreach and support opportunities.
- 9) Support community efforts to establish systems for universal screening and subsequent referral to indicated early childhood services and supports.
- 10) Strengthen and replicate successful local integrated service delivery models.
- 11) Strengthen the provision of evidence-based home visiting services.**
- 12) Expand community and employer-based breastfeeding support.
- 13) Support early childhood providers in offering breastfeeding education and support.
- 14) Assure that emergency preparedness plans and policies address the unique needs of young children and their families
- 15) Sustain and expand the availability of injury prevention and environmental hazard reduction information and resources to families of young children.
- 16) Enhance the availability of care coordination services for young children and families who need them.
- 17) Strengthen cross-system support of children and families served by the child welfare system.
- 18) Enhance multidisciplinary understanding and response to drug-endangered children.
- 19) Enhance the availability of affordable, high quality respite care for children with special needs.

8. Initial Implementation Plan

Implementation Steps Toward Infrastructure Development

I-1 Collaborative Leadership:

Year 1:

- Continue and strengthen collaboration between the 4 State agencies responsible for jointly leading the Early Childhood System.
- Engage new and existing partners in furthering the objectives and strategies of the Statewide Early Childhood Comprehensive Systems (ECCS) Plan.

- Clarify and enhance the role and membership of the Early Childhood Steering Committee.
- Create an Early Childhood Steering Committee work plan to operationalize selected implementation steps.
- Structure the activities and membership of the State Early Childhood Team to accomplish statutory, charter, and ECCS objectives.
- Continue and strengthen collaboration between lead State early childhood agencies and other public, private, state and local early childhood partners.
- Identify and pursue collaborative leadership training and development opportunities.

I-2 Public Awareness, Will and Action

Year 1:

- Develop a communications plan for Oregon’s early childhood agenda
- Create, disseminate, and present a family/partner- friendly version of key elements of the ECCS Plan to increase coordinated stakeholder involvement in strengthening the early childhood system.

Year 2:

- Disseminate standardized early childhood brain development presentation materials to local speakers’ bureaus.
- Build on pre-existing public awareness campaigns to develop consistent early childhood messaging.

Year 3:

- Launch a statewide early childhood public awareness campaign.

I-3 Sustainable Investments

Year 1:

- Develop capacity for the 4 lead State early childhood agencies to jointly review and advise on the use of non-legislatively appropriated early childhood funding and resource opportunities.
- Coordinate budget review and development efforts with the Children’s Institute’s Children’s Budget Project.

I-4 Policy and Resource Alignment

Year 1:

- Engage partners in identifying, developing, and implementing policies and activities consistent with the statewide ECCS Plan.
- Integrate the ECCS plan into State partners’ plans and planning processes.
- Conduct periodic surveys of local Early Childhood Teams, Local Interagency Coordinating Councils, and community providers to update priorities and review local system development and service coordination progress.

Year 2:

- Develop mechanisms to enhance early childhood technical assistance and consultation to community service providers, local Early Childhood Teams and Interagency Coordinating Councils.
- Align State and local priorities through continued implementation and review of coordinated comprehensive planning.

I-5 Cultural Proficiency

Year 1:

- Engage the Cultural Diversity and Gender Appropriate Services Training Committee of the Partners for Children and Families in the review and implementation of the Early Childhood Comprehensive Systems Plan.

Year 2:

- Implement the previously adopted “Respect for Diversity” Quality Assurance Standards developed as guidelines for Oregon’s system of services and supports for all children and families.
- Identify and disseminate across the early childhood system information about effective cultural self-assessment tools and culturally proficient services and supports.

I-6 Family Partnerships

Year 1:

- Collect and disseminate information on the current level of family/consumer involvement in the design, delivery, governance and evaluation of early childhood policies and services.
- Collect and disseminate information on mechanisms currently in place to support family involvement in early childhood system development, services, and supports.

Year 2:

- Coordinate the multiple community forums convened by various early childhood entities.
- Systematically review and synthesize input from consumer satisfaction surveys and agency-sponsored community forums.
- Expand the system-wide consultation role of existing parent and family advocacy organizations.
- Develop and implement methods to routinely inform and update parent/family organizations and advisory groups about early childhood system activities, projects, and issues.

Year 3:

- Incorporate specific family involvement recommendations into early childhood quality standards.
- Research, customize and disseminate information on effective protocols and practices for enhancing and sustaining family involvement.

I-7 Shared Accountability for Quality and Outcomes

Year 1:

- Develop common evaluation questions and strategies across all early childhood system components.
- Continue integrated client data system development.
- Develop a Behavioral Health Module for the integrated client data system.
- Develop outcome measures for the behavioral health pilots of the Oregon Children’s Plan.
- Gather, aggregate, and report Early Childhood data to State and local early childhood partners.

Year 2:

- Increase capacity to measure fidelity to evidence-based practice models.

Year 3:

- Improve collection of baseline and program evaluation data related to health, safety and child development indicators in early care and education settings.

I-8 Workforce Capacity and Development

Year 1:

- Review, synthesize, update and disseminate core early childhood competencies, building on the previous work of early childhood partners.
- Map current training needs and opportunities across the early childhood system.
- Develop cross-training strategies for the early childhood workforce based on mapping outcomes.

Year 2:

- Develop and offer training regarding early childhood mental health diagnosis and clinical formulation.
- Strengthen and expand articulation and transfer agreements among higher education institutions.

Year 3:

- Increase cross-training of early childhood providers in early childhood development and family support issues.
- Increase cross-training of early childhood providers in substance abuse, attachment and mental health issues.
- Strengthen and expand pilot projects to improve salaries and benefits for early childhood providers.

Implementation Steps Toward Service and Support Capacity

(note: S-I and S-2 strategies and implementation steps are imbedded in infrastructure and component-specific strategy and implementation step lists)

S-3 Health

Year 1:

- 1) Develop and implement mechanisms to further the Governor's Healthy Kids Plan Initiative to increase health insurance coverage for low-income children and their families.
- 2) Create methods to sustain and expand the coordinated provision of social/emotional, health and mental health supports and consultation in early childhood settings.
- 3) Reconvene a Medical Home Workgroup to further develop and guide Oregon's universal medical home agenda.
- 4) Increase partnership activities with healthcare organizations to further inform and support healthcare providers in endorsing and expanding essential elements of medical home in their practices.
- 5) Assure that current screening, intake and enrollment protocols across early childhood system components include medical home questions and referrals.
- 6) Strengthen benefits counseling to improve utilization of existing coverage and services for children with special healthcare needs.
- 7) Expand health linkages with local early childhood providers and Early Childhood Teams.

Year 2:

- 8) Identify, disseminate and build on lessons learned from current community pediatrics pilots and medical home expansion efforts.

- 9) Research, identify and disseminate information about standardized developmentally appropriate screening and assessment tools.

Year 3:

- 10) Research and disseminate information about effective community-based systems of universal screening, referral and follow-up.

S-4 Social Emotional Development and Mental Health

Year 1:

- 1) Identify core competencies needed across disciplines to promote the healthy social/emotional development of young children.
- 2) Build on current models and pilots to develop consistent approaches for increasing social-emotional, health and mental health supports and consultation in early childhood settings.
- 3) Continue to review, adopt and implement evidence-based early childhood mental health practices.
- 4) Implement early childhood-specific diagnostic and treatment guidelines for mental health providers.

Year 2:

- 5) Disseminate and sustain learnings from evaluation of mental health / physical health service integration pilots and other early childhood systems change efforts.
- 7) Explore the feasibility of statewide expansion of an MHO (managed mental health organization)- developed post-partum depression screening Project.
- 8) Identify core competencies needed for providing early childhood mental/behavioral health services.

Year 3:

- 9) Develop mental health policy to address infant and early childhood mental health issues.

S-5 Early Care and Education

Year 1:

- 1) Support efforts to initiate and review child care quality indicator pilot projects.
- 2) Continue to implement the Early Childhood Assessment process with additional early care and education partners throughout the State.
- 3) Reconvene a statewide Social/Emotional Supports Work Group to expand and disseminate curriculum and training for enhancing social emotional development and providing behavioral supports in early care and education settings.
- 4) Build on current pilots and models to strengthen and expand a coordinated and comprehensive continuum of social/emotional, health and mental health supports and consultation in early care and education settings.
- 5) Intensify and sustain cross-system efforts to identify and refer eligible children to early intervention services.
- 6) Research the feasibility of utilizing a statewide screening tool with all parents to increase the early identification and referral of young children with disabilities to early intervention and early childhood special education services.
- 7) Improve local partnerships to increase the number and variety of placements in natural and typical early childhood settings available to children with disabilities.

Year 2:

- 8) Contribute to the dissemination, implementation and review of Early Childhood Foundations (early learning guidelines for children aged 0 – 5).
- 9) Further integrate the implementation of health and safety standards in early care and education settings through enhanced consultation, training and technical assistance.

Year 3:

- 10) Strengthen collaborative transition policies and practices to facilitate children's Kindergarten readiness and success.
- 11) Engage additional partners and communities in implementing coordinated Kindergarten transitions.

S-6 Family Support

Year 1:

- 1) Expand the Early Childhood Steering Committee to include and engage self-sufficiency, child welfare, and behavioral health representatives.
- 2) Develop mechanisms to improve linkage between services, supports and initiatives within and between levels and components of the early childhood system.
- 3) Continue efforts to develop and implement a web-based universal application process.

Year 2

- 4) Align home visiting services in a clear and comprehensive continuum.
- 5) Cross-train the early childhood workforce in identification and response to children exposed to the production and use of methamphetamines and other drugs.

Year 3:

- 6) Identify and expand positive fatherhood initiatives.
- 7) Develop methodology for statewide information and referral helpline expansion.

S-7 Parent Education

Year 1:

- 1) Develop mechanisms to coordinate and expand evidence-based parent education resources.
- 2) Determine the feasibility of statewide expansion of a web-based parent education resource directory.
- 3) Increase linkages between resource and referral entities, parent education resources and local early childhood team.

Year 2:

- 3) Develop mechanisms to strengthen and update the parent education information database of existing resource and referral services.
- 4) Strengthen coordination between home visiting and parent education resources.

Year 3:

- 5) Develop capacity to routinely disseminate information about evidence-based parent education curricula, materials and programs to parents and providers.
- 6) Develop approaches to support and improve the systematic provision of anticipatory guidance.

10. Core Indicators for Early Childhood Health Status and System

Performance

Does the comprehensive early childhood systems plan help improve the lives of Oregon's young children and families? To determine if the plan achieves this ultimate purpose, Oregon utilizes a logic model approach that links plan implementation and system development outcomes with changes in population health status and shared high and intermediate level early childhood outcomes.

While it is difficult to establish a direct, causal relationship between system development / plan implementation outcomes and population outcomes, especially during initial implementation (an

often disruptive period), Oregon's logic model assumes that these events are logically related and can be tested independently. It may be many years before we can determine the effects that system outcomes have on the entire population of young children in Oregon and use our developing information systems to relate those effects back to the system of services we are building. Nonetheless, if all events evidence a measure of improvement, then the logically-related earlier events can be said to have helped achieve improvement in the subsequent events. Oregon's early childhood systems development efforts began with improved child and family outcomes in mind. Shared high and intermediate level early childhood outcomes previously developed and adopted by State level early childhood partners have been reaffirmed (with suggestions for review and refinement of outcomes and measures), and constitute an important tier of evaluation to be further developed and conducted by system partners. Health status indicators related to these high level outcomes, for which reliable data sources exist or are being developed, form a second tier. Plan implementation and systems development indicators and outcomes constitute yet another tier toward which ECCS evaluation efforts will be largely directed.

These three evaluation tiers, presented on the following pages in chart form, are imbedded in an iterative logic model in which all aspects of the ECCS plan and the early childhood system are logically and integrally linked. The assumed progression can be summarized as follows: inspired by our **vision**, if we pursue our **mission** by using our **resources** to take **steps** to **implement strategies** to accomplish the **objectives** that achieve system **goals** and **priorities**, then **health status** may be more likely to improve, contributing to attainment of shared **early childhood outcomes**, further fulfillment of our **mission**, and fuller realization of the ECCS **vision** for Oregon's children and families.

Preliminary plan implementation and system development indicators, and the health status and population outcomes to which they are linked, are outlined in the chart below.

Tier 1: Plan Implementation and System Development	
Outcome: The ECCS Plan is used and implemented as intended	
Indicators (by number /percent and/or process reporting)	Data Sources
<ul style="list-style-type: none"> • Partners who are aware of the plan • Partners who agree that the plan adequately addresses early childhood needs and priorities • Partners whose planning and activities align with plan priorities, goals, objectives and/or strategies • Partners who implement initial steps in accordance with agreed-upon roles and schedules • Plan implementation steps that are initiated and accomplished • Plan strategies that are adopted and operationalized • Plan modifications made in response to emerging issues, changing needs and conditions &/or initial oversights/deficits 	Meeting Rosters & Minutes Stakeholder Survey Early Childhood Team Survey Accomplishment Inventory ECCS Tracking Tool / Tally
Outcome: Changes in the Early Childhood System are consistent with the ECCS Plan	
Indicators (reported biennially)	Data Sources
<p>Infrastructure and service and support capacity changes consistent with plan priorities, goals and objectives, including:</p> <ul style="list-style-type: none"> • Number of partners identified as early childhood system leaders • Number of partners who consider system leadership effective • Number of new and enduring collaborations and public/private partnerships • Evidence of enhanced levels of partner collaboration • Number of public awareness activities launched • Number and nature of aligned policies and resources • Changes in levels and sources of early childhood funding • Number of partners & families reporting family involvement • Number of cultural proficiency trainings and trained providers • Number of shared evaluation questions and measurements implemented • Number of partners and communities reporting and demonstrating increased early childhood service and support capacity in: <ol style="list-style-type: none"> a. Systems of voluntary universal screening, referral and coordinated care b. Health insurance and comprehensive healthcare c. Social-emotional development and mental health d. Early care and education e. Parent education f. Family support 	Early Childhood Team Biennial Legislative Report / Data Stakeholder Survey Pre-Post Collaboration Survey Early Childhood Team Survey ECCS Tracking Tool / Tally Legislatively Approved Budget Agency practitioner reports Children's Access to Healthcare Survey

Tier 2: Population Health Status Indicators

Outcome: Children are healthy and safe

Indicators	Data Sources
Percent of newborns whose mothers began prenatal care in 1st trimester	Birth Certificate Data FamilyNet
Percent of all pregnancies among women aged 15-44 that are intended.	PRAMS, Abortion Reports FamilyNet
Percent of mothers abstaining from tobacco use during pregnancy	FamilyNet, SFMB database Birth Certificate, PRAMS
Percent of mothers abstaining from alcohol use during pregnancy	FamilyNet (FN) Birth Certificate, PRAMS
Percent of women breastfeeding their infants at 6 months old	Ross Products Division, Abbott Laboratories, FN
Percent of newborns screened for metabolic disorders per current standards	FamilyNet Public Health Laboratories
Percent of newborns receiving a hearing screening test	Public Health Laboratories FamilyNet
Percent of children with lead poisoning	FamilyNet and Office of Dis- ease Prevention & Epidemiology
Percent of children 0-3 observed properly restrained in carseats	Oregon Dept of Transportation Observational Survey
Percent of SCHIP & Medicaid eligible children enrolled in the OHP	FamilyNet & Oregon Medical Assistance Programs (OMAP)
Percent of OHP eligible children who have received at least 1 dental visit per year	FamilyNet OMAP MMIS/CPMS
Percent of OHP eligible children who receive one or more service paid for by the Oregon Health Plan	OMAP MMIS/CPMS
Percent of 2-year-olds adequately immunized	National Immunization Survey FamilyNet
Percent of children w/ special health care needs who have a "medical home"	SLAITS/ NSCSHCN; FamilyNet
Percent of children who have a "medical home"	National Survey of Children's Health
Number of child care slots available for every 100 children under age 13	Child Care Research Partnership
Percent of students in K-12 with access to a school-based health center	School-based Health Center Database, FamilyNet
Rate of abuse/neglect per 1000 children	DHS/CAF Evaluation & Quality Standards Unit
Percent of children entering school ready to learn	ODE Kindergarten Survey

TIER 3: Shared High and Intermediate Level Early Childhood Outcomes

Shared Intermediate Outcomes (reported biennially through partners)

- Percent of children who show appropriate patterns of growth and development
- Percent of families reporting increased skills in parenting their children
- Percent of families who regularly read to their children
- Percent of Oregonians who have health insurance
- Percent of two-year-olds who are adequately immunized
- Percent of children with identified conditions receiving appropriate services
- Percent of children in the general population aged birth to five who are diagnosed with a delay or disability and who are receiving early intervention or early childhood special education services
- Percent of children removed from their homes by Child Protective Services
- Percent of children in quality child care settings
- Percent of children with special needs who receive care appropriate to their needs in community child care settings
- Percent of pregnant women who access chemical dependency treatment
- Percent of Oregon parents and children with access to alcohol / drug treatment and mental health care

Shared High Level Outcomes (as measured biennially by partners through the Oregon Benchmarks indicated):

- Decreased rate of child abuse and neglect (Benchmark 50)
- Increased percent of children entering school ready to learn (Benchmark 18)
- Decreased infant mortality (Benchmark 4)
- Increased percent of children fully immunized at age two (Benchmark 42)
- Increased percent of women accessing early prenatal care (Benchmark 40)
- Increased number of child care slots available for every 100 children (Benchmark 48)
- Decreased percent of infants whose mothers used alcohol and/or tobacco during pregnancy (Oregon Department of Human Services statistic)

17. Data Collection

The ECCS initiative will rely primarily on the existing data collection and performance measurement efforts of multiple partners for evaluation of health status and high and intermediate level early childhood outcome changes. While encouraging (and contributing to) the refinement and expansion of these data sources and measurement processes (especially further development of FamilyNet), ECCS evaluation efforts will be dedicated primarily to tracking the progress of plan implementation and system development and linking these to the other tiers, in keeping with the Initiative's systems development focus.

Five measurement processes will be utilized to evaluate plan implementation and system development. Progress toward completion of time- and resource-sensitive plan implementation tasks will be measured by the number and percent of tasks completed. Process results will be measured qualitatively as documented by partner and project reports and documents. Infrastructure and system development outputs, and items produced, will be measured by review of partner policy and resource changes, plans and reports. Acceptability, durability, relevance and feasibility of outputs and processes, including collaboration and partnership-building, will be measured by a survey of stakeholders and a pre/post collaboration survey. The impact of plan

implementation and system development activities on Oregon's young children and families will be analyzed in relation to changes in health status and high and intermediate level outcomes. This will include context analysis to identify other possible contributory factors to system and population outcomes.

While a final report will synthesize the results of each of these measurement processes, periodic monitoring and updates will also occur to assure that plan implementation and system development are responsive to emerging trends, needs and opportunities.

11. Family and Community Involvement

The ECCS Initiative recruited, oriented and engaged family members and advocates as active partners in the ECCS strategic planning process. Parents and advocates served on the ECCS health advisory board, medical home workgroup, mental health diagnostic system workgroup, and component-specific strategy groups. Parent focus groups, and key informant interviews with parents and advocates, were conducted. The planning process benefited from the involvement of parents representing numerous family and advocacy organizations, including NAMI Portland, the Oregon Family Support Network, Family Voices (CSHCN), Family Connections, Parent Voices (parent group affiliated with the statewide Childhood Care and Education Council), and the Parent Council of the Oregon Head Start Association.

However, family involvement has not yet reached optimal partnership levels within the ECCS initiative or within Oregon's early childhood system infrastructure. The breadth and depth of family partnerships vary across and within system components, and family participation is absent from the State Early Childhood Team and Partners for Children and Families. Recognizing the crucial need for enhanced and enduring family involvement at all levels, the ECCS Plan promotes family partnerships as an essential infrastructure goal to be addressed during implementation. It is anticipated that family consultants will assist the ECCS initiative and the Office of Family Health in furthering this goal.

Community involvement has been present, but also less direct and robust during planning than it will be during implementation. ECCS efforts have focused largely on strengthening State level infrastructure in order to better support local system development, service and support capacity, and integration. Communities contributed to ECCS planning efforts through representative participation in workgroups and strategy sessions. Local level representatives to the State Early Childhood Team were integral contributors to planning process and content. Local Early Childhood Teams in each of Oregon's 36 counties completed a survey regarding the status, needs, and priorities of their local early childhood work. Community activities, needs and priorities were also ascertained through review of local plans and documents, including local health department plans and each County's most recent early childhood and comprehensive community (0-18) plans and plan updates.

Community involvement in the next phase of the ECCS initiative will be facilitated through regional and community conversations to disseminate, validate and update the plan; technical assistance to community partners to support local implementation of the plan; web-based availability of the plan; further alignment of the plan with local processes and priorities, including integration of the plan with upcoming local comprehensive community planning for children age 0-18 and other local planning processes; ongoing collaboration and periodic surveys

of local Early Childhood Teams; and continued engagement of community representatives in statewide early childhood workgroups and initiatives.

12. Alignment Methodology for Funding Streams, Resources, and Policies

Plan implementation, and further Early Childhood Steering Committee expansion and collaboration, comprise the major approaches to resource and policy alignment at this time. As identified through the environmental scan and strategic planning processes, policy and resource alignment is a major system goal, for which objectives and strategies have been outlined in Section 9 of the plan. Only some of the possible strategies for effective alignment are enumerated there, and a few have been highlighted so far for action during initial implementation. This reflects Oregon's current, though progressing, developmental stage, and underscores the importance of implementing other ECCS Plan steps, both simultaneously and sequentially, to promote further alignment. Progress toward collaborative leadership, public and political will and awareness, public/private and family partnerships, shared accountability and other infrastructure and capacity goals will strengthen alignment. Oregon will also build on current successes, including interagency agreements, memoranda of understanding, blended funding demonstration projects, and service integration sites, to identify and strengthen alignment opportunities.

13. Maternal and Child Health Leadership and Participation in Multi-Agency Early Childhood Systems Development Initiatives and Description of Partner Agencies

The Office of Family Health's (OFH) numerous and expanding early childhood leadership activities contribute considerably to the development of Oregon's early childhood system. OFH leadership is evident both within and beyond the Oregon Department of Human Services. It is evident through the appointment and involvement of the OFH Administrator (Title V Director) as the DHS Director's designee to the State Early Childhood Steering Committee, and through the active participation of the ECCS manager and numerous OFH staff in the many multi-agency early childhood initiatives and activities described in previous sections of this document. Please refer to Sections 2 (Multi-agency State level Partnerships) and 6b (MCH Relationships) for a partial listing of OFH's current leadership and partnership activities.

Due to document length constraints, only a few key agency partners + the four statutorily mandated to jointly lead early childhood systems development + are described here.

The *Oregon Child Care Division (CCD)*, situated in the Oregon Employment Department since 1993, administers the Child Care Development Fund. It supports family workforce participation and promotes a system of safe, affordable, accessible and high quality child care. CCD assures the safety of children in care by certifying childcare centers and certified family homes, registering family child-care homes, investigating complaints, and providing technical assistance to providers. CCD supports the Integrated Child Care Subsidy program (for children of low income working parents and post-secondary student parents) and some full-day/full-year Head Start programs administered by the Oregon Department of Human Services. CCD also provides CCDF funds for the Inclusive Child Care Program, the Oregon Child Care Resource and Referral Network, the Lane County Child Care Enhancement Project, Targeted High Risk Population projects, the Center for Career Development in Childhood Care and Education, the Child Care Research Partnership, Teen Parent Programs through the Department of Education, local child care improvement projects through the Oregon Commission on Children and Families, and the

Child Care Health Consultation (HCCO) Demonstration Program. The CCD is advised by the Childhood Care and Education Coordinating Council, an extensive collaboration of agencies, programs, providers and parents.

The *Oregon Commission on Children and Families* (OCCF) is charged with setting guidelines for the planning, coordination and delivery of services statewide for children aged 0-18 and their families, in conjunction with other state agencies and planning bodies. This agency is comprised of a governor-appointed 15-member State Commission; a State Office designed to support the goals and activities of the State Commission; and local County-Commissioner appointed Commissions along with Offices staffed to support them. While the State level Office does not provide direct services, it oversees comprehensive community planning and the distribution of multiple funding streams to local Commissions for local programs, including Court Appointed Special Advocates (CASA), local child care supply and quality improvements (through a transfer of CCDF funds), Healthy Start home visiting programs for first births, Relief Nurseries, and other local early childhood and child and family support services and initiatives identified through local needs assessments and planning.

The *Oregon Department of Education* (ODE) assists the State Superintendent of Public Instruction in meeting responsibilities for all elementary and secondary school students in Oregon's public schools and education service districts through statewide curriculum and instruction programs, school improvement efforts, a statewide educational assessment testing system, the State Schools for the Blind and the Deaf, regional programs for children with disabilities, education programs in Oregon youth corrections facilities, and public preschool programs. In addition, the Oregon Department of Education acts as a liaison and monitors implementation of a variety of state and federal programs, including the No Child Left Behind Act. The ODE administers four early childhood programs: Early Intervention/Early Childhood Special Education; Even Start (Family Literacy); Oregon Head Start Prekindergarten, and Teen Parent / Child Development programs. ODE is also the designated co-lead partner with the Office of the Governor for the Oregon Head Start Collaboration Office. ODE initiates and participates in both State and local level partnerships, and supports collaborative early childhood systems development through the Collaboration Office, through statewide initiatives, and through the direct service programs for which it is responsible.

The *Oregon Department of Human Services*, the State's health and human services agency, is comprised of three major program areas connected through administrative infrastructure. For each program area, related regional and local structures (such as local health and mental health departments, regional managed care organizations, self-sufficiency /child welfare and developmental disabilities field offices, and local area agencies on aging,) facilitate service delivery and system development at the community level.

- Children, Adults and Families (CAF) administers self-sufficiency, child protection and some vocational rehabilitation services, including JOBS, TANF, Employment Related Day Care, employment-related vocational rehabilitation services, Food Stamps, child abuse investigation and intervention, foster care, and adoptions.
- Seniors and People with Disabilities (SPD) administers programs and services to protect and empower seniors and people with disabilities, including abuse investigations related to seniors and people with disabilities, licensing nursing facilities, subsidizing some in-home services through specialized projects and lifespan respite, oversight of group home and crisis

services for adults and children with developmental disabilities, and determination of federal Social Security Disability benefits.

- Health Services (HS) is comprised of Public Health (PH), the Office of Mental Health and Addiction Services (OMHAS), and the Office of Medical Assistance Programs (OMAP). This cluster administers medical assistance programs for low-income Oregonians through Medicaid and SCHIP, oversees mental health and addiction services, operates state mental health institutions, and provides and promotes public health through protecting individuals and communities against the spread of disease, injuries, and environmental hazards; responding to disasters and emergencies and assisting communities in recovery; assuring the quality and accessibility of healthcare services; and promoting and encouraging healthy behaviors. The Office of Family Health, the State MCH / Title V agency that oversees the ECCS initiative, is situated in the Public Health segment of Health Services.

Examples of the public/private partnerships OFH is strengthening include collaborative relationships with the Northwest Early Childhood Institute and the Children's Institute. The *Northwest Early Childhood Institute* is a collaboration of interdisciplinary professionals dedicated to advancing healthy social, emotional and mental development of young children aged 0-5 through prevention, clinical service, public education and awareness, research and community collaboration.⁵⁷ The *Children's Institute*, founded in 2003 by business and philanthropic leaders, is an independent, non-profit, research-driven organization that "stimulates dialogue and collaborative action to ensure the greatest return on investment for Oregon's disadvantaged children."⁵⁸ Current projects of the Children's Institute include a Ready for School Campaign and an Oregon Children's Budget Project.

14. Integration of Healthy Child Care America Objectives

Healthy Child Care America objectives have been integral to the ECCS Initiative since its inception and are clearly articulated in the statewide plan. Quality improvement through enhanced use of health, safety and developmental standards; infrastructure building through the development of health consultation; and access to medical homes and health insurance for children in early care and education settings were identified by multiple stakeholders as both needs and important strategies to promote healthy growth and development. The Child Care Health Links / Child Care Health Demonstration Project (HCCO) and the ECCS Initiative are co-located in the Office of Family Health, and their respective coordinators continue to collaborate around implementation efforts. While further enhancements are warranted, improved quality standards have been systematized somewhat through regulation and policy development. Access to insurance and medical homes has improved through implementation of screening procedures in child care health consultation demonstration sites. Infrastructure building through child care health consultation, however, faces a less secure future. Funding for the current 4-County demonstration project runs out in June 2006, and financial resources have not yet been procured to sustain or expand, let alone bring to statewide scale, this important and effective service. The Early Childhood Steering Committee has prioritized child care health consultation, and plans to take a closer interagency look at integration methodology.

15. Positioning for Policy Impact

Elevating early childhood as a statewide policy priority is one of the ECCS Plan's explicit objectives. While there is growing recognition of the importance of the early childhood years and the advisability of investing more therein, early childhood is not yet a major policy priority within and across all levels of Oregon's public and private service delivery and financing

infrastructures. Administrators, legislators, other policymakers, business, philanthropic and community leaders, and other actual and potential funders are confronted with multiple high priorities, limited resources, competing demands, and the absence of a clear collaborative early childhood agenda. The ECCS Plan, through its roll-out and implementation, is poised to positively influence policy. It synthesizes diverse stakeholder input and organizes multiple infrastructure and capacity elements into a comprehensive and comprehensible system development framework. It promotes the leadership, public will and awareness, public/private partnerships, and collaborative priority-setting required to effectively impact policy. It clearly articulates the need for policy and resource alignment and outlines initial strategies to do so. Diverse public and private sector partners have already identified the anticipated value of the plan in both amplifying and influencing their policy, resource and action agendas.

16. Sustainability Plan

Sustainability is an explicit, essential early childhood system goal, which many of the plan's other goals, objectives, strategies and implementation steps are collectively designed to advance. All essential system elements -- leadership, public will and awareness, partnerships, policy and resource alignment, a trained and stable workforce, an effective evidence-based continuum of services and supports -- clearly require sustainability, and also help engender it. Implementation of the ECCS Plan is thus a major approach to promoting sustainability of the early childhood system.

While some system developments will be largely self-sustaining and less resource-intensive once achieved, others need immediate and long-term funding stability and continuity. Sufficient and sustained financing is essential for system development and improved child and family outcomes. The coalescence of the State's economic recovery struggles and related State budget deficits, multiple high priorities, and the current developmental stage of the early childhood system, suggest that public expenditures for early childhood may continue to be limited to current levels. While advocacy for expanded and sustained public investments is a crucial aspect of the sustainability plan, diversifying funding streams, and promoting increased private investments and public/private partnerships, are also critical. Partners must continue devising additional creative, efficient, and effective ways to utilize current resources, including increasing access to and flexible use of existing funds, maximizing matching opportunities, and building on and expanding successful pooling, blending and fund leveraging strategies.

Sustainability will also be facilitated through building on existing infrastructure, including:

- the statutory mandate requiring jointly led efforts to develop and maintain a voluntary system of early childhood services and supports;
- the evolving empowerment of the State Early Childhood Steering Committee (an executive level advisory group previously described herein);
- Renewed focus on shared high and intermediate level early childhood outcomes and the development of common evaluation questions;
- Continued data system coordination efforts and integrated client data base development despite resource limitations; and
- Connecting early childhood systems development and the ECCS Plan with subsequent rounds of the community comprehensive planning processes.

Early Childhood System Partners and Resources

Assn.of Or. Community Mental Health Program Directors	OHSU Rural Practice-Based Research Network
Association of Public Health Nurse Supervisors	Oregon Academy of Family Physicians
Babies First	Oregon Administrative Rules and Statutes
Birth to Three	Oregon Association for the Education of Young Children
CaCoon	Oregon Association of Hospitals and Health Systems
Childhood Care and Education Coordinating Council	Oregon Association of Treatment Centers
Children First for Oregon	Oregon Ctr for Career Development in Childhood Care & Ed.
Children's Institute	Oregon Center for Children & Youth w/ Special Health Needs
Children's Trust Fund of Oregon	Oregon Child Care Research Partnership
City Club of Portland	Oregon Child Care Resource and Referral Network
Community Action Programs	Oregon Child Development Coalition / Migrant Head Start
Community Centers and Organizations	Oregon Commission for Child Care
Community Connections Network (CSHN)	Oregon Commission on Children and Families
Conference of Local Health Officials - MCH Committee	Oregon Dental Association
County Community Mental Health Programs	Oregon Department of Community Colleges and Workforce Development
County Health Departments	Or. Dept of Ed Office of Student Learning & Partnerships (Early Childhood Programs – PreKindergarten, EI, ECSE)
Dept. of Corrections Children of Incarcerated Parents Project	Oregon Department of Education Teen Parent Program
Early and Continuous Screening Learning Collaborative	Oregon Department of Housing and Community Services
Early Childhood Cavities Prevention Coalition	Oregon Department of Human Services
Early Head Start	Oregon DHS Children, Adults & Families (SS/CW)
Early Words Literacy Program	Oregon DHS Office of Disease Prevention and Epidemiology
EC Cares	Oregon DHS Office of Family Health
Ecumenical Ministries of Oregon	Oregon DHS Office of Medical Assistance Programs
Eugene Relief Nursery	Oregon DHS Office of Mental Health & Addiction Services
Even Start	Oregon DHS Office of Multicultural Health
Family Connections	Oregon DHS Office of Public Health Preparedness
Family Involvement Network	Oregon DHS Seniors and People with Disabilities
Family Voices	Oregon Employment Department - Child Care Division
FAS Partnership	Oregon Family Support Network
Governor's Council on Alcohol and Drug Abuse Programs	Oregon Head Start Association
Governor's Office	Oregon Health and Sciences University
Head Start Collaboration Project	Oregon MothersCare
Healthy Child Care Oregon / Child Care Health Links	Oregon Out of School Time Network
Healthy Kids Learn Better Coalition	Oregon Pediatric Society
Healthy Start	Oregon Primary Care Association
Hunger Relief Task Force	Oregon Progress Board
Inclusive Child Care Project	Oregon PTA
Interagency Agreements and Memoranda of Understanding	Oregon Public Health Association
Legacy Health Systems	Oregon SafeNet
Legislatively Approved Budget	Oregon School Counselors Association
Linn-Benton Community College	Oregon State Legislators
Local Commissions on Children and Families	Oregon State Library
Local Early Childhood Teams	Oregon State University - Dept of Human Development & Family Sciences
Local Service Delivery Areas	Oregon Youth Authority
Managed Mental Healthcare Organizations	Parent Voices
March of Dimes	Parenting Institute
Morrison Center / Hand in Hand Early Childhood Prog.	Parents Anonymous of Oregon
Multnomah County Educational Service District	Partners for Children and Families
Multnomah County Library - Early Childhood Services	Portland State University Child Welfare Partnership
NAMI Multnomah County	Portland State University Research and Training Center
Northwest Early Childhood Institute	Portland State University Infant Toddler Mental Health Cert. Program
Northwest Educational Laboratories	Providence Health Systems
Northwest Health Foundation	Ready Schools Initiative
Oregon Academy of Family Physicians	Ready for School Initiative
Oregon Administrative Rules and Statutes	School Age Care Enrichment and Recreation Prog (SACER)
Oregon Association for the Education of Young Children	School-Based Health Centers
Oregon Association of Hospitals and Health Systems	Stand for Children
Oregon Association of Treatment Centers	State Early Childhood Steering Committee
Northwest Obesity Prevention Project	State Early Childhood Team
NPC Research	State Interagency Coordinating Council
Nurse Family Partnership	United Way of the Columbia-Willamette
Nursing Mother's Council	Univ. of Oregon Institute on Violence & Destructive Behavior
Office for Oregon Health Policy and Research	
OHSU Center for Evidence-based Policy	
OHSU Child Development and Rehabilitation Center	
OHSU Department of Child & Adolescent Psychiatry	
OHSU Office of Rural Health	

Appendix A: A Profile of Oregon's Young Children and Their Families

Demographics	
Total Oregon child population	883,999 ⁵⁹
Early childhood population aged 0-8	421,020 ⁶⁰
# births / birth rate per 1,000 women 10-49	45,935 ⁶¹ , 61.37 ⁶²
# births to teens age 15-17 (per 1000)	26.4 ⁶³
Children under age 18 living in poverty	19.1% ⁶⁴
Children 0-8 living in poverty (\leq 100% FPL)	18.7% ⁶⁵
Unemployment rate	7.5% ⁶⁶
Health Status	
Infant mortality rate	5.4% ⁶⁷
Breastfeeding initiation rate	88% ⁶⁸
Low birth weight rate	6.1% ⁶⁹
Adequate prenatal care	82% ⁷⁰
2 year olds adequately immunized	76.5% ⁷¹
Unintentional injury rate for children 0-9	2.24 per 1000 ⁷²
% children 0-8 w/ blood lead levels \geq 10 mcg per deciliter	1% ⁷³
Access to Insurance and Healthcare/Medical Home	
Medicaid & SCHIP enrollment of children aged 0-5	41,843 ⁷⁴
Insured children aged 0-8 (medical / dental)	86.8% / 72.7% ⁷⁵
Uninsured children aged 0-8 (medical / dental)	13.2% / 27.2% ⁷⁶
Children 0-5 (or 0-8) without a personal doctor or nurse	16.2% ⁷⁷
% children with special healthcare needs aged 0-5 / aged 6-11	7.1% / 14.3% ⁷⁸
Children with special healthcare needs without a usual source of care	12.6% ⁷⁹
% children 0-5 receiving preventative check-up in last 24 months	67.2% ⁸⁰
Social / Emotional Development and Mental Health	
Children 0-8 receiving \geq 1 public mental health service in 2003	8,711 ⁸¹
% of parents reporting mental health concerns for ages 0-3 / 4-5 / 6-9	6% / 8% / 18% ⁸²
Child Care and Early Education	
Children entering school ready to learn	79.8% ⁸³
Child care slots per 100 children (benchmark: 20)	17 ⁸⁴
% children ages 0-5 in child care	33% ⁸⁵
% Families spending $>$ 10% of income on child care	39% ⁸⁶
# children \leq age 12 receiving child care subsidies	25,271 ⁸⁷
# Licensed child care centers / registered family child care homes	886 / 5,882 ⁸⁸
# known exempt child care centers / family child care homes	337 / 992 ⁸⁹
% Children enrolled in EI / Early Childhood Special Ed	1.34% / 5.07% ⁹⁰
% eligible children enrolled in Head Start	59% ⁹¹
Family Support and Parent Education	
Children abused and neglected (ages 0-5: 4598 / 6-8: 1657)	10,600 ⁹²
Children ages 0-5 in foster care	4,101 ⁹³
WIC enrollment (0-5)	79,273 ⁹⁴
Births to mothers of all ages with less than a 12 th grade education	20.0% ⁹⁵

Appendix B. MCH Early Childhood System Involvement by Program

Office of Family Health - Scan of Early Childhood System Involvement						
OFH (MCH) Program/Activity	Early Childhood System Components					
	Infra-Structure	Health	Early Care and Education	Parent Ed.	Family Support	Social Emotional and Mental Health
Pregnant Women						
State Perinatal Program	X	X		X	X	X
Local Perinatal Services	X	X		X	X	X
Smoke-Free Mothers/Babies		X		X		
PRAMS	X	X				
Young Children						
Babies First! Program		X	X	X	X	X
Newborn Screening	X	X		X		
WIC Program		X		X	X	X
Breastfeeding Promotion	X	X	X	X	X	
Newborn Hearing	X	X	X	X	X	
Children w Heritable Conditions	X	X				
Genetics Program	X	X		X		
Fetal Alcohol Spectrum Disorder Prevention Project	X	X		X		X
Early Childhood Comprehensive Systems Initiative	X	X	X	X	X	X
State Child Health Program (including HCCO)	X	X	X	X	X	X
Local Child Health Services	X	X	X	X	X	X
Adolescents						
State Adolescent Health Program	X	X				X
Teen Pregnancy Prevention		X		X	X	X
Family Planning		X		X	X	
Children All Ages						
Child Injury Prevention	X	X	X	X	X	X
School-Based Health Centers	X	X	X	X	X	X
Oral Health	X	X	X	X		
Immunization Program	X	X	X	X	X	
Children w/ Special Healthcare Needs						
State CSHCN Program	X	X	X	X	X	X
CaCoon (care coordination and home visiting)		X	X	X	X	X
Community Connections	X	X	X	X	X	X
Family Involvement Network	X	X		X	X	
Women						
Fetal Alcohol Spectrum Disorder Prevention Program	X	X		X	X	X
Domestic and Sexual Violence Prevention	X	X			X	X
Oregon SafeNet	X	X	X	X	X	X

Appendix C. Children's Budget

Figure 1. Percentage of OFH Budget by Population

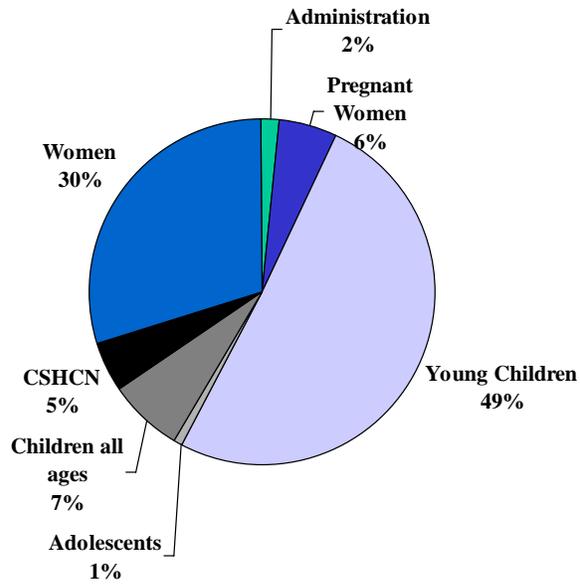


Figure 2: Department of Human Services Budget for Services to Children

The Oregon Department of Human Services budget includes approximately \$2,877.87 million dollars for child and family related services. This chart depicts how the funds are allocated across DHS.

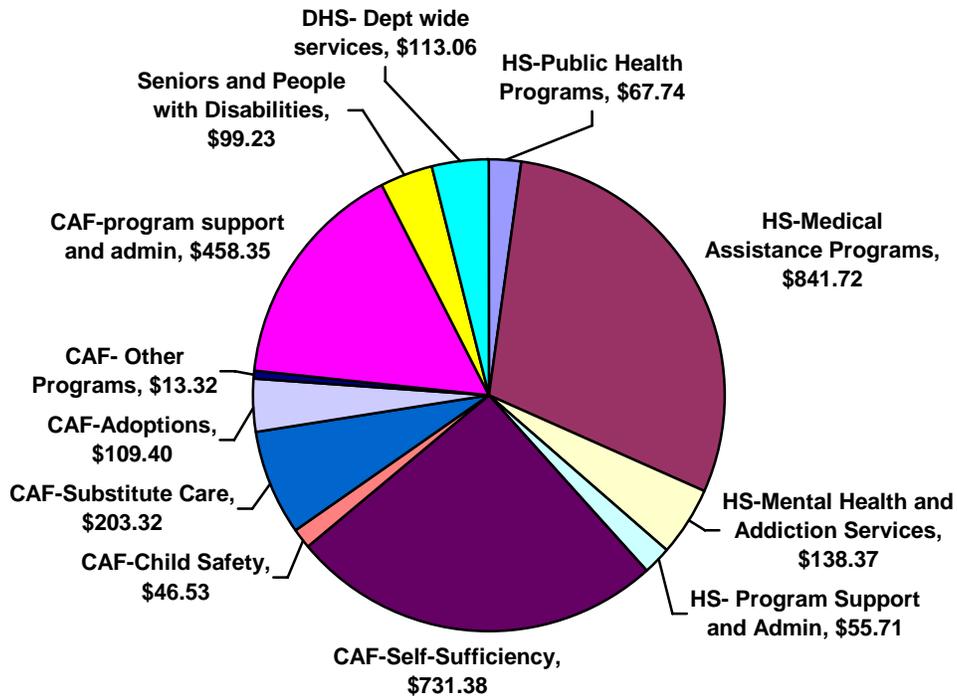


Figure 3: Major funding streams for State Agencies serving children, by % of total budget (in millions)

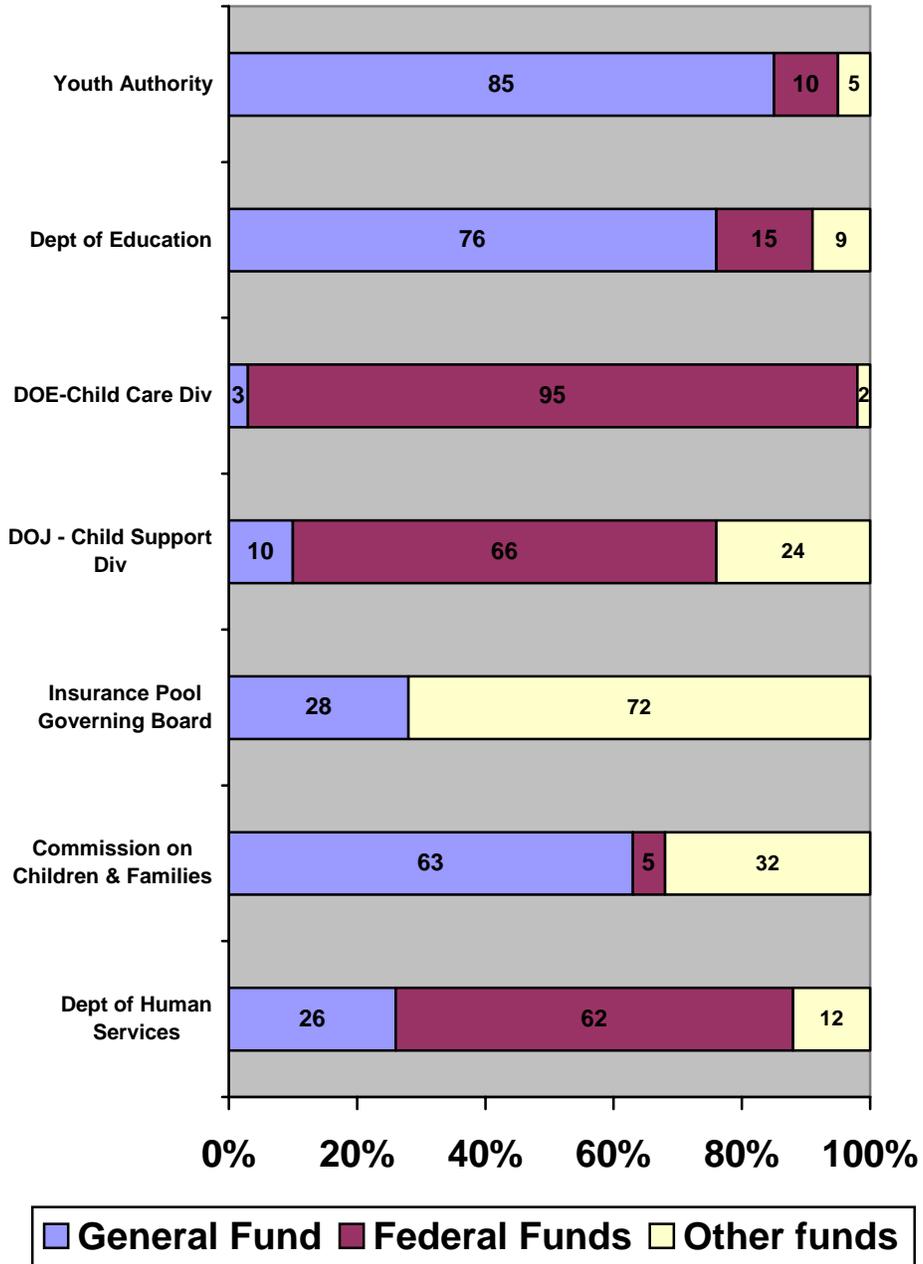
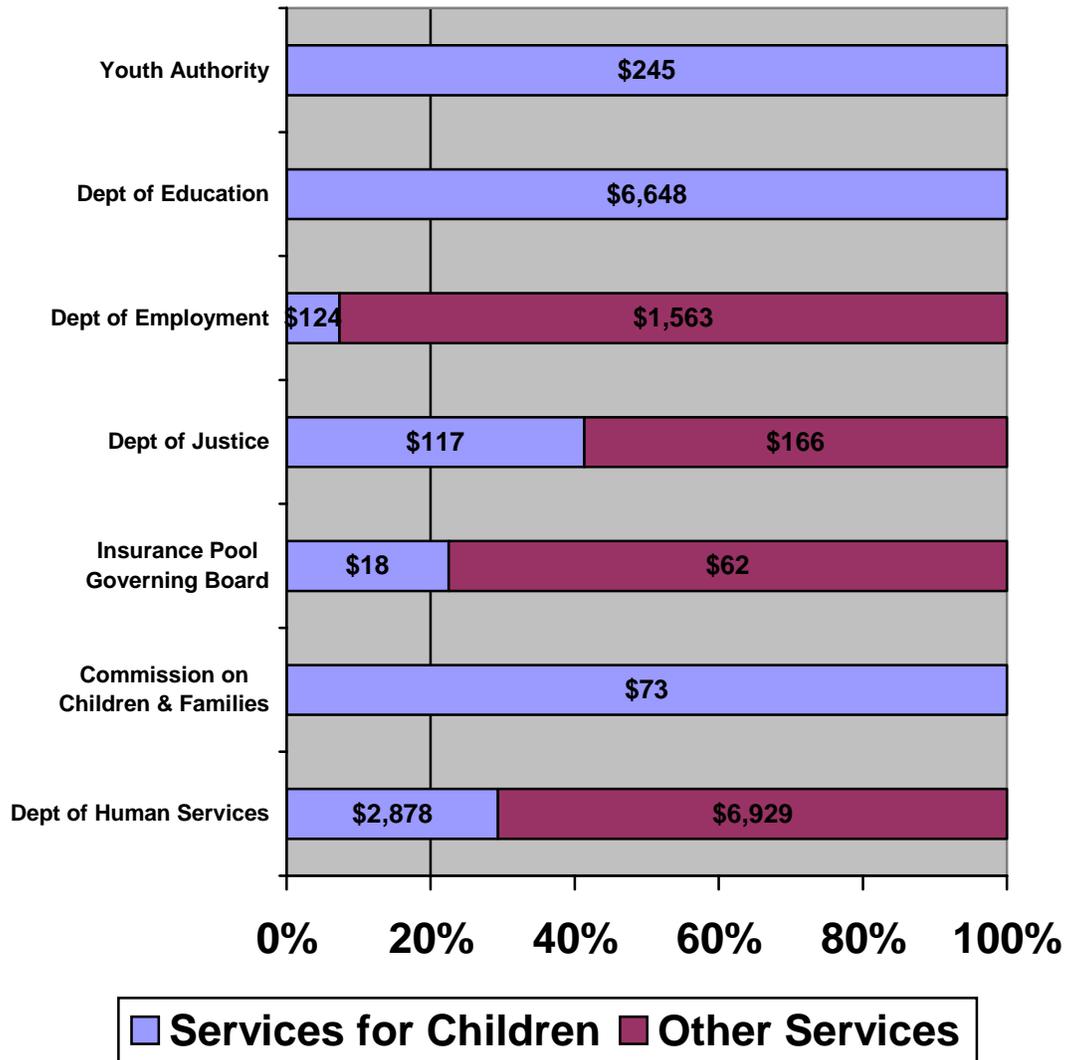
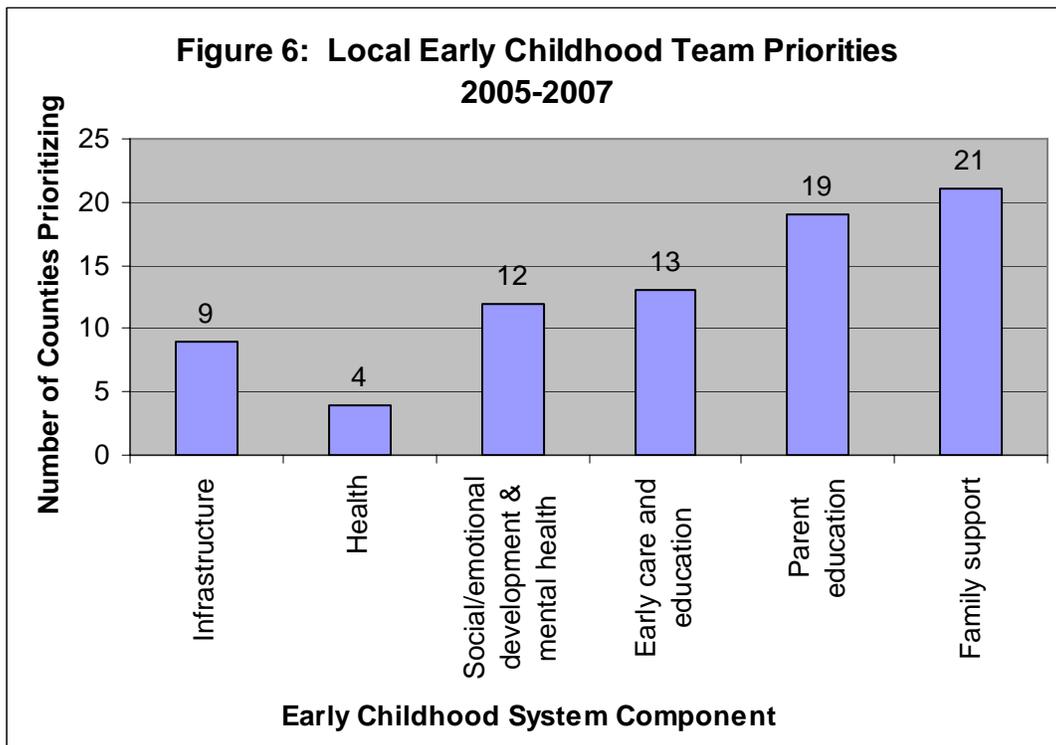
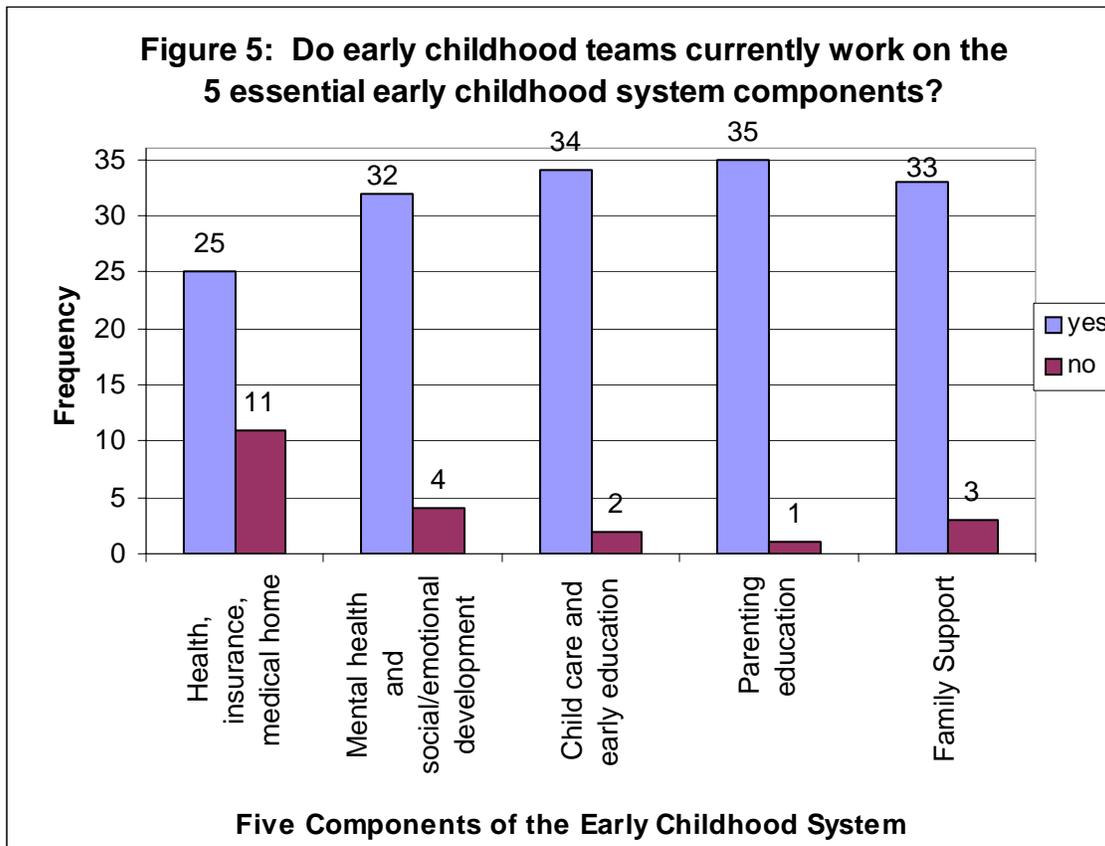


Figure 4: Dollars and Percentages of State Agencies Budgets Dedicated to Services for Children (in Millions) *



* figures are rounded

Appendix D. Local Early Childhood Team Component Survey Results



Appendix E. Endnotes

- ¹ *Children in Oregon*. Children's Defense Fund. 2005.
- ² *Status of Children in Oregon: 2005 Report Card*. Children First for Oregon. January 2006
- ³ *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Shonkoff and Phillips, Institute of Medicine, 2000, p 15.
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