



WEST VIRGINIA'S EARLY CHILDHOOD COMPREHENSIVE SYSTEMS PLAN

TABLE OF CONTENTS

PROLOGUE.....	1
INTRODUCTION.....	2
WHERE WE ARE.....	5
OPPORTUNITIES.....	26
WHAT WE ARE GOING TO DO	34
WHAT'S NEXT	50
SUMMARY.....	51
REFERENCES.....	52
APPENDIX A: Implementation Schedule	
APPENDIX B: SEARCH Institute Early Childhood Development	



PROLOGUE

Prologue

The following pages comprise West Virginia's plan for the Early Childhood Comprehensive Systems grant program, per the requirements of the United States Department of Health and Human Services/Health Resources and Services Administration/Maternal and Child Health Bureau.

The West Virginia Early Childhood Comprehensive Systems Plan is a collaborative and comprehensive strategic framework for enhancing and strengthening the early childhood system in West Virginia in order to improve outcomes for children.

This plan was developed with the participation of the West Virginia Department of Health and Human Resources Early Childhood Health Project, the West Virginia Department of Health and Human Resources Division of Early Care and Education, and the West Virginia Department of Education, as well as members of Partners Implementing an Early Care and Education System (PIECES), and early childhood stakeholders at the community, local, and state levels. The Plan belongs to all interested families, stakeholder groups and organizations who believe that working collaboratively toward common goals and outcomes will lead to greater success than is possible by working alone.

The creation of the plan is a culmination of three years of collaborative input from a wide variety of partners in West Virginia. The plan is designed to strengthen connections between existing early childhood systems and lead to children being healthy and ready to enter school. The planning process provided the opportunity for early childhood stakeholders across disciplines to communicate, share information about early childhood programs and activities, and define shared goals. A concerted effort was made during the entire planning process to build on existing early childhood initiatives and align strategies and resources.

West Virginia is very fortunate to have a Governor and First Lady who are dedicated to very young children. They continually show interest in early childhood issues and have used their positions to encourage support from business and the community. During his inaugural address, the Governor showed his commitment to West Virginia's children in his pledge for every child to have a healthy start in life. This pledge, known as the Five Promises, assures West Virginia children the opportunity to develop into productive adults, by supporting their health, emotional, and educational needs. With the Governor and First Lady's tireless commitment to early childhood issues, this plan will be a key component in achieving their goals for the State.



INTRODUCTION

Introduction

The plan is divided into the following sections:

- Where We Are – the current environment for early childhood efforts
- Opportunities – our programming philosophy and areas of concern we will address
- What We Are Going To Do – specific activities we will complete
- What's Next – our future activities

As directed by HRSA, our planning complies with the required components of the Early Childhood Comprehensive Systems.

- Access to Health Insurance and Medical Home
- Mental Health and Social-Emotional Development
- Early Care and Education/Child Care
- Parenting Education
- Family Support

We integrated the objectives of Healthy Child Care America:

Improving Early Care and Education Quality Through Health and Safety Standards. The West Virginia Division of Early Care and Education will continue to support the development and implementation of new child care licensing rules, using the “Caring for Our Children” as a primary reference.

Building Infrastructure Through Development of Child Care Health Consultant Networks. While West Virginia does not have funding to support child care health consultant services, we have a system in place to support mental health consultation in child care locations. These Behavioral Specialists consult with child care professionals and parents, and offer ideas and resources on many subject areas regarding children. Research during the planning stage of our project confirmed that behavior issues are a high priority for West Virginia families, and our plan will strengthen this aspect of the state’s early childhood infrastructure.

Improving Access to Medical Homes and Health Insurance for Children in Child Care Settings. Our environmental scans indicate that West Virginia has made

tremendous progress in this area and that other key partners in the system are committed to continuing their efforts until all children have a medical home and access to health insurance.

In addition, certain internal principles that we use regularly, across program lines, guided us and are evident in this plan:

- Respect families and the needs they express. We believe in listening to those we are charged to serve.
- Value the contributions of our collaborative partners. There is a strong early childhood community in West Virginia and we want to be a valuable partner in that community.

We have also adhered to tenets of our programming philosophy:

- Build bridges rather than silos
- Don't reinvent what's working
- Base decisions and actions on facts
- Investigate ways to enhance existing efforts
- Add vision and knowledge

We believe the sections that follow will describe an effective planning process, an achievable plan, and anticipated results that will be valuable additions to the efforts of the early childhood community to improve the lives of West Virginia families.

During the 2006-2007 grant year, West Virginia will be implementing the following activities to support the areas of concern identified by families based on our environmental scans, focus groups and survey responses:

- **Increase the knowledge level and skills of DHHR Behavior Specialists, Child Care Resource and Referral Specialists, child care professionals, and parents regarding childhood behavioral issues** Components addressed include: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.
- **Increase parent knowledge of proper oral health care, and increase the number of children receiving oral health services.** Components addressed include: Parenting Education and Family Support.

- **Expand the Early Childhood Health website by increasing the information and resource links offered to parents through the Early Childhood Health website. The site will provide a centralized hub, known as the Family Information Center, for parents to easily access family information and services.** Components addressed include: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.
- **Seek technical assistance from Health Systems Research to design activities to help educate families and the community about the life-long negative effects of family violence on children.** Components addressed include: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.



WHERE WE ARE

WHERE WE ARE

SOCIO-ECONOMIC AND DEMOGRAPHIC DATA

LIFE IN WEST VIRGINIA

West Virginia offers a balance of exceptional natural beauty, a large variety of culture and history, excellent recreational opportunities, and vast potential for economic development. The state is home to some of the world's best-known companies, such as Toyota and Amazon.com, while the state also nurtures such innovative firms as Extreme Endeavors, which specializes in bioelectric telemetry research, and MD Biotech, Inc., a bio-imaging company that focuses on discovery and development of automated medical screening and diagnostic equipment.

Our state also has a work force that has earned an incredible reputation for dedication and loyalty as well as low absenteeism and turnover. According to the Harbour Report, a major automotive study, the Toyota facility in West Virginia continues to set the standard for engine production, a testament to the consistent high quality of West Virginia's workforce.

West Virginia offers many other advantages including:

- A violent crime rate that is consistently among the lowest in the nation
- The seventh lowest cost of living rate in the U.S.
- A high percentage of health coverage for very young children, with over 90% of children five and under receiving medical coverage
- A high rate of immunization coverage, with nearly 90% of children 19 to 35 months completely immunized
- A high percentage of early prenatal care with 86% of pregnant women receiving prenatal services during their first trimester
- The highest rate of home ownership in the United States

POPULATION

West Virginia is the second most rural State in the nation. Winding secondary roads connect the majority of the state's population, with little or no public transportation

available. The Economic Research Service of the United States Department of Agriculture reports West Virginia's population as 1.8 million. The population is relatively homogeneous with 95 percent of the population Caucasian and only 5 percent non-white residents. African-Americans make up 3.2 percent of the population, followed by Asians at 0.5 percent and American Indians and Alaskan Natives at 0.2 percent. The remainder of non-whites self-identify as Latino.

CHILDHOOD POVERTY

Many risk factors impact the lives of West Virginia's children, reducing their likelihood of success and ultimately the quality of their lives.

- West Virginia is among the states with the highest poverty rate in the nation. Twenty-nine percent of children under the age of six live in poverty, with 12 percent living in extreme poverty.
- West Virginia had the lowest 2004 median household income (\$31,504) among the fifty states and the District of Columbia, according to the U.S. Census Bureau's American Community Survey.
- The Census survey also rated West Virginia as the state with the lowest percentage of people 16 years and over who are in the labor force.
- West Virginia ranks among the lowest in the nation in the percent of children under six with all parents in the labor force.
- West Virginia ranks 50th in the nation in the percent of children living with parents who do not have full-time, year round employment. This affects nearly forty percent of our children.
- Fifty-two percent of children K-12 qualify for free and reduced cost school meals.
- West Virginia ranked 47th nationally in child well-being by the 2005 WV Kids Count Data Book. This is a drop from the 2004 rating of 42nd in child well-being.

EDUCATION

- According to the U.S. Census, 2004 American Community Survey, West Virginia ranks 48th in the nation in the percent of residents 25 years and over who have completed high school.
- One out of six students in grades seven through twelve drops out of school.
- West Virginia ranks lowest in the nation for the percent of residents 25 years and over who have completed a bachelor's degree. Many residents move out of state after receiving a degree due to higher salaries in surrounding states.
- West Virginia ranks third lowest in the nation for the number of resident's that have completed an advanced degree (6 percent)
- In 2005, 25 percent of West Virginia's births were to mothers with less than a 12th grade education.

Other significant factors may include the following:

A HIGHER DIVORCE RATE

The Division of Vital Statistics, National Center for Health Statistics reports that in 2004 West Virginia had the third highest divorce rate in the nation. In almost half the divorces, children were involved. Children from divorced families are more likely to:

- have academic problems;
- be aggressive;
- have low self-esteem and feel depressed;
- have difficulties getting along with family members and friends;
- engage in delinquent activities;
- get involved in early sexual activity;
- experiment with illegal drugs.

In addition, children living in single-parent families are more likely to live in poverty.

A HIGHER RATE OF DOMESTIC VIOLENCE

It is estimated that more than 3.3 million United States children witness domestic violence each year. Domestic violence may be the single major precursor to child abuse and neglect fatalities in this country. In 2003, more than 10,400 domestic violence allegations or incidents were reported in West Virginia, with twenty-five of the incidents resulting in death. During the fiscal year 2003-2004, domestic violence programs directly served 18,579 citizens. An average of two domestic violence homicides occurs each month in West Virginia, an average that has held steady since the late 1970's.

The link between domestic violence and sub-optimal life outcome, long suspected, has now been substantiated by the Adverse Childhood Experiences (ACES) study conducted by Dr. Rob Anda. The ACEs study is the largest study ever done to examine the health and social effects of adverse childhood experiences. The conclusions reached by Dr. Anda and the relationship to domestic violence are summarized below:

Adverse Childhood Experiences are experiences that lead to health or social problems of national importance. In this study, exposure during childhood included: childhood abuse and neglect; **growing up with domestic violence**; or having a parent who has a substance abuse problem, a history of mental illness, or criminal behavior.

Adverse Childhood Experiences are very common and often cluster. Persons with four or more Adverse Childhood Experiences had:

- Up to a twelve-fold risk for alcoholism, drug abuse, depression, and suicide attempts.
- Up to a four-fold risk for smoking, poor self-rated health, having 50 or more sexual partners, and sexually transmitted diseases.

The total number of ACEs increased dramatically for persons who witnessed domestic violence during childhood. As the frequency of witnessing domestic violence increased, there was a positive, graded risk for illicit drug use, IV drug use and depression. A positive grade risk means that as the frequency of witnessing domestic violence increases, the risk of experiencing alcoholism, illicit drug use, IV drug use and depression also increases.

Adverse Childhood Experiences also have a graded relationship with Ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

COMMITMENT TO VERY YOUNG CHILDREN

West Virginia's leaders are aware of the obstacles our children face and they are dedicated to improving the lives of children and families. They have made a strong commitment to early child care, education, and the general well-being of West Virginia's children. Examples of commitment to very young children (five years of age and under) include the following:

From Governor Joe Manchin's Five Promises:

The first promise: Every child should have a caring adult in their lives.

The second promise: Every child should have a safe place.

The third promise: Every child should have a healthy start.

The fourth promise: Every child should have a marketable skill.

The fifth promise: Every child should be taught to be a caring adult and be given an opportunity to serve their communities.

Senate Bill 247 mandated a partnership between the West Virginia Department of Education (WVDOE) and the West Virginia Department of Health and Human Resources (WVDHHR) and charged it with the design and implementation of universal Pre-K education for West Virginia's four year olds by 2012. This partnership is called Partners Implementing an Early Care and Education System (PIECES).

The State Legislature amended chapter sixteen of the code of West Virginia by adding Article 22B which requires that hospitals, birthing facilities, attending physicians, and other persons attending a birth ensure that each infant is risk-scored and that the score is reported to determine if the infant needs follow-up services.

House Bill 2745 mandating the establishment of the West Virginia Birth Score Program.

Senate Bill 672 establishing a Birth Defects Surveillance System.

House Bill 216 requiring screening of all children under the age of 72 months for lead poisoning.

House Bill 3017 requiring the creation of a state oral health program.

House Bill 2388 establishing a mandate for the universal testing of newborns for hearing loss.

COLLABORATION

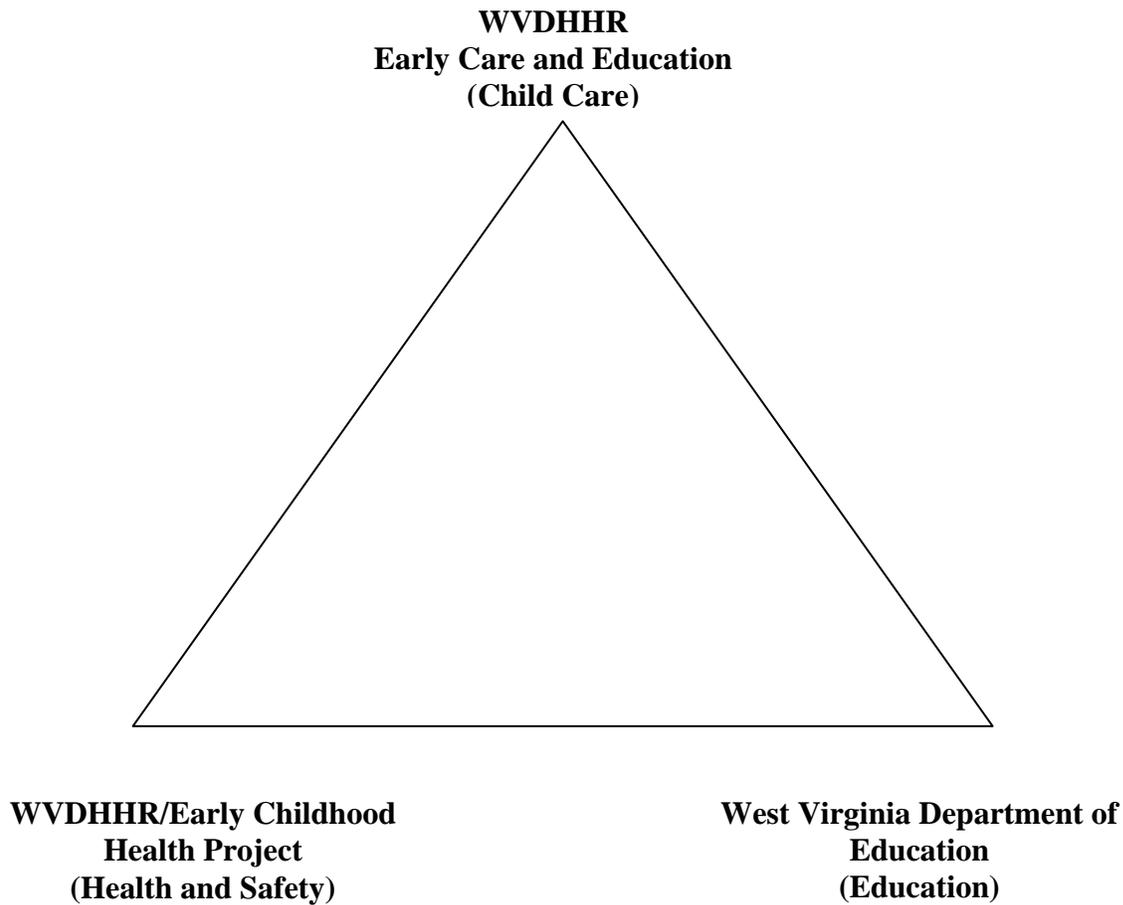
Historically, many West Virginians have had to survive with fewer of life's essentials than many others in the United States. This lack of resources made working together essential. Because this lesson has not been lost on those in public service and advocacy organizations at the state and community level, we have learned the value of collaboration. We know we cannot afford to duplicate systems that exist and are working well, and we know we must join with other stakeholders to create partnerships to achieve our goals.

For West Virginia's ECCS project, the primary collaborative platform is **PIECES**, Partners Implementing an Early Care and Education System. In 2002, the West Virginia State Legislature mandated a partnership between the Department of Education and the Department of Health and Human Resources to design and implement universal Pre-K education for West Virginia's four year olds by 2012.

The following diagram illustrates the three major components of PIECES: the West Virginia Department of Education, the WVDHHR/Bureau for Children and Families Division of Early Care and Education and the WVDHHR/Bureau for Public Health/Office of Maternal, Child and Family Health/Division of Infant, Child and Adolescent Health/Early Childhood Health Project.

The PIECES collaborative also includes representatives from other State and local programs, the advocacy community, child care providers and parents. The vision initially adopted by PIECES was for all children and families in West Virginia to have access to high quality early care and education programs that provide a foundation for academic success and lifelong learning while supporting parents' ability to work. However, all stakeholders understood the need to address more than simply Pre-K education for West Virginia's young children to be ready to learn and to later become healthy,

productive adults. Five focus areas were designated: collaboration, professional development, quality initiatives and curriculum, regulations and standards, and **child well-being**. The realization of the need for a stronger health component led to the Office of Maternal, Child and Family Health (OMCFH) being asked to take on this assignment. Considering other key programs in OMCFH, and that OMCFH has been involved with PIECES since its inception, this was a perfect fit. Accordingly, West Virginia designed its ECCS project to fill that role (rather than duplicate parts of the system that are working well) and named it the Early Childhood Health Project (ECH).



It is evident from conversations with counterparts from other states that partnerships between education and human services organizations such as PIECES are rare. This collaboration has been supported by two governors and continues to be the platform for pooling resources, human and financial, to benefit our state's very young children. Using an established collaborative relationship that includes representation from all relevant sectors is considered the most efficient and effective platform for collaboration.

OTHER COLLABORATORS/INTERNAL AND EXTERNAL SCANS

While PIECES is the primary collaborative for our ECCS project, it is important to understand the other relationships that help us define the project's role and that will help us succeed.

INTERNAL SCAN:

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH**

West Virginia's Office of Maternal, Child and Family Health (OMCFH), located within the WVDHHR Bureau for Public Health, under the umbrella of DHHR is West Virginia's Title V agency and has responsibility for West Virginia's ECCS grant. In addition to the ECCS project, OMCFH has responsibility for all but two of the State's major children's health programs, Women, Infants, and Children Program (WIC) and Immunizations. Although they are not administered by OMCFH, we collaborate and work closely with both programs. OMCFH programs serving very young children children aged five and under include:

Birth Score

The West Virginia Bureau for Public Health, OMCFH and the West Virginia University School of Medicine, Department of Pediatrics worked collaboratively to develop the Birth Score-Developmental Risk Screen and Newborn Hearing Screen initiatives. This population-based surveillance activity provides identification of infants at risk of post-neonatal death in the first year of life and ensures appropriate interventions for those determined at risk. Every infant is screened at birth using specific screening criteria. The follow-up of these infants occurs through the Right From The Start (RFTS) Program.

Newborn Metabolic Screening Project

The Newborn Metabolic Screening Project works with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, galactosemia, hypothyroidism and hemoglobinopathies including sickle cell. Any necessary follow-up is provided by children's reportable disease nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. Title V children's reportable disease nurses and administrative personnel track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family.

Newborn Hearing Screening Project (NHS)

All children born in WV are screened at birth for the detection of hearing loss. Children who fail the screen are followed and assisted in obtaining further diagnostic services by community-based Right From The Start personnel. Children who need hearing aids are referred to and assisted by Children with Special Health Care Needs (CSHCN) and WV Birth to Three.

Right From The Start Project (RFTS)

RFTS provides comprehensive perinatal services to low-income women and infants up to one year of age. The project provides services including: Recruitment of medical practitioners to care for low income, government sponsored populations (Title XIX, Title V); and care coordination for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Care Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, and nutrition). The OMCFH and West Virginia University finalized a contract for joint implementation of the Risk Reduction through Focus on Family Well-Being (HAPI) Project. This project works in tandem with Right From The Start and uses Healthy Start monies from the Maternal and Child Health Bureau. HAPI participants receive additional services not provided to traditional RFTS clients including mental health and child care services. The long-term goal of the Project is to decrease infant mortality. OMCFH serves as the fiscal agent for HAPI, and all personnel training and education is jointly shared.

Childhood Lead Poisoning Prevention Project (CLPPP)

The CLPPP is a collaborative effort between two offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health Services, funded by the Centers for Disease Control (CDC). Extensive data gathering, analysis, and information distribution take place routinely. The Office of Environmental Health Services, using its local network of community-based sanitarians, provides assessment of home and other environments for children with elevated blood lead levels. The OMCFH's CLPPP nurses case manage all children with positive BLL of >10mcg. Recent legislative action has resulted in the mandated screening/assessment of all high risk children under the age of six years for lead poisoning.

WV Birth To Three/Part C IDEA

WV Birth to Three provides therapeutic and educational services for children age 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual

child/family assessments and delivered by community-based providers who are credentialed by Birth to Three. The service system is supported by Title V, Part C, State appropriation and Title XIX.

Genetics Project

The OMCFH provides funding to support West Virginia University/Department of Pediatrics clinical genetic services pre-conceptually and for children with congenital defects at six satellite locations. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. Given West Virginia's geographical terrain, the services would otherwise be under utilized since travel for children and families remains a barrier to health care access.

Sudden Infant Death Syndrome Project (SIDS)

The SIDS Project collects and reports data regarding the occurrence of SIDS deaths in West Virginia. An advisory committee, made up of the Medical Examiner, medical personnel, a member of the Child Fatality Review Team, clergy, mental health professionals, and parents provide ongoing direction for this project. When a SIDS death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families.

Medical Home Learning Collaborative

A process to develop a model for medical home for children with special needs was initiated in 2003 by applying to join the Medical Home Learning Collaborative (MHLC) supported by the MCHB. West Virginia received training and technical assistance through the Federal Medical Home Learning Collaborative. The MHLC provided educational support to two practices while they modified their style of practice to be consistent with the medical home aspect for CSHCN. Based on that experience a model for medical home practice was developed. Dr. Jim Lewis, Professor of Pediatrics for the Joan C. Edwards School of Medicine is pursuing implementation of that model for their pediatric practice.

INTERNAL SCAN:**OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
DIVISION OF INFANT, CHILD AND ADOLESCENT HEALTH (ICAH)**

West Virginia's ECCS project, the Early Childhood Health Project (ECH), is housed within the OMCFH Division of Infant, Child and Adolescent Health (ICAH). There are four other ICAH programs working with ECH to serve children five and under:

HealthCheck (EPSDT)

The HealthCheck (EPSDT) Program benefit to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exam, even if the service is not part of the Medicaid State Plan. West Virginia currently has over 450 medical providers who have signed a letter of agreement with OMCFH to participate in the HealthCheck Program.

HealthCheck has an extensive outreach component responsible for meeting federal EPSDT informing, linking, and follow-up requirements. Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish the outreach activities. The Program Specialists are responsible for provider recruitment, training, technical assistance, and all compliance related to monitoring issues. The FOW's are paraprofessionals, housed in the community in which they live and work.

Oral Health Program/Children's Dentistry Project

The Children's Dentistry Project (CDP) is a component of the OMCFH/ICAH/Oral Health Program (OHP). The CDP works in concert with other OMCFH programs, Head Start and public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services.

Children with Special Health Care Needs Program

The Children with Special Health Care Needs Program (CSHCN) is structured to be community-based and family-centered. Through a cooperative agreement dating back more than twenty years between the OMCFH and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide case management services to Title XIX sponsored children, which maximizes Title V monies for non-insured and/or underinsured, medically indigent children.

Systems Point of Entry

Systems Point of Entry (SPE) is the centralized information, education, and referral center for the OMCFH as well as serving the intake unit for statewide applications made to CSHCN. Families who are not eligible for CSHCN or other OMCFH services are referred to health, education and social service programs. Toll free lines, established in 1980, average 3,000 calls per month.

Collaboration of OMCFH Programs

The OMCFH is committed to blending the efforts of its programs. Leadership constantly stresses **interaction and collaboration** to provide holistic support to families. Examples include:

Systems Point of Entry (SPE) is required to have working knowledge of all OMCFH programs for the purpose of referrals. This requires constant information sharing between SPE and all other OMCFH units, and united efforts to refer families for services internally and externally.

Right From the Start, Children with Special Health Care Needs, Birth to Three, Newborn Hearing Screening and Systems Point of Entry work together to ensure children ages 0 to 3 who are identified with hearing loss are promptly referred to OMCFH by audiologists and that the children receive hearing aids as quickly as possible. This involved writing and adopting common policies, creating informing documents for audiologists, and monitoring of the system by all programs involved.

Right From the Start and HealthCheck have used coordinated case management techniques for many years to make sure high-risk infants receive well-child examinations as recommended by the American Academy of Pediatrics.

HealthCheck works with the Childhood Lead Poisoning Prevention Project to inform all medical practitioners who perform EPSDT about the need to testing blood lead levels on all children aged five and under. During site visits with these providers, HealthCheck field representatives, known as Program Specialists, monitor provider compliance on this issue and report their findings.

At the request of West Virginia's ECCS project, the Early Childhood Health Project, HealthCheck distributed a guide to all EPSDT providers to screen for signs of domestic violence. The guide was obtained from the West Virginia Coalition Against Domestic Violence.

The Coordinator of the Children's Dentistry Project (CDP) and the Director of the Children with Special Health Care Needs Program participate in Steering Team meetings for the Early Childhood Health Project.

When the Coordinator of the Early Childhood Health Project (ECH) project recently traveled to West Virginia's Child Care Resource and Referral agencies (CCR&R), the Coordinator of CDP accompanied her. Because one of the primary needs identified in ECH focus groups was dental care for very young children, this gave the CDP Coordinator the chance to hear the field perspective from the CCR&R's and for them to hear what CDP is doing.

**INTERNAL SCANS:
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

The West Virginia Department of Health and Human Resources (WVDHHR) touches the lives of all West Virginians, regardless of age. Its mission statement reads as follows:

The Department of Health and Human Resources' mission is to promote and provide appropriate health and human services for the people of West Virginia in order to improve their quality of life. Programs will be conducted in an effective, efficient and accountable manner, with respect for the rights and dignity of the employees and the public served.

The WVDHHR is the State agency charged with oversight of child care, public health, social services and family support, and financing for medical care for West Virginia's most-disadvantaged children. Units housed within WVDHHR includes the: Office of Behavioral Health Services, the Office of Family Support, Food Stamp Issuance, the West Virginia Works Program, the Developmental Disabilities Council, the Office of Community Health Services, the Bureau for Medical Services (Medicaid), and the Community Health Promotion.

Bureau for Children and Families/ Division of Early Care and Education

The primary partner of the Early Childhood Health Project within WVDHHR is the Division of Early Care and Education. West Virginia is dedicated to improving the affordability, accessibility, and quality of child care services. To meet these goals, Early Care and Education administers units responsible for child care licensing and quality (including health and safety requirements), subsidy, assistance to parents in finding and selecting a child care provider, and technical assistance for child care providers.

In addition, the Division of Early Care and Education is working on the following initiatives:

One Step at a Time Infant and Toddler Training. Recent brain research shows that a person's brain is more active through the age of three years than at any other time in life. In response to this finding, The Early Care and Education Division of the WVDHHR used federal child care monies to develop special training for providers serving this population.

WV Early Care and Education Professional Development System: WV STARS. This project, planned through the Governor's Early Childhood Implementation Commission, is a collaborative effort. The system includes core competencies as the basis for professional development, with career pathways to encourage higher levels of skills, credentials, and wages. A registry and credentialing system tracks and recognizes a provider's level of skill and accomplishment on the career pathway. The training approval system ensures that training meets minimum standards and trainers are qualified to provide such training.

The West Virginia Careers in Education Project. The WVDHHR, Office of Early Care and Education and Head Start Collaboration Office in cooperation with the WVDOE, and West Virginia Community and Technical College System have developed the West Virginia Careers in Education Project. This project provides a seamless teacher education model that provides an efficient and effective transition from one education level to another. The program affords a simple transition from the high school or certification to the associate's degree to a bachelor's degree program (2+2+2) in education.

West Virginia Child Care Resource and Referral Agencies. A resource and referral agency is a local nonprofit organization involved in supporting child care services. In WV, at a minimum, the resource and referral agencies provide the following:

- Manage the subsidy program
- Link parents with child care options
- Provide consumer information
- Offer technical assistance and training to providers
- Inform parents of other resources in their community

The Division of Early Care and Education accomplished the following during 2005:

- Piloted infant/toddler system training revisions
- Piloted medication administration training
- Implemented WV Early Learning Standards Framework (WVELSF)
- Developed and implemented WVELSF training modules
- Developed core cadre of Early Childhood Environment Rating Scale evaluators
- Assisted with articulation agreements between West Virginia University and Fairmont Community and Technical College early childhood programs
- Reviewed 55 county Pre-K plans
- Provided technical assistance to counties on WV Pre-K and to Child Care Resource and Referral Agency on policy and training implementation
- Increased eligibility for subsidy to 2000 Federal Poverty Level
- Developed core knowledge for all child care regulatory staff
- Reformatted Child Care policy manual
- Revised self-employment policy and trained staff on implementation
- Finalized parent brochure and provider handbook
- Completed, with grants and contracts, monitoring of all Child Care Resource and Referral Agencies (CCR&R)
- Developed interviewing guides for CCR&R staff to take complaints.
- Developed protocol for CCR&R staff to loan assistive technology
- Provided playground grants to child care centers through CCR&R agency application process
- Assisted CCR&R with development of local training plans
- Submitted CCDF and CBCAP federal plans
- Visited Starting Points and Early Parent Education programs
- Created logic model for development of Starting Points scope of work

- Established three work groups for revision of child care center licensing regulations and two for revision of family child care regulations
- Held six forums on the current status of child care rates

The Office of Maternal, Child and Family Health also contracts with the Bureau for Children and Families/Temporary Assistance for Needy Families (TANF) Program, WV WORKS, to administer a project which has the responsibility to arrange dental and vision care for persons moving from Welfare to Work.

Bureau for Medical Services

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements for services offered through the Right From The Start Program, Family Planning, and Children with Special Health Care Needs. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services.

Organizational proximity within WVDHHR allows many other close working relationships and **collaboration**, as exemplified by the following:

The Bureau for Children and Families (BCF)/Division of Early Care and Education, the body governing child care licensing and administering child care funding, is a key member of the Bureau for Public Health (BPH)/Early Childhood Health (ECH) Project Steering Team.

The BPH/OMCFH is the outreach administrator for the Bureau for Medical Services/Early and Periodic Screening, Diagnosis and Treatment (EPDST) Program.

The BCF/Division of Early Care and Education works with the Bureau for Public Health, Immunization Program to improve immunization rates.

The BPH/ECH is a part of the steering team for the BCF Healthy Families Initiative, primarily focused on healthy marriages and relationships.

The BPH/HealthCheck Program works closely with the Immunizations Program to ensure that children participating in HealthCheck receive complete immunizations by age two. The HealthCheck program publicizes the Childhood Immunization Schedule in a HealthCheck Provider Manual that is used by over 450 HealthCheck providers. The OMCFH Quality Assurance Team reviews the documented immunizations when monitoring HealthCheck pediatricians.

EXTERNAL SCAN

The Office of Maternal, Child and Family Health is well known for collaborations with other State agencies and community-based organizations. We know we must use the power of partnership if we are to move West Virginia families forward with the limited resources available to us.

A comprehensive early childhood system requires the collaboration of the entire community of stakeholders. Unlike many states, West Virginia is fortunate to have extensive collaboration at multiple levels. Examples of that collaboration follow:

Partners Implementing an Early Care and Education System (Pieces)

In addition to the earlier section on PIECES, it is notable that two WVDHHR units, the Bureau for Children and Families Division of Early Care and Education and the Bureau for Public Health Division of Infant, Child and Adolescent Health are two of the three major components of PIECES. In addition, the Director of the OMCFH/Division of Infant, Child and Adolescent Health is also a member of the PIECES Executive Council, a smaller group which makes key decisions for the collaborative based on input from the members of the larger group.

Policy Matters Inventory

PIECES is currently working with Dr. Sharon Lynn Kagan, Co-Director of the National Center for Children and Families, and Associate Dean for Policy at Teachers College, Columbia University to help us assess West Virginia's current policy inventory.

Domain-specific work groups have been formed to identify current policy levels, compare current West Virginia policy to national recommendations, and to set goal policy levels for each feature.

The purpose of the policy inventory is to assess state policies across domains critical to school readiness. The Policy Matters Committees consist of:

- I. Quality Early Care and Education Settings
- II. Early Care and Education Professional and Workforce Development
- III. Informed Families, Informed Public
- IV. Accountability and Results Orientation
- V. Adequate Early Childhood Education Financing
- VI. Governance and Coordination
- VII. Education in the Early Grades
- VIII. Health, Oral Health, and Mental Health

The Policy Matters work committees have performed policy inventories for each of West Virginia's identified domains and are currently in the process of completing goal setting for policy across all domains. Members of PIECES will be meeting in November 2006 to continue working on prioritizing policy changes and identifying needed policy tools.

The ECH will continue to work with members of PIECES as they begin to prioritize policy changes and identify needed policy tools.

West Virginia University

In addition to the Birth Score, Genetics, and HAPI Projects, OMCFH contracts with the West Virginia University (WVU) Center for Excellence in Disabilities to provide a network of family representatives to the Children with Special Health Care Needs (CSHCN) Program. These representatives, collectively known as Parent Network Specialists, contact families of children enrolled in CSHCN to obtain feedback for the program.

The West Virginia University School of Medicine provides practitioners and clinical facilities for CSHCN clinics. In addition, two professors from the School serve on the CSHCN Medical Advisory Board.

The WVDHHR/Bureau for Public Health (organizational home of OMCFH), in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists, and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

Medical Advisory Board

The OMCFH maintains a Pediatric Medical Advisory Board (MAB) which includes pediatricians, family practice physicians, dentists, other State agency personnel, and representatives from the State payers for medical services (Medicaid, CHIP and Public Employees Insurance Agency). The MAB allows for discussion of key issues, input from practitioners, policy guidance to State agencies and alignment of objectives among partners. Using these champions to voice public policy about immunizations and other child health issues assists the Department with compliance and keeps the medical community engaged in the provision of service.

American Academy of Pediatrics (AAP)

The President of the West Virginia Chapter of the American Academy of Pediatrics is a member of the MAB and a consultant to the CSHCN Program.

West Virginia Children's Health Insurance Program

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 93 percent of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. OMCFH has assisted by ensuring that HealthCheck medical

practitioners are aware of CHIP and that they have application forms families can complete when they present for care.

Also, CHIP has become an ally in the effort to promote the HealthCheck screening protocol as the standard for all of West Virginia's children. This is a key part of the effort to promote AAP standards for well child examinations.

March of Dimes

OMCFH partnered with the West Virginia March of Dimes on the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Other collaborations with the March of Dimes include: low birth weight prematurity summits and increasing the number of newborn metabolic disorders screenings.

West Virginia Early Childhood Comprehensive Systems Steering Team

West Virginia's ECCS Steering Team is composed of representatives from each of the five ECCS critical component areas. Members include:

Randy A. Bridgette, L.G.S.W., Executive Director, River Valley Child Development Services

Lena Rapp, Director, Office of Head Start State Collaboration

Alicia Hundley, Training Specialist, Choices Child Care Resource and Referral

Patty Kelley, Child and Adolescent Specialist, WVDHHR/Office of Behavioral Health Services/Children's Mental Health Services

Rebecca King, RN, MSN, MEd, Coordinator, West Virginia Department of Education, Office of Student Services and Health Promotion

Diana R. Kreitzer, LPN, Health/Nutrition Coordinator, Northern Panhandle Head Start

Renate E. Pore, Project Director, WV Healthy Kids and Families Coalition

Julie Pratt, State Coordinator, Prevent Child Abuse West Virginia

Kay Tilton, Director, Division of Early Care and Education, Bureau for Children and Families

Joan Skaggs, RN, MSN, Health Consultant, WVDHHR/BCF, Division of Early Care and Education/Quality Initiatives. Ms. Skaggs is a graduate of the National Training Institute for Child Care Health Consultants (NTI) and the former Coordinator of the ECH Project

Charles Young, Assistant Commissioner, Office of Children and Family Policy, Bureau for Children and Families.

Other

Over 450 letters of agreement with private physicians, community health centers, local health departments, and hospital based clinics for the provision of HealthCheck (EPSDT).

Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.

Memoranda of Understanding with WIC and the Social Security Administration for referrals to OMCFH; and expedited handling of SSI applicants identified and served by OMCFH.

Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through MCFH's medical provider networks.

Working agreement with the Office of Social Services for interagency training for professionals and paraprofessionals serving young children, including use of assistive technology and understanding the ADA.

Agreements with eight agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies who employ over 233 licensed social workers and nurses agencies to provide care coordination and other services to mothers and infants.

Interagency Coordinating Council for Birth to Three/PartC (state statute established).

Starting Points Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies).

West Virginia Head Start Association, OMCFH partner in an oral health conference and subsequent efforts designed to increase services for very young children.

Head Start

Membership, West Virginia Association of Community Health Centers

WV Commission for the Deaf and Hard of Hearing (Board Member)

Children's Mental Health Collaborative

Department of Education/Healthy Schools

Family Resource Networks

Parents as Teachers

Maternal and Infant Health Outreach Worker Program

Family Support America

A Vision Shared

Community Voices

The West Virginia Developmental Disabilities Council

Marshall University Medical School

West Virginia Childcare Centers United

Identification of Funding Streams

West Virginia has compiled the following list of primary collaborators with significant funding:

During 2005 the following programs in OMCFH serving children five years old and under include:

Birth Score	\$280,000
Newborn Metabolic Screening	\$869,000
Newborn Hearing Screening	\$175,000
Right From The Start	\$4,772,000
Genetics	\$280,000
HealthCheck (EPSDT) Outreach	\$2,496,000
HealthCheck (ESPDT) Screening and Treatment (birth-20)	\$198,275,000
Children w Special Health Care Needs	\$1,367,000
SIDS	\$52,000
Childhood Lead Poisoning	\$120,000
Birth to Three	\$20,000,000
Immunizations	\$15,000,000
WIC	\$32,000,000
Division of Early Care and Ed	\$55,965,000
Head Start	\$54,000,000
Dept of Ed (Pre-K)	\$39,000,000

At present, it is not possible or desirable to pull all those funding streams into one entity. However, the organizations listed have very effective collaborative relationships with ECH.

To summarize, the commitment and collaboration necessary for an early childhood comprehensive system is ongoing in West Virginia, and we are well-positioned to meet our goals. Our Governor and our Legislature understand the need to focus on early childhood, and they are prepared to continue financial support for the state's children. Programs within the WVDHHR which touch the lives of very young children and their families are making progress in moving our state forward. OMCFH has a presence and credibility throughout the stakeholder community; that credibility has resulted in increasing involvement with the key stakeholders necessary to address the five ECCS components, and they are working closely with our project. Finally, we are adept at seeking new partners and building productive relationships when necessary. We feel the Early Childhood Health Project, West Virginia's ECCS project, is a vital part of the effort to improve the lives of West Virginia's children.



OPPORTUNITIES

OPPORTUNITIES

West Virginia's Title V agency, the Office of Maternal, Child and Family Health (OMCFH), emphasizes infrastructure and capacity building, not direct service. We do so in accordance with the guidance of the HRSA/Maternal and Child Health Bureau. At the same time OMCFH began to consider the role of its ECCS project in this effort, the key members of the Partners Implementing and Early Care and Education System (PIECES) realized that a stronger health presence was necessary to address child well-being, a key component of their mission. Therefore, they added the Division Director of ICAH (organizational home of the ECCS project) to the PIECES Executive Council. Because of this request to strengthen child well-being and the long-standing presence OMCFH has in the health care community as the State's Title V agency, we named our project the Early Childhood Health Project (ECH).

After we were included in PIECES, we began to further define our role. As we have said repeatedly, West Virginians have learned to work together during times of resource scarcity. We have learned that we cannot afford to duplicate or reinvent what is working well. OMCFH has learned this lesson well over the years and we have articulated the following tenets:

- Build bridges rather than silos.
- Don't reinvent what's working.
- Base decisions and actions on facts.

As OMCFH performed internal and external environmental scans of programs and organizations, and their activities, we began to add tenets that would guide ECH:

- Find ways to enhance existing efforts.
- Add vision and knowledge.

We realized that many parts of West Virginia's early childhood system were in place and working well. For example, we knew:

- The WVDHHR offered a vast umbrella of services for families.
- OMCFH had long-standing relationships throughout the WVDHHR.
- West Virginia had a single application system to enroll families in Medicaid, CHIP, and other programs including WV Works; School Clothing Allowance:

- Food Stamps; Medicaid; Transportation Remuneration Incentive Program; Emergency Assistance; and the Low Income Energy Assistance Program.
- PIECES is an effective, inclusive collaborative body.
- Early education was well on its way to becoming a statewide reality. West Virginia is considered a model in these efforts.
- The child care system is working well.

Trying to reinvent any of these systems would be wasteful and would cause tension within the early childhood community. In fact, that is exactly what happened when some of our partners first heard of the ECCS grant, and OMCFH had to assure them that we did not intend to duplicate or "take over" their efforts. All this reinforced our belief that the only way we could be successful and meet the objectives HRSA/ECCS set for the system was to work within the existing system that had many parts in place and was succeeding in West Virginia.

The question may arise as to why West Virginia's project is focused on health. There were several reasons the decision was made and why it is appropriate:

- It is a long accepted fact that children cannot be ready to learn and cannot achieve their full promise unless they are healthy.
- We were asked to assist with child well-being by our partners in the early childhood community.
- OMCFH, the ECCS grantee for West Virginia, is a public health agency.
- The HRSA/Maternal and Child Health Bureau focuses on health issues.

As we considered all these factors-the internal and external scans, the requests from our partners, the needs of our partners-we were reassured that we understood how we could best help the effort to improve the lives of West Virginia's very young children and their families. To find the opportunities where we could do the most good, we needed more input from our ultimate consumers, West Virginia families and those who directly serve them.

FAMILY INPUT

FOCUS GROUPS

In order to better understand the current challenges facing West Virginia's very young children and their families, we conducted a series of focus groups with families and community members throughout the State.

A total of twenty-six focus groups were held during 2005. Fourteen of these groups were held with parents of young children and twelve were held with representative providers who routinely deliver services to the birth through age five population.

Focus group questions discussed by parents highlighted health, development, and safety issues that affect young children and their families. Similar questions were discussed with the "provider groups" but the questions were modified somewhat to fit the provider's perspective. For example, parents might be asked: *What kind of healthcare information do you need? However, providers were asked: What kind of health care information do you make available to parents? What kinds of information do parents ask you for?*

Two special populations of parents were convened. One group was held just with fathers of young children and this group included single fathers. A group was also held with parents of children with special health care needs. Additional parents with "special needs" children participated in other parent focus groups as well.

The focus groups revealed the following issues were identified by both parents and providers as significant areas of concern across the state.

- **Behavioral Health Services and Counseling:**

A major concern identified by provider and parent groups was the lack of mental health services for young children related to behavioral issues and child development. Parents complained about having no local access to behavioral health services, particularly counseling services, and having to drive long distances to see a counselor. Head Start programs reported that behavioral health professionals no longer participate in the screening of children for developmental problems due to cuts in funding and low reimbursement for such services. Other providers expressed concern about many parents they work with who have unaddressed emotional needs of their own and who are ill equipped to properly supervise and nurture their young children.

- **Dental care access and affordability/oral health education**

Access to dental care was clearly one of the most significant concerns expressed by both parents and providers. Availability of dental services for young children is

limited in much of the state in some very rural areas such services are non-existent. This issue was raised in half of the parent groups and in two-thirds of all provider groups. Parents appear to be unaware of the importance of dental care for very young children and are also generally uninformed about practices that promote oral health in young children. Some physicians participating in focus groups indicated that they do not routinely examine young children for signs of oral health problems. Providers report that many of the young children they encounter do not have any access to dental care. Both parent and provider groups felt that more education is needed regarding the importance of oral health in young children.

- **The Need for More Information**

Focus group participants expressed a great need for information relating to how their children grow and learn. Parents are aware of the importance of the first years in brain development and learning, and they report being anxious because they wonder if their children are developing at a normal rate. Parents and providers spoke of the need for simple guides to help them recognize the milestones of average childhood development and typical childhood behaviors for each stage of their child's growth.

In addition to childhood behavior and development, focus group participants also asked for more information on oral health, nutrition, health screenings, and child care. When asked how they would like to receive information, the majority of parents and providers expressed they would like to access the information via the internet.

PARENT SURVEY DATA

In early 2006, a parent survey was conducted to gather more input from parents with children under six years of age. Due to the geographic diversity of the parents participating and the number of surveys submitted, the survey results are considered to be representative of the statewide population of parents with children under the age of six years. All responses were anonymous and confidential.

Copies of the survey were distributed widely across the state through local organizations serving families with young children. The types of programs participating included local community planning organizations known as Family Resource Networks, Head Start, child care programs, preschool education programs, and home visiting programs. Thirty eight different community-based organizations assisted with the distribution and collection of parent surveys.

The survey results mirrored the results of the focus groups. Two of the most important concerns were behavioral issues and dental care for very young children, findings which mirrored those of the focus groups. Again, parents reported a need for more

information about child development, behavior, nutrition and dental health, and cited the internet as a primary resource for information on child health issues.

DISCUSSIONS WITH KEY PARTNERS/STEERING TEAM

The next step was to share data with PIECES and the ECH Steering Team. This allowed us to gather more information, share information with those who could best use it and to work together to blend our efforts more efficiently and effectively.

COMMUNITY MEETINGS ON CHILD HEALTH

In 2006, the West Virginia Healthy Kids and Families Coalition (WVHKFC) and the West Virginia Chapter of the American Academy of Pediatrics (WVAAP) met with professionals from around the state to discuss the status of child health in West Virginia. Meetings were held in Martinsburg, Morgantown, Charleston, Parkersburg, Huntington, and Lewisburg. The purpose of the community meetings was to share information about the state of child health in West Virginia; discuss community concerns about child health; learn how to support the work of health, education and social service professionals in communities across the state; and to strengthen the network of West Virginians who want to collaborate to improve the health of children. Many of the needs discussed during these meetings further validated the findings of the ECH focus groups and surveys. Common concerns included mental/behavioral health and oral health issues.

HOW WE CHOSE OUR ACTIVITIES

The creation of the plan is a culmination of three years of collaborative input from a wide variety of partners in West Virginia. The planning process provided the opportunity for families and early childhood stakeholders across disciplines to communicate, share information about early childhood programs and activities, and define shared goals.

The five components of ECCS were an overriding construct for the discussions. Those components are:

- 1) Access to Health Insurance and Medical Homes
- 2) Early Care and Education/Child Care
- 3) Mental Health and Social-Emotional Development
- 4) Parenting Education
- 5) Family Support

Based on environmental scans, we decided current efforts addressing two of the components were succeeding and did not need to be directly addressed by ECH:

Access to Health Insurance and Medical Homes. West Virginia has made tremendous progress regarding this ECCS component. Over ninety percent of West Virginia's children have health insurance. West Virginia's Governor and Legislature have approved a program allowing buy-in to Medicaid which should provide insurance to all children in the near future. About 60 percent of all children are insured through publicly-funded programs (Medicaid, CHIP and the Public Employees Insurance Agency). This presents an excellent opportunity to work with payers and practitioners on issues of prevention, quality of care and coordination of care.

Regarding medical home, respondents to our surveys for ECH and Children with Special Health Care Needs indicate approximately 80% of our children have a medical home. The ECH survey indicated most young children in West Virginia see a doctor or other health care provider on a regular basis. A small percentage (2.7%) do not appear to have a regular medical home and rely on hospital emergency rooms or urgent care facilities for any level of healthcare received. And ninety percent of West Virginia Medicaid recipients are enrolled in managed care which includes assignment to a medical home.

We will continue to monitor this part of the system and play a supportive role.

Early Care and Education/Child Care. A primary partner in PIECES, the Bureau for Children and Families/Division of Early Care and Education has done a wonderful job making quality child care more accessible to West Virginia to more of the state's families. See "Where We Are" for more information.

Of course, ECH will support efforts addressing these two components as opportunities arise.

This left three ECCS components for ECH to address: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.

As we considered ways to address these components, we looked at the needs identified by families, examined the services that were currently being provided, and studied the systems that were already in place. The ECH Steering Team identified gaps in the system where opportunities exist for improvement without duplication, and then proceeded to develop realistic objectives to fill those gaps. As a result, the Steering Team recommended that the ECH Project focus on the following:

- **Increase the knowledge level and skills of DHHR Behavior Specialists, Child Care Resource and Referral Specialists, child care professionals, and parents regarding childhood behavioral issues** Components addressed include: Mental Health and Social-Emotional Development, Early Care and Education/Child Care, Parenting Education, and Family Support.
- **Increase parent knowledge of proper oral health care, and increase the number of children receiving oral health services.** Components addressed include: Parenting Education and Family Support.
- **Expand the Early Childhood Health website by increasing the information and resource links offered to parents through the Early Childhood Health website. The site will provide a centralized hub, known as the family information center, for parents to easily access family information and services.** Components addressed include: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.
- **Seek technical assistance from Health Systems Research to design activities to help educate families and the community about the life-long negative effects of family violence on children.** Components addressed include: Mental Health and Social-Emotional Development, Parenting Education, and Family Support.

West Virginia was asked, by the HRSA ECCS Project Officer, to strengthen the family support component of our plan. While the state has addressed many of the elements associated with family support, family violence remains a problem. After continuing discussion, we agreed that West Virginia would work toward addressing domestic violence as a family support issue, and would offer support to families to reduce the occurrence of family violence within our communities. We also agreed that we would seek technical assistance from Health Systems Research in the design of this activity.

We also discovered a potential opportunity for the 2007-2008 project period. As we reviewed all of the information available to us, we were impressed by the number of programs and the financial commitment the State of West Virginia has put forth to support families. However, we know the importance of the community in making these programs work. Communities that are family-friendly can harness their energy, ideas and determination to achieve good outcomes, often with minimal resources. Communities that are indifferent or hostile to youth and families can undermine any program and any amount of funding. That is why we believe we need to assist communities in creating environments that nurture youth and families, and we believe the best way to do this is through the positive youth development approach advocated by SEARCH Institute. OMCFH has been very successful in promoting this approach for adolescents and is thus well-positioned for this role. In 2007, SEARCH will be releasing

materials on asset development for very young children and we will be reviewing those materials as we plan activities for the 2007-2008 ECH project period.

As a result of our environmental scans, extensive input from families and our partners, and the help of our Steering Team, we feel we have identified the best opportunities for ECH to enhance the existing system and make a significant contribution.



**WHAT WE
ARE GOING
TO DO**

Now that we had consulted with families and our partners, identified opportunities and worked with our Steering Team to choose the most appropriate areas of concern for ECH to focus on, we needed to select specific activities to address those areas of concern. After receiving further input from those working in the field (at the urging of the HRSA/ECCS Project Officer), we decided upon the following goals for the 2006-2007 period of West Virginia's ECCS project. See Appendix A to view the detailed Implementation Schedule.

AREA OF CONCERN: BEHAVIORAL ISSUES

West Virginia's needs assessment identified problems relating to mental health/social-emotional development and parent education on the subject. In response to these needs, the ECH Steering Team realized the importance of supporting families and those serving them by increasing the information available to them on proper management of challenging childhood behaviors.

Unfortunately, access to behavioral health practitioners is limited in West Virginia. Many areas do not have a practitioner. The number of practicing psychologists and psychiatrists is sufficient to serve only those with the most severe needs and mid-level practitioners such as Licensed Professional Counselors are not eligible for reimbursement by West Virginia's Medicaid Program. These barriers demonstrate the difficulty of referral, and the need for lay professionals and parents to deal with less severe problems. In response to this reality, the WVDHHR created a network of Behavior Specialists, who consult with the Child Care Resource and Referral Agencies (CCR&R's)

The ECH Coordinator met with Behavior Specialists from each of the CCR&R agencies across the state to gather information, and to obtain expert recommendations about prospective training and resource information regarding the management of challenging childhood behaviors.

As effective as they may be, the Behavior Specialists cannot be everywhere at once. The CCR&R's, child care providers, and parents need assistance in handling these behaviors when a Behavior Specialist is not immediately available. Therefore, we realized we needed to supply these groups information also and that it should be consistent with the information supplied to the Behavior Specialists.

We also knew that the expertise and needs of each target group – the Behavior Specialists, CCR&R's, child care providers, and parents – would differ. That led us to decide to vary the delivery method, the complexity of the information and the amount of information for each group.

After consideration of all of the above, we decided upon the following activities to address this area of concern.

The ECH Coordinator will obtain samples of the recommended materials, and will share them with Behavior Specialists and CCR&R personnel. The professionals will then select the appropriate training and resource materials for use throughout the State.

The following four target groups have been identified as having a need for the materials:

- DHHR Behavioral Specialists
- Child Care Resource and Referral Agency Personnel
- Child Care Professionals, and
- Parents

While the underlying principles and ideas will be consistent for each group, there will be three significant differences:

- Delivery Method
- Amount of Information
- Complexity of Information.

The DHHR Behavior Specialists are professional childhood development specialists who are available to serve every licensed child care professional in West Virginia. The Behavior Specialists will receive advanced training by a nationally-recognized authority in the field of childhood behavior management. This will include a one-day training that will be at a complexity level appropriate for their expertise and experience.

Child Care Resource and Referral personnel, including trainers and specialists, will receive materials and technical assistance from the Behavior Specialists. CCR&R trainers typically train child care providers on various topics related to child care. The amount of information and the complexity for this group will be less than that received by the Behavior Specialists, to align with their experience and expertise.

Child care professionals will receive materials and technical assistance from the CCR&R personnel, and Behavior Specialists. The amount of information and the complexity of information will be adjusted to the appropriate complexity level.

Parents will receive materials from the child care providers. The amount of information and the complexity of the information will be modified to meet their needs. Again, content will have common threads and propose common tactics for all in the system to use. In this manner, all those involved will be acting in a concerted effort for the benefit of the child.

BEST PRACTICE SUPPORTING THIS APPROACH

The following three excerpts from Halfon, Inkelas, and Rice (2004) address the social-emotional development and infant mental health in early childhood systems.

Integrate Infant Mental Health into all child and family service systems

“Pediatric, early care and education, and family support providers have roles in providing education, conducting assessment, performing interventions, and care management. The provider’s role in these categories will vary, depending on their professional level of training, resources, their relationships with parents, and community resources.”¹

Strategies: “Build the capacity of existing early childhood systems to address infant mental health serve more children...”¹

Expand system capacity through workforce development

“Medical, early childhood education, and family support providers need the knowledge, skills, and resources to most effectively support early social and emotional development.”¹

Strategies: “Enhance the knowledge and skills of existing providers through continuing education programs in the most effective strategies to promote healthy development, prevent problems and treat those that do occur.”¹

Provide access to mental health consultation and support to early childhood education providers.

“Early care and education providers (center and non-center based) can serve as early learning opportunities and ways to promote the social and emotional development of young children. Previous recommendations and strategies addressed the role of workforce development, and this recommendation addresses direct involvement of appropriately trained mental providers in early care and education settings to provide on-site, tailored education, technical assistance, and some services.”¹

The following bullet points from the Washington State Department of Health (2005) also address improving the social, emotional, and mental health of young children.²

- Ensure that communications with all who work with young children emphasize the importance of social, emotional and mental health
- Promote caregivers’ knowledge of social, emotional, and mental health of young children
- Promote collaboration among policymakers, providers and other stakeholders

COMPONENTS ADDRESSED:

Mental Health & Social-Emotional Development
Early Care and Education/Child Care
Parenting Education
Family Support

TIMELINE:

This activity will begin upon receipt of approval of the plan by HRSA. In anticipation of that approval, we will do the following:

Obtain consensus recommendations from the Behavior Specialists on trainer(s) and materials.

Contact the nationally-recognized authority recommended by the Behavior Specialists for information on fees and possible dates.

Obtain pricing information on the materials recommended by the Behavior Specialists.

Request a listing of possible training dates from the Behavioral Specialists.

Prepare the documents necessary to contract with the trainer(s) and purchase the materials. These documents will not be submitted until HRSA approval is received.

Design response cards for CCR&R personnel, child care providers and parents who receive information, to be collected at distribution points and returned to the ECH Project.

Within 30 days of receipt of HRSA approval, we will:

Schedule the training for the Behavior Specialists.

Submit the documents necessary to contract with the trainer(s) and purchase the materials.

We expect this activity to be completed by August 31, 2007.

OUTCOME:

Pre and post tests administered to Behavior Specialists. Questions will assess level of knowledge, satisfaction with the content and delivery method, and the anticipated value of the training/information received.

Response card survey of CCR&R personnel, child care providers, and parents who receive information. Questions will assess satisfaction with the content and delivery method, and the anticipated value of the training/information received.

APPROXIMATE COST TO PROJECT: \$37,480

Training for Behavior Specialists	\$15,000
Educational Modules for Child Care Resource and Referral Agencies	\$13,780
Educational Materials for Child Care Providers and Parents	\$ 8,700

AREA OF CONCERN: INCREASING PARENT KNOWLEDGE OF PROPER ORAL HEALTH CARE AND INCREASING THE NUMBER OF CHILDREN RECEIVING ORAL HEALTH SERVICES

In response to the expressed need for increased oral health education and services for very young children, the ECH has partnered with the Children's Dentistry Project to work toward development of a pilot project designed to screen and provide basic oral health education and dental services for the State's children using portable dental equipment.

A sister program to ECH, the Children's Dentistry Project, has funds to initiate this activity in up to three locations. Those funds will be used for portable dental equipment at a cost of \$10,000 per location. If ECH wishes to implement in more than three locations, ECH will have to provide the funding for the equipment.

The activity is self-sustaining if third-party payers are billed. It is a rare Head Start child that does not have Medicaid or CHIP, both of which pay for dental services. Services for that child would be paid by Head Start.

Children encountered in other venues will be served. If the children have third party coverage, it will be billed. If the child is not covered under insurance, the parents will be given the option to receive dental services for their child based on a sliding fee scale.

Oral health education will be offered to Head Start and early childhood education programs. In addition, oral health and early dental care information materials will be distributed to parents through child care centers, pediatricians' offices, high schools, WV

Pre-K sites, WVDHHR County Offices, WIC Offices, Head Start Centers, Child Care Resource and Referral Agencies, Starting Points Centers, Family Resource Network Offices, In-home Family Education (home visiting programs), and health fairs. We will also work with one of our closest collaborators, Valley Health Systems (a community health center), to support mutual efforts toward this goal.

Information on oral health practices for very young children will be available to families accessing the EHC website, along with the West Virginia Dental Directory Referral Resource Guide.

BEST PRACTICE SUPPORTING THIS APPROACH:

“Compared to conventional prevention, the results suggest that risk-based prevention can be effective in reducing both costs and dental caries in preschool children provided that the screening and preventive measures are delegated to preventative dental assistants” (Pienihakkinen, Jokela, & Alanen, 2003).³

“The age at the first preventative dental visit had a significant positive effect on dentally related expenditures” (Savage, Lee, Kotch, & Vann, 2004, p. 418).⁴

Jim Crall (2005), discusses the vision of early childhood oral health. The following excerpts focus on the importance of oral health in young children.⁵

Vision of Early Childhood Health

- Families, child care/learning environments and communities actively engaged in effective oral health promotion (partners)

Per Jim Crall, Strategic Elements for Creating a Foundation for a lifetime of good oral health in early childhood within communities include:⁵

Developing and implementing effective oral health promotion activities to instill healthy habits that promote health and reduce the risks, prevalence and severity of oral diseases in early childhood;⁵

- Educating and motivating parents/caregivers to take an active role in their children's oral health to reinforce and extend oral health promotion activities to the home and child care environments;

Vision for Early Childhood Oral Health

- On-site assessments and individualized prevention and disease management

Gaps in Oral Health and Oral Health Care -- What We Need: "Continuous, coordinated, risk-based use of effective measures that promote oral health..."⁵

Keys to Good Oral Health

Regular "self-care" practices

COMPONENTS ADDRESSED:

Parenting Education
Family Support

TIMELINE:

This activity will begin upon receipt of approval of the plan by HRSA. In anticipation of that approval, we will do the following:

Obtain pricing information on materials recommended by the Children's Dentistry Project.

Contact partners for information on the number of parents using their services.

Prepare the documents necessary to purchase the materials. These documents will not be submitted until HRSA approval is received.

Meet with the oral health educators of the Children's Dentistry Project to preview this activity and ask them to prepare to implement this activity after HRSA approval.

Design response cards for parents who receive information, to be collected at distribution points and returned to the ECH Project.

Identify counties and partners for the oral health screening and preventive services, and begin discussions with them.

Within 30 days of receipt of HRSA approval, we will:

Submit the documents necessary to purchase the materials.

Notify the oral health educators of the Children's Dentistry Project of HRSA approval and request an implementation schedule from them.

Develop an implementation schedule for the oral health screening and preventive services from the partners previously identified.

We expect this activity to be completed by August 31, 2007.

OUTCOME:

Number of oral health education presentations and number of persons encountered.

Number of children receiving oral health screening or preventive services

Response card survey of parents, to be collected by partners serving as distribution points for the information. Questions will assess satisfaction with the content and delivery method, and the anticipated value of the information received.

Printing and distribution of oral health information to 120,000 families.

APPROXIMATE COST TO PROJECT: \$2,900

Area of Concern: Increasing the information and resource links offered to parents through the ECH website

West Virginia is fortunate to have several entities working to support parents in their effort to raise healthy children. Parenting education comes from a variety of state and community resources including pediatric providers, home visiting programs, family resource centers, early intervention programs, Head Start, child care professionals, and from various state health, education, and social service agencies.

However, there is still work to be done according to the parents of very young children who responded to our survey and those who participated in our focus groups. They feel they need more information regarding the development, health, and safety requirements of young children. In addition, these parents told us they prefer to get that information from two sources: their child's health care provider and the internet. The latter is necessary particularly between medical visits or when a medical provider is not immediately available.

Because no single entity is responsible for parenting education, materials are available online, but the information is located on a multitude of websites. Currently, families must navigate several websites in order to obtain the information they need. For instance, guidance on finding quality child care and the listing of licensed providers is found on one website, while information on how to apply for health insurance is on another, and the directory of local mental health services is on yet another site. Because the information is not located in a central area, it is difficult for families to find the services and information they need.

We feel the ECH role is to offer additional information directly on our site and to link to more resources. To meet this need, ECH will move toward filling the gap by collaborating with partners to identify parenting education resources that are currently

available, and work to expand the ECH website to provide parents with seamless access to these resources. This "seamless" approach will make parents' searches for information more convenient, faster and more productive. It will also reduce duplication.

The expanded ECH website will serve as a clearinghouse for resources created by our partners that help build and facilitate effective partnerships by providing a centralized hub, known as a family information center, for parents to access parenting and early childhood information. In addition to general childhood health and safety topics, the expanded site will include developmental and behavioral milestones, oral health education materials, and links to the Division of Early Care and Education that will assist families with locating and selecting quality child care. Directories of state health professionals, including private health practitioners, dentists, mental health professionals, primary health centers, and local health departments will also be available on the site. The website will provide easy access to emergency services and family support via linkage with WV-211. It will also link to West Virginia's electronic application system to enable families to apply for multiple family support services through a single application procedure.

The expansion of the website represents a collaboration between federal, state, and local agencies; national and state organizations and associations; and foundations to gather, develop, and share information and materials relating to child well being. We believe the collaboration will strengthen parenting education by optimizing the efficiency of existing programs and by capitalizing on existing platforms that parents of young children trust and use. Additionally, parents and community partners will be more aware of the parenting education programs and services that are available within their community.

To increase public awareness of the website, we will work with partners to develop a marketing strategy to promote the use of the ECH website as the family information center for distribution of information regarding early childhood resources. ECH will coordinate with PIECES, internal and external partners, and community stakeholders to build family and community awareness of the family information center.

BEST PRACTICE SUPPORTING THIS APPROACH:

A plethora of credible national organizations believe web-based resources are part of a valuable and effective toolkit for parent education. These organizations include:

American Academy of Pediatrics. [Http://www.aap.org](http://www.aap.org). This website provides parents with information on topics such as safety and injury prevention, immunization information, child development information, and seasonal tips for child safety. It also links parents to helpful resources including finding pediatricians and specialists.

Bright Futures. [Http://www.brightfutures.org](http://www.brightfutures.org). Bright Futures at Georgetown University is national health promotion initiative supported by the Maternal and Child Health

Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. This website provides parents with tip sheets written in family-friendly language. Their materials, which may be used by families, educators, and child care professionals, cover a range of disciplines including health, education, and child care.

Center for Effective Parenting. [Http://www.parenting-ed.org](http://www.parenting-ed.org). This is a multi-site collaboration effort between the University of Arkansas Children's Hospital, University of Arkansas Center for Medical Services, and Jones Center for Families. The site contains helpful information including, parenting handouts, parenting education resources, and resource links for parents and parent educators. The parenting section includes not only links to general parenting information, but to mother specific sites, father specific sites, new and expectant parents, single parents, parents of children with special needs, and parents of twins. State-specific information is also contained on site including parenting class schedules, and links to the Parenting in Arkansas Magazine.

National Association for the Education of Young Children. <http://www.naeyc.org>. NAEYC recognizes parents and families are their children's first teachers, and they dedicate a special section of their website to resources for them. This site provides information concerning the early learning years, books for families and children, tips for helping young children after a disaster, and a tool for families to search for an NAEYC accredited program online.

COMPONENTS ADDRESSED:

Mental Health & Social-Emotional Development
Parenting Education
Family Support

Additionally, the expanded site will also promote access to health insurance and medical home by providing parents links to apply for health coverage, and it will promote early care and education/child care by providing links for parents to locate licensed child care providers in their community.

TIMELINE:

This activity will begin upon receipt of approval of the plan by HRSA. In anticipation of that approval, we will compile a list of web sites we wish to link to and resources we wish to add to the ECH web site.

Within 30 days of receipt of HRSA approval, we will:

Begin to link to the web sites identified and add the resources to the web site;
Create a list of ideas to promote the site and pursue those ideas. This will include presentations at meetings, visits to Child Care Resource & Referral agencies, and contacting community-based organizations.

We expect this activity to be ongoing through the life of the project.

OUTCOME:

Number of new links

Number of new resources

Increasing the number of “hits” on the web site

Accounts of promotional activities

APPROXIMATE COST TO PROJECT: \$0

There should be no additional cost to the ECH Project. The duties fit within those already assigned to the ECH Coordinator and nothing described herein increases the cost of the site.

AREA OF CONCERN: FAMILY VIOLENCE IDENTIFICATION AND PREVENTION ACTIVITY

West Virginia was asked, by the HRSA ECCS Project Officer, to strengthen the family support component of our plan. While the state has addressed many of the elements associated with family support, family violence remains a problem. After further discussion, we agreed that West Virginia would work toward addressing domestic violence as a family support issue, and would offer support to families to reduce the occurrence of family violence within our communities.

During the 2006-2007 grant year, the West Virginia ECH will seek technical assistance from Health Systems Research, the HRSA/ECCS technical assistance contractor, to design activities to help educate families and the community about the life-long negative effects domestic violence has on children. The activities will be implemented in the 2007-2008 grant year, and they will focus on the following objectives:

- Educating parents on the long-term adverse effects of family violence on children
- Recognizing signs of imminent danger
- Resolving conflict without violence
- The ECH project has begun to meet with the West Virginia Coalition Against Domestic Violence and other stakeholders as part of the West Virginia Bureau for Public Health effort to decrease domestic violence. Obtaining technical assistance from the HRSA contractor will greatly strengthen this

effort and enhance the ECH contribution to it.

BEST PRACTICE SUPPORTING THIS APPROACH:

According to a study conducted by Felitti, et al., (1998):⁶

- “A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease.”
- “We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥ 50 sexual intercourse partners, and sexually transmitted disease; and 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.”

Dube, Anda, Felitti, Edwards, & Williamson (2002), state the following:⁷

- “Intimate partner violence (IPV) damages a woman's physical and mental well-being, and indicates that her children are likely to experience abuse, neglect and other traumatic experiences.”
- “Compared to persons who grew up with no domestic violence, the adjusted odds ratio for any individual ACE was approximately two to six times higher if IPV occurred ($p < 0.05$). There was a powerful graded increase in the prevalence of every category of ACE as the frequency of witnessing IPV increased. In addition, the total number of ACEs was increased dramatically for persons who had witnessed IPV during childhood. There was a positive graded risk for self-reported alcoholism, illicit drug use, i.v. drug use and depressed affect as the frequency of witnessing IPV increased.”
- “This data strongly suggest that future studies, which focus on the effect of witnessing IPV on long-term health outcomes, may need to take into consideration the co-occurrence of multiple ACEs, which can also affect these outcomes.”

Cassidy (2006), addresses intimate partner violence in the following two excerpts: ⁸

- "A primary challenge in studying intimate partner violence has been the understanding that prevalence rates likely under-estimate this public health problem because of the stigma and shame associated with it. The studies in this issue of the American Journal of Preventative Medicine provide us with some of the highest numbers yet reported."
- "Consistent with findings from the comparison study by Bonomi, et al., several studies have associated victimization by and exposure to intimate partner violence with physical health problems, psychological problems such as depression and post-traumatic stress disorder, drug use at young ages, and attempted suicide."

Treichel (2003), has included these two facts to address the child maltreatment epidemic in the United States: ⁹

- A study was headed by Valerie Edwards, Ph.D. of the Centers for Disease Control and Prevention in Atlanta. The results appeared in the August American Journal of Psychiatry. Being a witness of maternal battering was assessed with four items adapted from the Conflict Tactics Scale relating to having seen their mother being pushed, grabbed, or slapped or having something thrown at her.
- "Researchers also looked to see whether having been maltreated as a child had a negative impact on adult mental health in a dose-response manner. The answer was essentially yes, they found. For instance, 7 percent of men who reported having witnessed maternal battering, 10 percent who reported having witnessed maternal battering and having been physically or sexually abused, and 16 percent who reported having witnessed maternal battering plus having been physically and sexually abused had a low mental health score as an adult. Similarly, 14 percent of women who reported having witnessed maternal battering, 19 percent who reported having witnessed maternal battering plus having been physically or sexually abused, and 20 percent who reported having witnessed maternal battering plus having been physically and sexually abused had a low mental health score as an adult."

COMPONENTS ADDRESSED:

Mental Health and Social-Emotional Development
Parenting Education
Family Support

TIMELINE:

This activity will begin upon receipt of approval of the plan by HRSA. In anticipation of that approval, we will consult with the HRSA Technical Assistance (TA) Contractor and our partners in the domestic violence prevention community on possible dates for a meeting in 2007.

Within 30 days of receipt of HRSA approval, we will:

Submit a formal request for technical assistance

Schedule a visit to West Virginia by the HRSA Technical Assistance Contractor that will include a meeting with our partners

By June 1, 2007, we will design an activity to address domestic violence that will be implemented in the 2007-2008 grant year. This will allow it to be included in the application for 2007-2008.

EVALUATION:

Design of an activity to address domestic violence that will be implemented in the 2007-2008 grant year.

APPROXIMATE COST TO PROJECT: \$500

The HRSA Technical Assistance Contractor and the ECH Coordinator will be performing most of the work for this activity. Therefore, there will be no additional cost for their services.

We project a cost of \$500 or less to host a meeting with our domestic violence partners and the HRSA Technical Assistance Contractor.

SUSTAINABILITY PLAN

Because many of the components of the system are already in place, our continuing effort will focus on working with partners to enhance existing efforts, and to fill gaps identified within the system. Most of these efforts will have little or no cost associated with them, with the exception of the continued support of the Project Coordinator. The Project Coordinator will act as a liaison between the many partners making up the system, carrying out the coordination and collaboration required to maintain the project.

INDICATORS OF SUCCESS

Statistical indicators are essential to measure the State's progress. These indicators and their accompanying trends cannot be truly measured in time frames shorter than

five to ten years. Also, change in these indicators is a measure of activity throughout the system; thus, they are the responsibility of the entire system.

Positive changes we will be watching for include:

- Number of kindergarten or Pre-K schools using the standardized screening tool for well child screening;
- Number of children under the age of six who are fully immunized;
- Number of early care and education programs incorporating social and emotional competencies in their curriculum;
- Number of child care professionals who have completed training programs to support early childhood emotional development;
- Number of counties with an approved Pre-K plan;
- Number of licensed child care providers who can serve more than six children;
- Number of children entering Head Start or West Virginia Pre-K;
- Number of very young children who have had a dental visit within the last twelve months;
- Reduction in the number of homicides related to domestic violence;
- Number of higher education programs incorporating the early learning foundations in their teacher preparation programs.

These indicators may be supplemented or changed as we learn more from our Policy Matters Inventory. We believe this collaborative approach will be instrumental because we will be working together as a group to establish common indicators to measure the success of early childhood programs.

DATA COLLECTION

The Division of Research, Evaluation and Planning is responsible for the epidemiological and other research activities of the Office of Maternal, Child and Family Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal, Child and Family Health's planning efforts are data-driven. All of the Office of Maternal, Child and Family Health's program specific database and data entry personnel are housed in the Division, and are linked with program leadership to assure consistent visioning.

The Division administers the Newborn Hearing Screening Project, the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, the Childhood Lead Poisoning Prevention Project (CLPPP), and the Birth Defect Surveillance System, all sponsored by the Centers for Disease Control and Prevention (CDC); the Sudden Infant Death Syndrome (SIDS) Project mandated by State Statute but not financed by Title V; and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project also largely financed with Title V dollars. The Division is also responsible for SSDI activities and the Block Grant application.

The West Virginia Early Childhood Health Project will collaborate with the West Virginia Bureau for Public Health, Health Statistics Center, West Virginia Kids Count, West Virginia School Health Partnership, and any other partners which can be identified, to collect data regarding child health and well being.



What's Next

What's Next

In 2007-2008, the ECH Project will:

- Begin the process of implementing a positive youth development approach using the Search Institute's Early Childhood Developmental Assets Framework (ECDAF). We realize for the ECH Project to be effective in the long-term, we must move from a problem focus to one of creating better environments for very young children. Our partners must include all those who have opportunities to help young children form a foundation for a happy, healthy, successful life. More details on the ECDAF, including an explanation of terms, are included in Appendix B.

West Virginia is successfully implementing a youth development approach in its Adolescent Health Initiative and has been recognized as a leader for this programming on the national level. The community connections we have made through the Adolescent Health Initiative will be extremely beneficial, as we expand the positive youth development to include very young children. We feel strongly that we have the experience and the relationships with Search Institute and our community partners to expand this approach to early childhood.

- Implement the domestic violence prevention activity designed with the assistance of HSR during 2006-2007.
- Assess the progress of the 2006-2007 educational activity for management of challenging behaviors, and conduct another educational activity using the same model used in 2006-2007. We will consider input from the CCR&R's and child care providers on their educational needs, and seek to meet those needs using the same information distribution methods. Considering West Virginia's obesity status, nutrition and physical activity are likely areas of concern.
- Maintain the web site and continue to promote it.
- Continue efforts to link the early childhood and dental practitioner communities.



SUMMARY

Summary

We have chosen the activities described above based on the following factors:

- Environmental scans;
- Input from families;
- Discussions with our collaborative partners and our Steering Team.

We have planned with the five ECCS components in mind:

- 1) Access to Health Insurance and Medical Homes;
- 2) Mental Health and Social-Emotional Development;
- 3) Early care and Education/Child Care;
- 4) Parenting Education;
- 5) Family Support.

We have adhered to the tenets of West Virginia's programming philosophy:

- Build bridges rather than silos;
- Don't reinvent what's working;
- Base decisions and actions on facts;
- Find ways to enhance existing efforts;
- Add vision and knowledge.

The development of this plan is the result of relationship building open communication between families, stakeholder groups, and organizations who are working to build strong partnerships around common goals. We believe these activities will greatly enhance West Virginia's efforts to improve the lives of very young children and their families, and will provide opportunities to open new doors, build new bridges, and carry this state to higher levels of quality and service. The strength of family participation will continue to drive the efforts for the system to meet the needs of West Virginia children and their families.

References

- Halfon, N., Rice, T., Inkelas, M. (2004). Building *State Early Childhood Comprehensive Systems*. National Center for Infant and Early Childhood Health Policy.
- Grevstad, L., Froelicher, S., Kurtz, G. (2005). Kids Matter: Improving Outcomes for Children in Washington State, Social, Emotional and Mental Health. Retrieved 2005 from *Washington State Department of Health* Web site. http://www.washingtonlearns.wa.gov/materials/050928_el_kidsmatter.pdf
- Pienihakkinen, K., Jokela, J., Alanen, P. (2004). Economic evaluation of a risk-based caries prevention program in preschool children. *BMC Oral Health* (5). Retrieved March 23, 2005, from the BioMedical Web site. <http://www.biomedcentral.com/1472-6831/5/2>
- Savage, M., Lee, J., Kotch, J., Vann, W., (2004). Early preventative dental visits: Effects on subsequent utilization and costs. *Journal of Pediatrics*, 114, e418-e423.
- Crall, J. (2005). *Understanding oral health in young children*. Retrieved September 19, 2005, from the UCLA Center for Healthier Children, Families and Communities Web site. www.healthychild.ucla.edu/nohpc
- Felitti, V., Anda, R., Nordenburg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventative Medicine*, 14, 245-258.

References

- Dube, S., Anda, R., Felitti, V., Edwards, V., Williamson, D. (2002). Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence for health and social services. *Violence and Victims*, 17 (1), 3-17.
- Marks, J., Cassidy E. (2006), Does a failure to count mean that it fails to count? Addressing intimate partner violence. *American Journal of Preventative Medicine*, 30 (6), 530-531.
- Treichel, J. A. (2003). Clinical and Research News: Child Maltreatment Appears Epidemic in United States. *Psychiatric News*, 38 (18), 18.

WV ECCS IMPLEMENTATION SCHEDULE

This implementation schedule lists the annual goals for the ECCS Plan for the 2006-2007 grant period. The overall goals for the Early Childhood Health Project can be found in the 2006 grant application.

Area of concern: Behavioral Issues

Annual Goal: Provide support to families and those serving them by increasing the information available to them regarding proper management of challenging childhood behaviors.

In anticipation of HRSA approval, we will do the following:

- Activity 1** Obtain consensus recommendations from the Behavior Specialists on trainer(s) and materials.
- Activity 2** Contact the nationally-recognized authority recommended by the Behavior Specialists for information on fees and possible dates.
- Activity 3** Obtain pricing information on the educational materials recommended by the Behavior Specialists.
- Activity 4** Request a listing of possible training dates/availability from the Behavioral Specialists.
- Activity 5** Prepare the documents necessary to contract with the trainer(s) and purchase the materials. These documents will not be submitted until HRSA approval is received.
- Activity 6** Design response cards for CCR&R personnel, child care providers and parents who receive information, to be collected at distribution points and returned to the ECH Project.

The following activities will begin upon receipt of approval of the plan by HRSA.

- Activity 7** Initiate the purchasing process for trainers and materials. Schedule the training for the Behavior Specialists.
- Activity 8** Conduct trainings and disseminate educational materials and response cards. Compile and analyze responses.

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Activity 1												
Activity 2												
Activity 3												
Activity 4												
Activity 5												
Activity 6												
Activity 7												
Activity 8												
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG

Outcome: Pre and post tests administered to Behavior Specialists. Questions will assess level of knowledge, satisfaction with the content and delivery method, and the anticipated value of the training/information received.

This timeline is based upon receiving HRSA approval by January 1, 2007. Timeline will be modified if approval is delayed.

WV ECCS IMPLEMENTATION SCHEDULE

Area of concern: Increasing parent knowledge of proper oral health care and increasing the number of children receiving oral health services

Annual Goal: Develop a pilot project designed to screen and provide basic oral health education and dental services for the State's children using portable dental equipment.

In anticipation of HRSA approval, we will do the following:

- Activity 1** Obtain pricing information on informational materials recommended by the Children's Dentistry Project.
- Activity 2** Contact partners for information on the number of parents using their services.
- Activity 3** Contact the oral health educators of the Children's Dentistry Project to preview this activity and ask them to prepare to implement this activity after HRSA approval.
- Activity 4** Design response cards for parents who receive information, to be collected at distribution points and returned to the ECH Project.
- Activity 5** Identify counties and partners for the oral health screening and preventive services, and begin discussions with them.
- Activity 6** Prepare the documents necessary to purchase the materials. These documents will not be submitted until HRSA approval is received.

The following activities will begin upon receipt of approval of the plan by HRSA.

- Activity 7** Initiate the purchasing process for materials. Finalize the implementation schedule with the oral health educators of the Children's Dentistry Project.
- Activity 8** Implementation and collection of reports.

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Activity 1												
Activity 2												
Activity 3												
Activity 4												
Activity 5												
Activity 6												
Activity 7												
Activity 8												
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG

Outcome: Outcome measures include the number of oral health education presentations and number of persons encountered; the number of children receiving oral health screening or preventive services; and the distribution of information to 120,000 families.

This timeline is based upon receiving HRSA approval by January 1, 2007. Timeline will be modified if approval is delayed.

WV ECCS IMPLEMENTATION SCHEDULE

Area of concern: Increasing the information and resource links offered to parents through the early childhood health website.

Annual Goal: Expand the early childhood health website, making it a centralized hub, known as a family information center, for parents to access parenting and early childhood information.

The following activities will begin upon receipt of approval of the plan by HRSA:

- Activity 1** Compile a list of web sites to link to and resources we wish to add to the ECH website.
- Activity 2** Begin to link to the web sites identified and add the resources to the web site.
- Activity 3** Create a list of ideas to promote the site and pursue those ideas
- Activity 4** Promote website at meetings, visits to Child Care Resource and Referral agencies, and contacting community-based organizations

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Activity 1												
Activity 2												
Activity 3												
Activity 4												
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG

Outcome: Outcome measures include increasing the number of new links added to the site; increasing the number of new resources available on the site; increasing the number of “hits” on the website; and accounts of promotional activities.

This timeline is based upon receiving HRSA approval by January 1, 2007. Timeline will be modified if approval is delayed.

WV ECCS IMPLEMENTATION SCHEDULE

Area of concern: Family violence identification and prevention

Annual Goal: Offer support to families to reduce the occurrence of family violence within our communities by seeking technical assistance from Health Systems Research to design activities to help educate families and the community about the life-long negative effects domestic violence has on children.

The following activities will begin upon receipt of approval of the plan by HRSA. In anticipation of that approval, we will do the following:

The following activities will begin upon receipt of approval of the plan by HRSA:

- Activity 1** Consult with Health Systems Research and our partners in the domestic violence prevention community to find possible dates for a meeting in 2007.
- Activity 2** Submit a formal request for technical assistance.
- Activity 3** Schedule a visit to West Virginia by the Health Systems Research that will include a meeting with our partners.
- Activity 4** Design an activity to address domestic violence that will be implemented in the 2007-2008 grant year.

	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Activity 1												
Activity 2												
Activity 3												
Activity 4												
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG

Outcome: Outcome will be measured by the design of an activity to address domestic violence that will be implemented in the 2007-2008 grant year.

This timeline is based upon receiving HRSA approval by January 1, 2007. Timeline will be modified if approval is delayed.

40 Developmental Assets® for Early Childhood (ages 3 to 5)

Search Institute® has identified the following building blocks of healthy development—known as **Developmental Assets**®—that help young children grow up healthy, caring, and responsible.



External Assets	Support	<p>1. Family support—Parent(s) and/or primary caregiver(s) provide the child with high levels of consistent and predictable love, physical care, and positive attention in ways that are responsive to the child's individuality.</p> <p>2. Positive family communication—Parent(s) and/or primary caregiver(s) express themselves positively and respectfully, engaging young children in conversations that invite their input.</p> <p>3. Other adult relationships—With the family's support, the child experiences consistent, caring relationships with adults outside the family.</p> <p>4. Caring neighbors—The child's network of relationships includes neighbors who provide emotional support and a sense of belonging.</p> <p>5. Caring climate in child-care and educational settings—Caregivers and teachers create environments that are nurturing, accepting, encouraging, and secure.</p> <p>6. Parent involvement in child care and education—Parent(s), caregivers, and teachers together create a consistent and supportive approach to fostering the child's successful growth.</p>
	Empowerment	<p>7. Community cherishes and values young children—Children are welcomed and included throughout community life.</p> <p>8. Children seen as resources—The community demonstrates that children are valuable resources by investing in a child-rearing system of family support and high-quality activities and resources to meet children's physical, social, and emotional needs.</p> <p>9. Service to others—The child has opportunities to perform simple but meaningful and caring actions for others.</p> <p>10. Safety—Parent(s), caregivers, teachers, neighbors, and the community take action to ensure children's health and safety.</p>
	Boundaries & Expectations	<p>11. Family boundaries—The family provides consistent supervision for the child and maintains reasonable guidelines for behavior that the child can understand and achieve.</p> <p>12. Boundaries in child-care and educational settings—Caregivers and educators use positive approaches to discipline and natural consequences to encourage self-regulation and acceptable behaviors.</p> <p>13. Neighborhood boundaries—Neighbors encourage the child in positive, acceptable behavior, as well as intervene in negative behavior, in a supportive, nonthreatening way.</p> <p>14. Adult role models—Parent(s), caregivers, and other adults model self-control, social skills, engagement in learning, and healthy lifestyles.</p> <p>15. Positive peer relationships—Parent(s) and caregivers seek to provide opportunities for the child to interact positively with other children.</p> <p>16. Positive expectations—Parent(s), caregivers, and teachers encourage and support the child in behaving appropriately, undertaking challenging tasks, and performing activities to the best of her or his abilities.</p>
	Constructive Use of Time	<p>17. Play and creative activities—The child has daily opportunities to play in ways that allow self-expression, physical activity, and interaction with others.</p> <p>18. Out-of-home and community programs—The child experiences well-designed programs led by competent, caring adults in well-maintained settings.</p> <p>19. Religious community—The child participates in age-appropriate religious activities and caring relationships that nurture her or his spiritual development.</p> <p>20. Time at home—The child spends most of her or his time at home participating in family activities and playing constructively, with parent(s) guiding TV and electronic game use.</p>

Internal Assets	Commitment to Learning	<p>21. Motivation to mastery—The child responds to new experiences with curiosity and energy, resulting in the pleasure of mastering new learning and skills.</p> <p>22. Engagement in learning experiences—The child fully participates in a variety of activities that offer opportunities for learning.</p> <p>23. Home-program connection—The child experiences security, consistency, and connections between home and out-of-home care programs and learning activities.</p> <p>24. Bonding to programs—The child forms meaningful connections with out-of-home care and educational programs.</p> <p>25. Early literacy—The child enjoys a variety of pre-reading activities, including adults reading to her or him daily, looking at and handling books, playing with a variety of media, and showing interest in pictures, letters, and numbers.</p>
	Positive Values	<p>26. Caring—The child begins to show empathy, understanding, and awareness of others' feelings.</p> <p>27. Equality and social justice—The child begins to show concern for people who are excluded from play and other activities or not treated fairly because they are different.</p> <p>28. Integrity—The child begins to express her or his views appropriately and to stand up for a growing sense of what is fair and right.</p> <p>29. Honesty—The child begins to understand the difference between truth and lies, and is truthful to the extent of her or his understanding.</p> <p>30. Responsibility—The child begins to follow through on simple tasks to take care of her- or himself and to help others.</p> <p>31. Self-regulation—The child increasingly can identify, regulate, and control her or his behaviors in healthy ways, using adult support constructively in particularly stressful situations.</p>
	Social Competencies	<p>32. Planning and decision making—The child begins to plan for the immediate future, choosing from among several options and trying to solve problems.</p> <p>33. Interpersonal skills—The child cooperates, shares, plays harmoniously, and comforts others in distress.</p> <p>34. Cultural awareness and sensitivity—The child begins to learn about her or his own cultural identity and to show acceptance of people who are racially, physically, culturally, or ethnically different from her or him.</p> <p>35. Resistance skills—The child begins to sense danger accurately, to seek help from trusted adults, and to resist pressure from peers to participate in unacceptable or risky behavior.</p> <p>36. Peaceful conflict resolution—The child begins to compromise and resolve conflicts without using physical aggression or hurtful language.</p>
	Positive Identity	<p>37. Personal power—The child can make choices that give a sense of having some influence over things that happen in her or his life.</p> <p>38. Self-esteem—The child likes her- or himself and has a growing sense of being valued by others.</p> <p>39. Sense of purpose—The child anticipates new opportunities, experiences, and milestones in growing up.</p> <p>40. Positive view of personal future—The child finds the world interesting and enjoyable, and feels that he or she has a positive place in it.</p>

This page may be reproduced for educational, noncommercial uses only. Copyright © 2005 by Search Institute.

615 First Avenue N.E., Suite 125, Minneapolis, MN 55413; 800-888-7828; www.search-institute.org. All Rights Reserved.

The following are registered trademarks of Search Institute: Search Institute®, Developmental Assets®, and Healthy Communities • Healthy Youth®.



Search

Search InstituteSM Home

- > [About Search Institute](#)
- > [What's New](#)
- > [Support Search Institute](#)

Resources

- > [Search Institute Store](#)
- > [HC+HY Conference](#)
- > [Survey Services](#)
- > [Training & Speaking](#)
- > [Downloads](#)
- > [Participate](#)
- > [Publishing](#)
- > [Permissions / Reprints](#)

Knowledge

- > [Developmental AssetsTM](#)
- > [Five Action Strategies](#)
- > [Research](#)
 - [Positive Human Development](#)
 - [Community and Social Change](#)
 - [Research on the Assets](#)
 - [Insights & Evidence](#)
 - [Academic Book Series](#)
 - [Research Publications](#)
 - [Survey Services](#)
 - [Evaluation Services](#)
 - [Meet the Staff](#)
- > [Communities](#)
- > [Educators](#)
- > [Families](#)
- > [Faith Communities](#)
- > [Bibliography](#)
- > [Archives](#)

Information For

- > [Grant Seekers](#)
- > [Media](#)
- > [Booksellers](#)

Tools

- > [Printer Friendly Page](#)
- > [Send This Page](#)

The Early Childhood Developmental Assets Framework (ECDAF): A Practical and Ecological Approach to Promoting Positive Development

- [Introduction](#)
- [What is the Early Childhood Developmental Assets Framework \(ECDAF\)?](#)
- [What is special about the ECDAF?](#)
- [The production of the ECDAF](#)
- [Related ECDAF materials](#)
- [How can I find out more information about using the ECDAF?](#)

Download the [Early Childhood Developmental Assets Framework](#) (in PDF form).

Introduction

The significance of early childhood continues to capture heightened levels of governmental, public, parental, and professional attention. Many groups understand that school and life success requires positive early childhood development and a focus on early learning. Sustained interest in child care, development, and education has resulted in meaningful gains over the last decade.

Still, a number of issues that are vital to advancing the early childhood field remain. There is the need for a broader understanding of what aspects of development are really important and knowing what works. Policy makers, parents, and professionals are working to define the elements of child development in ways that establish measures of accountability and benchmarks of success. Many recognize the need for a holistic perspective on early childhood that takes more than just the child and primary caregiver(s) into account. While relationships between child and primary caregiver(s) will always be essential, there is an increased understanding that neighbors, organizations, institutions, and the larger community also have very important roles to play.

Search Institute's new Early Childhood Developmental Assets Framework (ECDAF) offers a response to these issues. The ECDAF combines knowledge of what fosters holistic early childhood development with a practical approach that offers specific guidance to practitioners, parents, family members, neighbors, community workers, officials, and policy makers—all of whom are concerned with ensuring that all young children get a good start in life, make a smooth transition to school, and attain success as they grow older.

**Search Institute
The Banks Building
615 First Avenue NE,
Suite 125
Minneapolis, MN 55413**

Map to Search Institute

**612-376-8955
or
800-888-7828**

When the ECDAF is linked to the recently formulated *Developmental Assets framework for middle childhood* and the well-established *youth Developmental Assets framework*, a powerful, practical, and unified approach to the healthy growth and well-being of young people across the first two decades of life is available.

[Back to Top](#)

What is the Early Childhood Developmental Assets Framework (ECDAF)?

The Early Childhood Developmental Assets Framework (ECDAF) contains a set of Developmental Assets, the essential ingredients of development, that research shows are crucial for young children's healthy and positive growth. These include a wide array of experiences that directly promote the physical, social, emotional, and cognitive development of young children, attributes that contribute to school readiness, school success, and happy and productive lives for young children.

The development assets framework consists of specific assets, organized under two major categories, *internal* and *external*.

External assets are environmental actions or factors that provide young children with *support, empowerment, boundaries and expectations, and constructive use of time*. *Support* refers to the ways children are nurtured and cared for by their families and other adults in the extended family and community. *Empowerment* refers to opportunities even young children have to make meaningful contributions and to feel valued, as well to their families having the necessary resources they need to provide well for both their children and themselves, including adequate health care. *Boundaries and expectations* clarify expectations for appropriate behavior in various settings, and encourage children to become as competent as they can. *Constructive use of time* refers to time spent in meaningful, developmentally appropriate activities provided either at home or by the community, including organized early childhood care and education programs.

Internal assets are attributes and qualities that emerge over time with assistance of the adults, peers, neighbors, and community members that make up young children's world. There are four categories of internal assets: *engagement in learning, positive values, social competencies, and positive identity*. *Engagement in learning* refers to curiosity, interest, and involvement in developmentally appropriate activities, with emphasis on play and literacy development. *Positive values* focus on development of behaviors such as caring, empathic concern for others, and acceptance of differences among people. *Social competencies* are those interpersonal skills young children need to develop positive relationships and that are crucial to setting the pathway for school success and overall positive development. *Positive identity* pertains to how children feel about themselves, including a sense of efficacy, positive self-esteem, and a

sense of purpose.

Download the [ECDAF table in PDF form](#).

[Back to Top](#)

What is special about the ECDAF?

There is a good empirical basis for assuming the Developmental Assets are interconnected. As a result, the presence or acquisition of any particular asset is likely to contribute to and reinforce the attainment of other Developmental Assets. Moreover, the more Developmental Assets, both external and internal, a young child possesses, the more likely s/he is on a positive developmental course. Specifically, the ECDAF:

- **Defines holistic development** by providing a comprehensive list of developmental ingredients touching all important developmental areas that are needed to raise healthy young children.
- **Emphasizes thriving and strengths** by supporting the positive and optimal growth of young children and enabling everybody involved with young children to recognize their role and responsibility in fostering developmental well-being.
- **Promotes resilience** by highlighting the qualities and features that help make young children resilient even when they encounter situations that put them developmentally at risk.
- **Addresses the total environment of the child** by offering a set of ideas around which parents, neighbors, and communities can positively influence the health, character, and vitality of young children and their families.
- **Promotes smooth transitions** by encouraging the development of all the research-based attributes young children need to successfully enter primary school and learn.
- **Enhances accountability** by providing an extensive list of developmentally sound and empirically based elements that can guide and shape early childhood indicator activities.
- **Fosters the establishment of community systems** by cataloging the factors that are needed to design and implement a community infrastructure that supports the development of young children.

[Back to Top](#)

The production of the ECDAF

This document was prepared by Karen VanderVen, Ph.D., Senior Visiting Fellow, Search Institute, and Professor, Psychology in Education, University of Pittsburgh; and Marc Mannes, Director of Applied Research, Search Institute. We wish to acknowledge the thorough review and high-quality suggestions made by Nina Sazer O'Donnell, Vice President, Family and Work Institute.

Feedback was sought and utilized throughout the process of creating the ECDAF from individual and group meetings and presentations with recognized experts in early childhood care and education and child development, as well as Search Institute staff. Special appreciation is extended to the following individuals:

- Annie Borja, United Way of America Success by Six, Washington, DC
- Sue Bredekamp, Director of Research, Council on Professional Development, Washington, D.C.
- Diana Dalsin, Minneapolis YMCA, Minneapolis, MN
- Kay Hong, Senior Projects Editor, Office of the President, Search Institute, Minneapolis, MN
- Ted Jurkiewicz, Technical Research Associate, High/Scope Research Foundation, Ypsilanti, MI
- Linda Likins, National Director, Devereux Early Childhood Initiative
- Eugene Roehlkepartain, Senior Adviser to the President, Search Institute, Minneapolis, MN
- Edna Runnels Ranck, Senior Research Associate, Early Childhood, Westover Associates, Annapolis, MD
- Nina Sazer O'Donnell, Vice President, Family and Work Institute, New York, NY

We also recognize the important contributions of Arturo Sesma, Applied Developmental Scientist, Search Institute, to the formulation of the ECDAF.

The ECDAF was crafted as part of the First Decade Project, funded by the Donald W. Reynolds Foundation to Search Institute.

[Back to Top](#)

Related ECDAF materials

A more detailed document entitled "The Early Childhood Developmental Assets Framework: Promoting and Facilitating an Ecological Approach to Young Children's Development" is available upon request.

Full elaboration of the concepts underlying the ECDAF and the empirical justification for it will be available in *Building Blocks for a Successful Start: A Comprehensive Approach to Understanding and Promoting Positive Development in Early Childhood*, by Karen Vander Ven. We anticipate this book will be available in 2007.

How can I find out more information about using the ECDAF?

If you or your community want more information about the ECDAF and have an interest in using it, please contact Marc Mannes at 612-692-5536 or marcm@search-institute.org.

