Supporting Whole Child Health in Early Childhood

A Scan of Early Care and Education Settings in Monroe County

Prepared for:

greater rochester Health foundation

Prepared by:

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Innovative Solutions in Human Service Delivery

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BACKGROUND

Early childhood development is critical for later positive developmental, social, physical health, and mental health outcomes (National Scientific Council on the Developing Child, 2007). During these early years, brain development is incredibly rapid; by age 6, children have developed 95% of their peak cerebral volume (Giedd et al., 2009). Healthy early relationships, in particular, lay the architecture of the brain and influence a range of outcomes for years to come – from cognitive skills and school performance to socio-emotional well-being and mental health (see National Scientific Council on the Developing Child, 2004). Fostering the relationships of young children with adults who care for them is thus an important area of focus for early childhood service delivery.

The majority (61%) of children under five in the United States are placed in some type of regular care arrangement outside of parental/guardian care (Laughlin, 2013). Early care and education (ECE) includes a range of settings, including day care centers, family child care, prekindergarten, nursery schools, Head Start[1], and legally exempt care[2] (NY State Office of Children and Family Services, 2016).

Young children spend a significant amount of time in ECE settings. In New York State, 57% of children under five of employed mothers spent 35+ hours in nonparental care (Capizzano & Adams, 2000). More recent data suggests that children under five spend on average 33 hours per week in ECE settings (Laughlin, 2013).

Research has demonstrated an impressive return on the billions of dollars invested in ECE. This includes a robust return as measured by improved education, employment, health, and reduced crime outcomes for children who attend ECE (Elango, Garcia, Heckman, & Hojman, 2015). The return on investment for high-quality ECE is upwards of 13.7% per year (Garcia, Heckman, Leaf, & Prados, 2016).

High-quality ECE is especially important for children with primary caregiver-related risk factors (e.g., parental insensitivity, poor modeling of social maturity), as quality ECE can buffer their negative effects. Children with both primary caregiver-related risk factors and who utilize low-quality ECE show the highest levels of behavior problems and lowest prosocial behaviors (Watamura, Phillips, Morrissey, McCartney, & Bub, 2011). Ensuring high-quality care is therefore imperative in preventing challenges in later childhood and in intervening with children who require services.

[1] Head Start is a federally-funded ECE program for children in low-income families.

[2] Legally exempt care includes informal child care of up to two children, in addition to the provider's own children. These providers can qualify for subsidies. Specific definitions of all types of childcare offered in New York State are provided by the Child Care Council here: https://childcarecouncil.com/wp-content/uploads/2014/09/Types-of-Child-Care.pdf

Despite evidence for the importance of ECE, professionals in the early care field are paid less and receive less training than teachers of school-age children (see Phillips, Austin, & Whitebook, 2016). Early care staff tend to be paid close to minimum wage. One report found that only five states paid child care workers enough to meet livable wage standards; 75% of New York center-based staff earn less than $15 per hour, with 91% of staff who work with infants and toddlers earning less than $15 per hour (Whitebook, McLean, Austin, & Edwards, 2018). Pay varies across ECE settings, with non-school-based settings typically offering lower pay for ECE staff than school-based programs (McLean, Dichter, & Whitebook, 2017). While several states and cities are testing approaches to provide better compensation for pre-K teachers (creating parity with Kindergarten teachers), they have faced challenges in creating parity in benefits and they have struggled to create parity in salaries for non-school-based settings where the pay gap is typically greater (McLean, Dichter, & Whitebook, 2017). Programs such as WAGE$ offer salary supplements for teachers who earn higher credentials, but this is merely a wage supplement and not a raise in pay (Child Care Services Association, 2018). Early care settings also require less training than elementary, middle, and high school educators. This contrast has roots in the historical devaluation of early care, which unlike school-age education, has remained predominantly in the private sphere (U.S. Department of Education, 2010).

The quality of care also ranges drastically across settings. While there are safety and training regulations at the state and county levels, there is a high level of heterogeneity within types of settings (e.g., across legally exempt and non-legally exempt home-based care; National Survey of Early Care and Education Project Team, 2016) and between settings (e.g., between home-based care and child care centers). A recent report by Public Sector Consultants (2018) indicates that barriers to high-quality ECE in Western New York include: limited use of the state-level quality rating system and therefore limited ability of families to assess quality; limited number of accredited and high quality-rated providers; the high cost of care for families and decline of number of providers; and difficulty attracting skilled staff to ECE. Parents and caregivers therefore are faced with a daunting task of identifying ECE that will promote their child's development and help them flourish during this critical period.

The challenges and unmet needs in Monroe County, NY, can be best understood within the greater context of New York States' allocation of funds for ECE. Though New York State spends approximately $3 billion on early childhood learning (e.g., Head Start, state child care subsidy program, preschool special education, professional development), New York spends seven times *less* on all public spending for children five and under (including early learning, home visiting, health, family-based programs, and infrastructure/governance) than it does for the public school education of children 6-18 (Augenblick et al., 2015). New York has not yet conducted data analysis (e.g., reports with statewide data, studies of unmet needs, analysis of program data, and provider surveys) of child care supply needs to determine which children are currently not being served effectively in early childcare (Banghart, King, Partika, & Perkins, 2018).

Within this context, stakeholders in Monroe County are working to address the needs of young children. The Rochester community has made strides in increasing screening for physical, behavioral, and mental health challenges with initiatives and collaborative community efforts supported by groups such as ROC the Future and the Early Childhood Development Initiative. For example, through the GROW-Rochester initiative launched in 2015, the Children's Institute has coordinated increased hearing, vision, dental, language/speech, cognitive, and social-emotional screenings for over 1,000 three-year-olds in Rochester (Children's Institute, n.d.). Yet the need is still great. The Children's Agenda (2018) found that 20% of children in Monroe County aged three and younger spent time on a waiting list for early intervention services in 2017 and approximately 10% of preschool age children were waiting to receive special education services in March 2018. The wait time from referral to resolution (e.g., service eligibility determination) for young children is approximately 208 days[3] (Children's Institute, personal communication, September 13, 2019). Stakeholders continue to work towards improving this system for its youngest children.

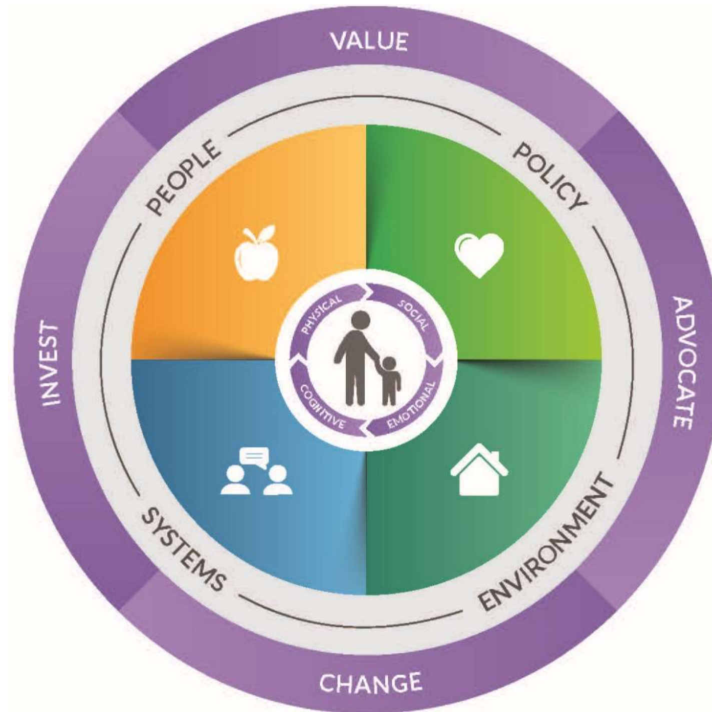
With its Healthy Futures strategy, the Greater Rochester Health Foundation has launched an initiative to improve the health and well-being of children 0-8. They have identified four whole child health components shown in the graphic below[4]: (1) foster healthy relationships, (2) create safe and secure environments and psychological safety, (3) cultivate skills and competencies, and (4) build healthy habits.

This scan seeks to provide information for the Healthy Futures initiative of the Greater Rochester Health Foundation to inform its funding to support whole child health in the early years.

[3] However, this number did not take into account children whose cases were still open, and thus this number is a low estimate.

[4] Due to the timing of data collection, the groups responded to a previous version of this graphic and whole child health definitions.

Whole Child Health Graphic from the Greater Rochester Health Foundation[5]



	Foster healthy relationships. Consistent, supportive relationships with caregivers, families, other adults and peers lay the foundation for the development of strong brain architecture and support learning, social-emotional well-being, and resilience.
	Create safe and secure environments and psychological safety. Safe environments limit children's exposure to violence and other trauma, physical injury, environmental risks, and other threats to healthy development, and enable children to fully engage in learning and play.
	Cultivate skills and competencies. Through play as well as developmentally and culturally appropriate instruction, children develop the social-emotional competencies, literacy and other core academic skills that foster achievement and well-being throughout life.
	Build healthy habits. Effective teaching and modeling as well as access to healthy food and spaces for play foster healthy eating, physical activity, adequate sleep and other habits that contribute to lifelong physical and mental health.

[5] Due to the timing of data collection, the groups responded to a previous version of this graphic and whole child health definitions.

CURRENT SCAN

Coordinated Care Services, Inc. (CCSI) was awarded a contract from the Greater Rochester Health Foundation to conduct a scan of ECE settings in Monroe County.

The objectives were to help the Greater Rochester Health Foundation identify:

a) **potential pilots** that will further support organizational practice changes around whole child health components described above;

b) **training and coaching needs** related to whole child health components within ECE settings; and

c) **policy changes** that would support whole child health components.

To meet these objectives, the scan has five specific aims, for which we used the following data sources and present information in the following report sections:

Aim	Data Source	Report Section
(1) To gather Monroe County data to support the scope of understanding of ECE settings	• Demographic data from public datasets • Provider data from the Child Care Council and the Office of Children and Family Services (OCFS)	Monroe County Data
(2) To gather national best practice information on whole child health components in ECE settings	• Interviews and focus groups with key informants, administrators, direct care staff, and parents • Literature review	Organizational Data (see Appendices 3-4)
(3) To gather organizational data related to whole child health components (including how ECE settings are currently supporting whole child health and what challenges they face)	• Interviews and focus groups with key informants, administrators, direct care staff, and parents • Parent survey	Organizational Data
(4) To identify which systems, if any, ECE settings use to record, monitor, or evaluate whole child health	• Focus groups	Organizational Data
(5) To offer recommendations to the Foundation	• All	Recommendations

We further describe these data sources and present our key findings below. This was an exploratory study, limited to the scope identified above. It is important to note that due to the timeline of the contract, the focus groups were held in June which is the end of the school year. This may have limited participation in the focus groups, which might not be representative of all stakeholders. Findings should be understood in the context of these limitations.

MONROE COUNTY DATA

A Snapshot of Young Children in Monroe County

To better understand the population of children in ECE settings, we obtained publicly available population and demographic data for children (under age 5 when available) in Monroe County.

Demographic Information

An estimated 5.5% (*n* = 41,381) of the population in Monroe County were under age 5 and 6.8% (*n* = 51,110) were under age 6 in 2016. Of all children under age 5 in Monroe County, approximately 24% (*n* = 9,899) were living in poverty.

Of children under five years of age, the majority of children were identified by their parents/caregivers as white (65%), with 22% Black/African American, 4% Asian, 1% American Indian/Alaskan Native, 3% "Other," and 6% identified as two or more races. Of children of any race, 13% were identified by their parents as Hispanic or Latino and 58% were identified as White, Non-Hispanic/Latino.

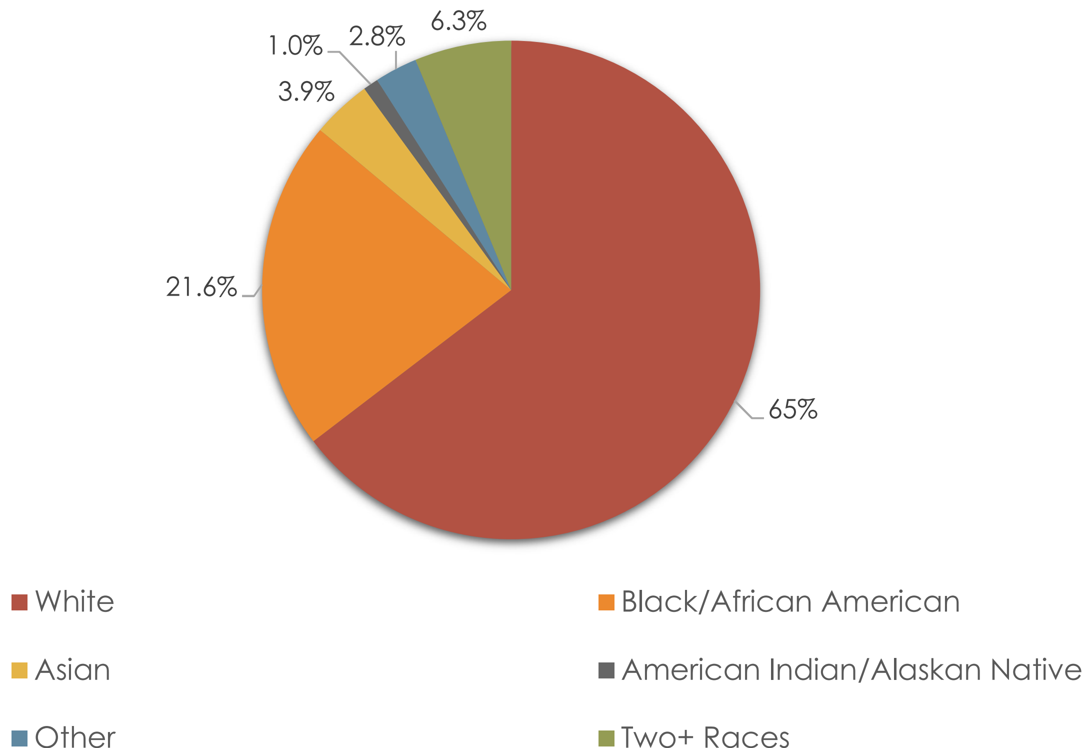
Table 1 depicts racial/ethnic disparities in income status. For example, 65% of children under five are white, but only 10% of children under five living below the poverty line are white; 22% of children under five are Black/African American, but 35% of children under five living below the poverty line are Black/African American; only 6% of children under five are multiracial, but 26% of children under five living below the poverty line are multiracial. Similarly, only 13% of children under five are Hispanic/Latino, however, 34% of children under five living below the poverty line are Hispanic/Latino.

Table 1. Demographic Information of Young Children in Monroe County

Demographics	Total		Below Poverty Line	
	N	(%)	N	%
Race	41,743	100%	~10,573	25.3%*
White	27,132	65%	~1,025	9.7%
Black/African American	9,016	22%	~3,648	34.5%
American Indian/Alaskan Native	209	1%	~4,197	39.7%
Asian	1,628	4%	~1,903	18.0%
Native Hawaiian/Pacific Islander	0	0%	~0	0%**
Other	1,169	3%	~3,479	32.9%
Two+ Races	2,630	6%	~2,749	26.0%
Hispanic Ethnicity				
Hispanic or Latino (of any race)	5,552	13%	~3,574	33.8%
White alone, not Hispanic or Latino	24,211	58%	~877	8.2%

*This number varies slightly from the 24% of children under five living in poverty listed above because this table is based on estimates of all children under 18, for example, 9.7% of all children under 18 living below the poverty line were identified as White.
**8.5% of children under 18 were identified as Native Hawaiian; however, since no children under five were identified as Native Hawaiian, this estimate was changed to 0. Population size estimated based on projections from 2010 census data. Monroe County, NY. (n.d.).
Race and ethnicity information retrieved from
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
Poverty information retrieved from https://datausa.io/profile/geo/monroe-county-ny/#medicare_geo

Figure 1. Race Information for Children Under 6 in Monroe County



Health Indicators

Table 2 depicts health information of young children in Monroe County. Heath indicators suggest that almost all (98.6%) children under age 6 in Monroe County have health insurance. Over half of children with health insurance reported having private coverage (60.8%, *n* = 29,737).

There is pronounced disparity whereby Black/African American mothers have the lowest rates of prenatal care and highest rate of infant mortality. As shown in Table 2, the rate at which mothers receive prenatal care in Monroe County is 70%, 75%, and 87% for Black/African American, Hispanic, and White mothers respectively. The rate of

infant deaths per 1,000 live births was 14.6 for Black infants, 11.6 for Hispanic infants; and 4.5 for White infants. This is in line with a significant body of research documenting marked racial/ethnic health disparities in obstetric care and infant mortality, with Black women at greatest risk for a wide range of poor birth outcomes (Anderson et al., 2017; Bryant et al., 2010; Hauck, Tanabe, & Moon, 2011; MacDorman, 2011), as well as research exploring how racism and discrimination contribute to negative maternal and child outcomes (Giurgescu et al., 2011; Schetter & Tanner, 2012; Spong et al., 2011).

Table 2. Health Information of Children Under 6 in Monroe County (Estimated *n* = 49,609)

Variable	
Insurance*	N
No Healthcare Coverage	683
Healthcare Coverage	48,926
Private Coverage	29,737
Employer Based	26,380
Direct-Purchase	3,125
VA	57
Tricare/Military	874
Public	21,881
Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability	21,881
Medicare (for children with certain disabilities)	54
Asthma Hospitalizations: Number and rate/10,000	
0-4-year-olds	94/10,000
Infant Mortality: Number of deaths of infants under 1 year per 1,000 live births by race/ethnicity**	
Black/African American	14.6/1,000
Hispanic	11.6/1,000
White, Non-Hispanic	4.5/1,000
Mothers with Prenatal Care by Race/Ethnicity***	
Black/African American	70%
Hispanic	75%
White	87%

View All KWIC Indicators: Monroe County. (n.d.). Retrieved from http://www.nyskwic.org/get_data/county_report_detail.cfm?countyid=36055&profileType=8&Go.x=16&Go.y=9&Go=Go
*Percentages and numbers may add up to more than 100% for health insurance coverage because adults/families can choose multiple types of insurance coverage.
**ACT Rochester - Community Indicators for the Greater Rochester Area | An Initiative of Rochester Area Community Foundation. (n.d.). Retrieved from http://www.actrochester.org/children-youth/child-health/infant-mortality-rate/infant-mortality-rate-race-ethnicity-monroe-county
***ACT Rochester - Community Indicators for the Greater Rochester Area | An Initiative of Rochester Area Community Foundation. (n.d.). Retrieved from http://www.actrochester.org/children-youth/child-health/prenatal-care/prenatal-care-by-race-ethnicity/data-tables

Education Indicators

Education indicators suggest that kindergarten readiness is a significant area of need in the City of Rochester. The Child Observation Record (COR) Advantage is one tool used to assess children's development in areas considered necessary to be successful in the classroom. Using COR, by the end of pre-K, approximately half (53%) of all children in Rochester public pre-K programs passed the kindergarten readiness screening.

Table 3 depicts school readiness indicators in Rochester City Schools. Children scoring at least 3.75 out of 5 in each area (and 4.0 overall) are considered ready for kindergarten. The scores for each category in this table represent the average scores of pre-K students in the City of Rochester in Spring 2016. Within specific domains, the highest average COR score was in physical development and health (5.1) and the lowest average score was in language, literacy and communication (4.2), suggesting that language and reading skills are an important area to target in Rochester pre-K programs.

Table 3. School Readiness in Rochester City Schools

Educational Functioning	Fall 2015		Spring 2016	
	Score	%	Score	%
School Readiness in Rochester City Schools				
Pre-K Students – Passed Developmental Screen*				63%
Pre-K Enrollment (% 4-yr-olds)**				75%
School Readiness by Category in Rochester City Schools***				
Approaches to Learning	2.9		4.4	
Social-Emotional Development	2.84		4.38	
Physical Development and Health	3.34		5.06	
Language, Literacy and Communication	2.7		4.17	
Mathematics	2.65		4.37	
Creative Arts	3		4.63	
Science and Technology	2.77		4.42	
Social Studies	2.74		4.37	
Overall Score	2.87		4.48	
Ready for K		1%		53%

*ACT Rochester - Community Indicators for the Greater Rochester Area | An Initiative of Rochester Area Community Foundation. (n.d.). Retrieved from http://www.actrochester.org/education/school-readiness/school-readiness-screening/data-tables

**ACT Rochester - Community Indicators for the Greater Rochester Area | An Initiative of Rochester Area Community Foundation. (n.d.). Retrieved from http://www.actrochester.org/education/school-readiness/prekindergarten-enrollment/data-tables

***ACT Rochester - Community Indicators for the Greater Rochester Area | An Initiative of Rochester Area Community Foundation. (n.d.). Retrieved from http://www.actrochester.org/education/school-readiness/childrens-developmental-levels/charts

While much of the available school readiness data is focused on the child, the ROC the Future School Readiness CAN (Collaborative Action Network) has identified four types of school readiness measures, which it is working to assess: (1) community indicators ("Does our community have sufficient capacity of quality resources and services to support school readiness?"); (2) school indicators ("Are schools in our community ready to support and serve each child who arrives at their door?"); (3) family indicators ("Are families in our community supporting the school readiness and general development of their child[ren]?"); and (4) child indicators.[6]

More broadly, in Monroe County, only 41% (*n* = 3,416) of all 4-year-olds are enrolled in public pre-K programs (compared to 75% in the City of Rochester).

A small percentage of children utilize early intervention services (1% of children under 2, and 4.3% of children under 4, respectively, as shown in Table 4) in Monroe County. Over a third (37%) of children in pre-K in the City of Rochester were considered delayed or below expectations on the BRIGANCE Early Childhood Screen III, which measures approaches to learning, academic competencies (i.e., literacy, math, science), and social, emotional, and physical health and development. Of all children screened and identified with possible needs, 81% (*n* = 348) remained open as of the end of the 2017-2018 school year without any resolution (Children's Institute, personal communication, September 13, 2018).

Table 4. Early Intervention in Monroe County

Early Intervention in Monroe County*	
Percent of children < 2 in EI	1.0%
Percent of children < 4 in EI	4.3%

*United States, New York State Department of Health, Division of Family Health Bureau of Early Intervention. (n.d.). State Performance Plan for the NYS Early Intervention Program FFY 2005 - 2010 (p. 43). Retrieved from https://www.health.ny.gov/community/infants_children/early_intervention/docs/2005-2010_state_performance_plan.pdf.

[6] A draft of the CAN's school readiness measures is linked here: http://rocthefuture.org/our-priorities-school-readiness-collaborative-action-network

Parent Demographics

Unfortunately, the Child Care Council and OCFS do not keep extensive records on the demographics of children in care. Of parents who requested referrals from the Child Care Council in the past 12 months, approximately 26% of parents identified as White, 17.5% identified as Black or African American, and 1% identified as Asian (i.e., Indian, Chinese, Filipino, Vietnamese). Approximately 7% identified as Hispanic/Latino. However, parents are not required to provide demographic information to the Child Care Council, and thus 53.5% of parents did not report their race and 57.9% did not identify their ethnicity. Over half (53.7%) of parents who requested referrals were living below the NY state poverty line.

See Appendix 1: Monroe County Data Tables for more detailed information on parent demographics.

Providers in Monroe County

Tables 5 and 6, provided by the Child Care Council, give an overview of the ECE providers in Monroe County as of June 2018.[7] Contact information for Directors can be found (in a downloadable format) at: https://data.ny.gov/Human-Services/Child-Care-Regulated-Programs/cb42-qumz.

Table 5. Number of Licensed/Registered Programs, Monroe County

Modality	Total Programs
Day Care Centers	129
Family Day Care	346
Group Family Day Care	227
School Age Child Care	70
Head Start	5
Total	**777**

Based on currently licensed/registered programs in Monroe County. Head Start Centers separated from Day Care Centers.
Table provided by Child Care Council June 2018.

Table 6 indicates that there are 28,833 spots available for the approximately 41,381 children under five in Monroe County. However, this gap in availability compared to the number of young children who may need care does not take into account families

[7] This information can also be compiled from: https://data.ny.gov/Human-Services/Child-Care-Regulated-Programs/cb42-qumz

who choose to remain at home to care for their children and choose to not utilize formal early childhood care.

Table 6. Sum of Capacities by Age Group, Monroe County

Modality	Preschool Capacity	School-Age Capacity	Toddler Capacity	Infant Capacity	6 wks – 12 yrs Capacity
Day Care Centers	5,475	2,730	2,313	1,567	0
Family Day Care	0	692	0	0	2,074
Group Family Day Care	0	794	0	0	2,682
School Age Child Care	0	7,566	0	0	0
Head Start	840	0	68	32	0
Total	**6,315**	**11,782**	**2,381**	**1,599**	**4,756**

Based on currently licensed/registered programs in Monroe County. Head Start Centers separated from Day Care Centers.
Table provided by Child Care Council June 2018.

Tables 5 and 6 include all licensed providers, including Day Care Centers, Family Day Care, Group Family Day Care, School Age Child Care, and Head Start. In addition, there are 1,180 legally exempt providers in Monroe County (per correspondence with the Child Care Council). Legally exempt providers provide care for one to two children in additional to their own children and receive subsidy payments.

Of all legally exempt providers in Monroe County, approximately 17.5% identified as White, 16.6% identified as Black or African American, <1% identified as Native American/Alaskan Native, <1% identified as Asian (i.e., Indian, Chinese, Filipino, Vietnamese), and 1.5% identified as "Other." Approximately 8.6% identified as Hispanic/Latino. However, providers are not required to provide demographic information to the Child Care Council, and thus 81.5% of legally exempt providers did not report their race and 91.4% did not report their ethnicity.

ORGANIZATION DATA

Interviews and Focus Groups

Between May 22 and June 20, 2018, the Early Care Settings Scan team at Coordinated Care Services, Inc. conducted **14 interviews and focus groups** with administrators, direct care staff members, parents of young children (ages 0-5) in care, and "key informants" (experts in the field). The goal was to learn how key stakeholders in Monroe County[8] perceive early care settings are supporting whole child health, challenges to supporting whole child health components, and recommendations for future funding from the Greater Rochester Health Foundation.

We recruited ECE staff and parents of young children (ages 0-5) in care in Monroe County via flyers and emails distributed with the help of the Child Care Council, OCFS, provider groups/councils, and local organizations that serve parents of young children. Staff and parents responded to the flyers and emails by filling out an online form or calling Coordinated Care Services, Inc. to express their interest. We also conducted a focus group with a participant advisory board at a local program that serves mothers of young children.

Direct care staff and parents received $20 for their participation. We also provided child care at three of the four parent focus groups, and the local program that hosted a focus group provided transportation for participants. We held groups at night, during different times of the day/week, and served light meals, as appropriate.

We identified and personally invited key stakeholders for interviews. This included contacts from the Child Care Council, OCFS, and policy experts.

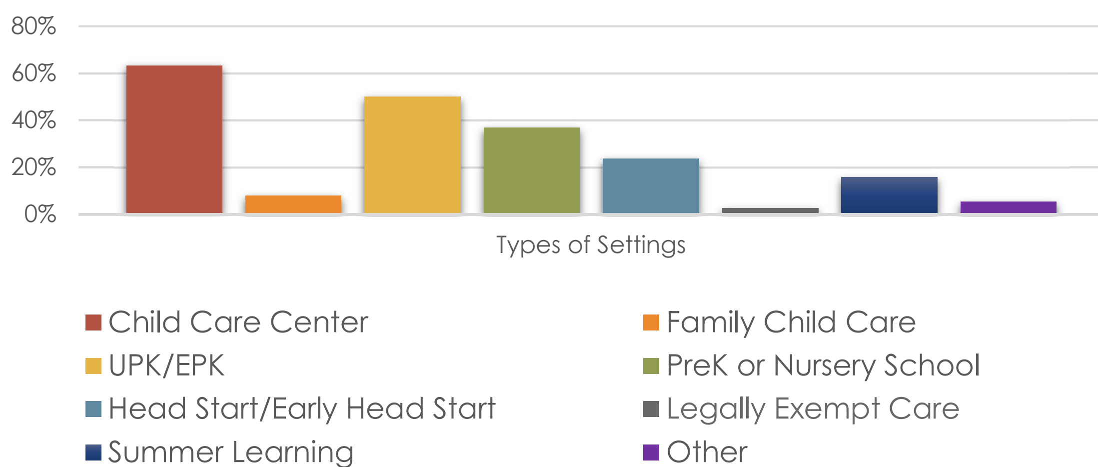
Table 7. Focus Group Participants

Participant Type	Number of Participants	Number of Interviews/ Focus Groups
Key informants	7	5 interviews (1-2 participants each)
Administrators	12	3 focus groups
Direct Care Staff Members	9	2 focus groups
Parents	17	4 focus groups
TOTAL	**45**	**14 interviews/focus groups**

[8] Two key informants were in Washington, DC. They offered insight into national ECE policy.

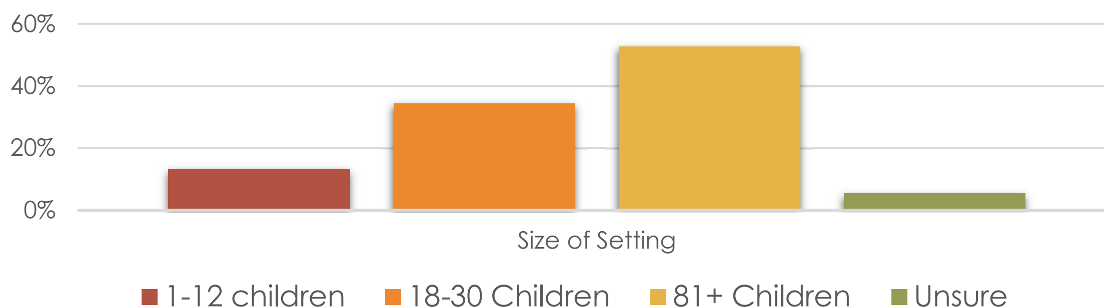
Focus group participants represented a range of child care settings, including child care centers, prekindergarten/nursery schools, summer learning programs, Head Start/Early Head Start, universal prekindergarten (UPK), expanded prekindergarten (EPK), family child care, and legally exempt care. Figure 2 shows the percent of the sample represented by each type of care setting and Figure 3 represents the percent of the sample represented by the size of each setting. Generally, over half of participants represented administrators or direct staff who work in, or parents with children enrolled in, large (81+ children) child care centers, though participants represented a range of voices from varied setting types and sizes.

Figure 2. Early Care Settings Represented by Focus Group Participants (*n* = 38)



Note: Percentage of early care settings represented adds up to greater than 100% because participants were able to identify having experience with multiple settings (e.g., parents with multiple children in various levels of care, and settings that provide multiple types of care).

Figure 3. Size of Focus Group Participants' Early Care Settings (*n* = 38)



Note: Percentage adds up to greater than 100% because participants were able to identify having experience with multiple settings (e.g., parents with multiple children in various levels of care).

See Appendix 2: Participant Settings for more information on the types and sizes of settings represented in this scan.

Participants highlighted the following successes, challenges, and recommendations for supporting whole child health in ECE settings:

Successes: Promising Programs and Practices

Key informants, administrators, direct care staff, and parents described many ways that ECE settings promote whole child health:

- **Healthy relationships:**
  - **Caregiver-child relationships[9]:** Providers place a strong emphasis on supporting staff to retain them, as staff turn-over is a barrier to developing healthy and long-lasting caregiver-child relationships. This includes efforts to make staff feel valued such as supporting them when they need assistance (e.g., carpooling and providing bus passes when staff face transportation issues; and giving staff time off when needed). A limited number of providers use continuity of care and primary caregiving as described in Appendix 3: Promising Programs and Practices in Monroe County. Key informants and staff described the caregiver-child relationship as the heart of ECE. Parents emphasized the importance of having caring and loving staff who they can trust.
  - **Parent-child relationships:** Providers described offering parent training, rooms where mothers can visit their child during the day to breastfeed, and encouraging parental access to children during the day.
- **Safety and security:**
  - **Physical safety:** Providers described using locked key entry, installing alarms on gates, conducting fire/evacuation drills, and using video recordings of staff with children. There was disagreement about the benefits of video surveillance, with some administrators disliking parents watching the video feed without being able to hear the audio to understand the full context of the situation. Others liked having the video saved if there was an incident. While some parents liked the ability to watch a video feed, others thought it was distracting.

[9] "Caregiver" refers to the staff person who cares for the child. "Parent" refers to the child's primary caregiver/guardian.

- **Emotional safety:** When asked about emotional and psychological safety, providers emphasized that this goes hand in hand with building healthy relationships. By building healthy relationships as described above, providers support the psychological safety for children in care—encouraging them to express their emotions and to try new things (e.g., tasting new foods, trying new activities).

- **Healthy habits:**
  - **Nutrition:** Providers described using family-style dining, putting out informational displays, banning sweets for birthdays, providing fresh and balanced meals, and encouraging children to eat fruits and vegetables and try new foods. Administrators described having to gently suggest healthy choices to parents whose children bring unhealthy snacks and food to their setting, describing the challenge of being respectful while also giving guidance to parents.
  - **Hygiene:** Providers reported a focus on handwashing and toothbrushing. Children in Head Start classrooms are required to brush their teeth once a day in care, and staff described this as an enjoyable activity for the children.
  - **Physical activity:** Providers described having gross motor rooms if possible for indoor play and utilizing outdoor spaces. Participants emphasized the importance of having staff engage in outdoor play rather than simply watching children on playground equipment.
  - **Sleep:** Providers described a focus on naps and giving guidance to parents on night-time sleep habits. Administrators described offering advice to parents about their children's sleep routines, noting that many children use technology to fall asleep at night.

- **Skills:**
  - **Social-emotional, cognitive, and literacy skills:** Providers described teaching children breathing and conflict resolution techniques, and promoting cognitive and literacy skills through play. Direct care staff expressed some concerns regarding the best strategy for developing cognitive and literacy skills. While key informants, administrators, and many direct care staff were in favor of curriculums that emphasize learning through play, some direct care staff suggested that children need exposure to traditional academics at a young age. Nearly all participants emphasized how important social-emotional skills development is, as the root of *all* skill development.

While most parents were unfamiliar with the specific programs and curriculums being used, they spoke to the importance of these practices, with a strong emphasis on building healthy relationships and safety. They strongly emphasized the importance of providers creating a loving, welcoming, and safe environment for their children. Some specifically stated that this is more important to them than any curriculums or skill development – that they want to know their children are loved and safe in their absence.

Key Finding #1: Many promising programs and practices that support whole child health are currently utilized in Monroe County, or have been in the past.

Key informants, administrators, and direct care staff identified numerous programs and practices as promising approaches to supporting whole child health. They emphasized that these could be expanded with additional funding. **See Appendix 3**: Promising Programs and Practices in Monroe County for descriptions of these programs and practices.

"The infrastructure is there. We have early learning guidelines. We have a core body of knowledge. We have the CDA [Child Development Associate credential]." "And we have training and coaching and we have Pyramid. But… [these models and training programs are] underfunded." – Key Informants

They identified the following challenges to implementing the programs and practices in Appendix 3:

- **Expense:** This is the greatest barrier. Programs are expensive because they require the purchase of curriculums, staff training, and in some cases, consultants/additional staff. Some additional examples of financial barriers include: Continuity of care and primary caregiving are expensive because it is difficult to keep enrollment high when children are not moved to different classrooms based on capacity. Administrators also perceive additional expense to being culturally responsive (e.g., having vegetarian or ethnic food options etc.) when feeding large numbers of children.
- **Buy-in:** Staff described challenges in getting buy-in from staff and parents when implementing new programs and practices.
- **"Paperwork:"** Staff noted the amount of "paperwork" and "hoops to jump" to participate in programs – for example, they noted this of the Child and Adult Care Food Program (CACFP). Providers also need to go through an additional approval process with OCFS to implement continuity of care and primary caregiving

practices (described in Appendix 3), which is seen as a barrier even though providers are being encouraged to implement these practices.

- **Lack of awareness of available programs:** Some providers are unaware of available programs – for example, participants thought that many legally exempt providers do not even know about CACFP.

Administrators also described participating in and receiving support from **coalitions and professional groups**:

1. National Association for the Education of Young Children (NAEYC) (www.naeyc.org), which has a local Rochester chapter;
2. Early Childhood Education Quality Council (ECEQC) (www.childrensinstitute.net/about-us/our-partners/eceqc);
3. QUALITYstarsNY, New York State's Quality Improvement and Rating System, which provides resources and supports to those who voluntary participate to improve their quality of care;
4. Early Childhood Development Initiative (ECDI) (http://ecdi-rochester.org); and
5. Local provider groups including (a) an administrator's group led by the President/CEO of Imagination Childcare Academy, Inc. and (b) a family and group providers group led by the owner of Nancy Family Daycare Inc.

Key informants and administrators spoke very highly of the education opportunities through NAEYC, the support from ECEQC and QUALITYstarsNY, the coalition-building efforts of ECDI, and the support from the local provider groups. The key informants with policy expertise emphasized the importance of utilizing such coalitions in the Foundation's efforts, for example by seeking their input, buy-in, and support of the Healthy Futures initiative.

However, some key informants and administrators expressed concern that many child care settings – in particular rural, private centers and home-based care – are not involved in these coalitions and professional groups. They urged the Foundation to also find ways to reach out and support those settings who might not be present at these tables. The provider groups described above likely better reach those settings.

In our review of promising practices and programs being used nationally, we also identified several models that are being used elsewhere, and not in Monroe County. **See Appendix 4**: Promising Programs and Practices Outside Monroe County for descriptions of these programs and practices.

See Appendix 5: For More Information on Promising Programs and Practices for a list of resources.

Challenges and Needs

Key informants, administrators, direct care staff, and parents also described many challenges in promoting whole child health in ECE settings:

Key Finding #2: These promising programs and practices have been underfunded and need expansion to additional settings and in length of implementation.

"There are a lot of great programs… They're like year projects. That's the hard thing. You get this project for a year and then they go away… So many things come [and go]… Consistency is what I'm looking for. Not we'll put all our focus on the [new] model and then it will disappear. [There's] an expensive training piece [for new programs]."
– Administrator

- There are many high-quality programs "that work" and resources/curriculums/materials that have been developed in this field. However, funding is inconsistent:
  - Often programs are piloted for a **short period of time**. This is a challenge given the expense of training staff and implementing a new model.
  - Often funding does not support programs with **enough reach and depth** across the county. Programs are often piloted in a select group of settings; eligibility requirements often limit which settings can implement the program; and sometimes eligible providers (especially smaller centers, and home-based/legally exempt providers) are not even aware of a program (e.g., CACFP).
- Key informants, administrators, and direct care staff noted the difference in resources for programs based on their funding streams and pointed to **Head Start as model of a high-quality program** providing much needed support to low-income families. Head Start is a federally-funded program designed to "break the cycle of poverty," promoting school readiness for children in low-income families by supporting their emotional, social, health, nutritional, and psychological needs (Office of Head Start, 2018).
  - They noted a high level of service provided through Head Start. Many focus group participants pointed to Head Start as an example of a program providing high-quality supports, which are very much needed for families who experience

intergenerational poverty and structural racism. In particular, they highlighted the benefit of Head Start Family Service Assistants dedicated to supporting families.

  - All Head Start programs in Monroe County are located in the City of Rochester. Key informants, administrators, and direct care staff indicated that **legally exempt providers and private centers, located both in the City of Rochester as well as in the suburbs/rural areas,** also provide services to children who have experienced **trauma** and live in **poverty.** These centers do not receive federal and state funding and therefore do not have the same resources to purchase/implement state-of-the-art curriculums, provide family supports, and use assessment tools and tracking systems, etc. They emphasized that children, particularly those with special needs, across the county could benefit from these resources.

Key Finding #3: The largest perceived gaps are in supporting children with intensive behavioral, social-emotional, mental health, cognitive, and physical needs.

- Providers do not feel adequately equipped to work with children with challenging behaviors and children who have experienced trauma. There is a need for increased focus on their **social-emotional health** and fostering resiliency. Providers need training, ongoing coaching, and early childhood mental health consultation to support these children.

"OT and speech, they don't have the providers. They're running out of therapists. And our Special Ed population is rising. By law they are supposed to have 30 days [to be evaluated], and these kids are waiting months…"
– Administrator

- Direct care staff described frustration with the lack of support that they receive in working with children with challenging behaviors. They described the difficulty in teaching a classroom of children when some are struggling with mental health and behavioral issues. They know that often these issues and behaviors stem from trauma and adverse experiences within the home. They suggest they need full-time, on-site **mental health/behavioral health specialists** who can work closely with them in the classroom and directly with the children.

"And mental health for early childhood, that's a big one too. You guys [Head Start administrators] are blessed. Even with my [non-District] UPK program, they say 'we don't have a counselor for UPK.' Yeah but the second they go to kindergarten, they do. I've had kiddos that have lost parents. I've had kiddos that have been homeless. I've had lots of kiddos that have experienced pretty significant trauma and we have no one to send them to."
– Administrator

- An administrator raised concerns that mental health consultants may be limited in the work they can conduct with children who have an Individualized Education Program (IEP) due to a NYS education law. For example, based on one interpretation of the regulation, mental health consultants cannot conduct observations/assessments or offer individual strategies for the child, as this might conflict with their IEP.
- There is a **lack of qualified service providers** (e.g., therapists) available to work with children with special needs. With stagnated reimbursement rates, service providers are closing their doors and young professionals are choosing alternate careers. There is backlog and long wait times for both evaluations and services.
- Providers also do not feel well equipped to care for children with high levels of physical needs, especially with the lack of on-site medical professionals in many programs.
- Parents identified the important role early care providers play in navigating early intervention services, coordinating with providers, and reinforcing therapy practices.

Key Finding #4: There are significant training and coaching needs, including a need for training on trauma-informed care and provider-parent communication.

> *"One of the biggest barriers is the legally exempt community. They don't have as much support and training."*
> *– Key Informant*

- Key informants and administrators suggested that providers need more training on:
    - **Trauma-informed care:** Administrators noted that even staff who work with infants and toddlers need training on this. They emphasized that many of their staff have experienced trauma and this affects their work with children.
    - **Provider-parent communication:** Some strongly emphasized this gap, noting that improving this communication is key to building healthy relationships. They did not know of any available trainings on this important topic.
    - **Infant Mental Health and reflective supervision:** Key informants noted that the New York State Association for Infant Mental Health's new endorsement system (see Appendix 3) requires training, which comes with a cost.
- A few participants suggested that providers need more training on:
    - **Child development:** Some parents perceived that staff do not have a firm understanding of child development, noting that staff judged their children when they exhibited behaviors the parents deem normal behavior for their age (e.g., 3 year-olds "being runners" and "saying 'no.'")
    - **Nutrition and physical activity:** A key informant noted that staff are required to complete training on "nutrition and health needs" (as part of their 30 hours every two years described below), however a training on asthma, for example, could fulfill this requirement. Participants suggested that staff could use more training on physical activity noting that they could use information on facilitating outdoor play.
- There is discrepancy in the training requirements and credentialing of providers. OCFS only requires lead teachers in child day care *centers* to have a Child Development Associate credential (CDA). Some centers require this of all staff. Staff at child day care centers, group family day cares, and family day care homes are all required to complete 30 hours of training every two years, covering a range of topics[10], such as child development, nutrition and health, safety and security, and

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[10] Topics include: principles of childhood development; nutrition and health needs; child day care program development; safety and security; business record maintenance and management; child abuse and maltreatment identification and prevention; statutes and

child abuse. Legally exempt providers, however, are only required to complete 5 hours of online health and safety training.

- It is particularly difficult for home-based providers to attend trainings, especially when they have children in their care all day long. On-site and online trainings are particularly helpful for them.
- While coaching and mentoring are needed, they are time-consuming to implement (e.g., staff are pulled out of classrooms).
- Trainings need to be universally available and accessible. Administrators noted that it would be helpful to have a centralized system for training and that trainings should be available to everyone in the community.

Key Finding #5: Parent engagement is a challenge; few providers are able to offer home visits and parent support staff.

- Providers need to **improve provider-parent communication**.
    - This includes the need for improved communication around screening and evaluation, as this can be a difficult topic to discuss with parents. A key informant noted that staff face challenges not only discussing evaluation results with parents, but also encouraging them to follow up on these assessments when needed.
    - Administrators described the pros and cons of new technology; for example, while many find apps to be useful for parents and staff to communicate during the day, administrators have concerns about blurred boundaries between parents and staff with the rise in social media.

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regulations pertaining to child day care; statutes and regulations pertaining to child abuse and maltreatment; and shaken baby syndrome.

- While many providers have events for parents and staff to mingle, few are able to offer **parent conferences, home visits, and parent support staff**. This requires staff time and training.
    - Providers need additional staff who can focus on working directly with families, like the Head Start Family Service Assistants who provide direct supports to parents in Head Start (e.g., helping them set goals and connecting them with community resources). Family Service Assistants work directly with parents to support their goals (e.g., buying a house, advancing their education, seeking employment).
    - Head Start serves as a model for providing comprehensive and individualized parent supports. For example, both Head Start Family Service Assistants and teachers conduct home visits. They also provide parent classes, parent orientations, and parent groups. In contrast, some private center administrators described not even knowing who to refer parents to when in need of support.
    - If mental health consultants were able to work directly with families (some work only with teachers), they could serve as important supportive resources to parents.

"The biggest thing… is if you can make people feel like they are loved and supported and cared for, we'll be forgiving on other things. So if you're feeling supported and your kid is being nurtured when we're not there – that's the thing it kills us to not be there with them and to be in the dark – so if you can make us feel like we're being supported, then we'll make exceptions for things that go wrong. We will remember how you make us feel."
– Parent

- Some providers perceive parents' limited time and interest in receiving supports as a barrier to parent engagement. While some parents did note that they were satisfied with their level of limited involvement (e.g., dropping off/picking up and sometimes receiving a written report at the end of the day), others suggested that building a community is important to them. They noted it is difficult to build relationships and talk with staff during hectic drop-offs and pick-ups and they wish providers would create more opportunities to build relationships. They emphasized it is important that they feel staff are warm, caring, and supportive.

Key Finding #6: Recruiting and retaining high-quality staff is a barrier, especially due to the low pay of ECE staff.

- Administrators have difficulty recruiting and retaining high-quality staff because **staff pay** is too low (and benefits are often insufficient). Pay is particularly low in private (vs. non-profit) and non-school-based (vs. school-based) centers. Administrators report that highly qualified staff often use the child care position as a stepping stone to entering the elementary school system where the pay and benefits are better.
- Participants across *all* focus groups described a **perceived low level of respect** for child care staff, noting that the profession is not given as much respect as school-age teaching.
- Child care staff need additional supports (e.g., for their own wellness needs). Many are living below the poverty level themselves.
- Staff described relatively simple strategies that make staff feel valued: calling them by their last names (e.g., Ms. Smith), wearing official uniforms, and showing parents results from cognitive skills testing to show it's not "just play." Administrators also described efforts to support staff (e.g., with transportation and time off) as described above.

"Teachers in a child care facility or a day care, we're not viewed as teachers. Our pay is not there. I'm not asking for a lot, but I'm doing this service and sometimes I feel like I'm not getting the benefits, I'm not getting the pay. I'm spending a lot of my own personal money because I'm taking money out of my pocket to provide hands-on [activities] for my kiddos. We're not getting paid what we're worth… I'm not a babysitter. It's an early learning facility. I'm a teacher…. I just don't think we're valued."
– Direct Care Staff

Key Finding #7: Providers face multiple challenges to using data systems to record, monitor or evaluate whole child health, including the cost of these systems. Outside of Head Start, UPK, and Pyramid Model pilot sites, few providers are using data systems to track this information.

Head Start, UPK/EPK, and Pyramid Model sites are required to conduct screenings for children in their care. Other providers are not required to do so, and most are *not* using data systems to record, monitor, or evaluate whole child health.

"Even centers are not really doing [assessments]. And I'm not even talking about family providers… centers, at least they have access to computers. It's more difficult, but I think it's attainable. But you have to have a reason for doing it. It's not required in the regulations, so unless they have some kind of reason to do it. The reason should be that you want to be up with children's development, but that's an extra task for them. Number two, they don't have data systems to then put in place for the follow up. Family providers, their main issue is that they're with kids all day long… the provider has to be able to do [the screening] with the children during the day, but they're the only adult with 6-7 kids at a time." "And it's expensive… and the training that goes along with how to use it."
– Key Informants

Administrators and direct care staff (including those from Head Start, UPK/EPK, and Pyramid Model sites) listed the following assessments and data systems in use in Monroe County:

Assessment tools / instruments / questionnaires / checklists:	Website
Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)	http://www.brookespublishing.com/product/asqse-2
Bracken School Readiness Assessment	https://www.pearsonclinical.com/childhood/products/100000165/bracken-school-readiness-assessment-third-edition-bsra-3.html

Assessment tools / instruments / questionnaires / checklists:	**Website**
BRIGANCE	https://www.curriculumassociates.com/products/BRIGANCEoverview.aspx
CLASS	http://teachstone.com/class
Developmental checklists	Provided by the Center for Disease Control and Syracuse University
High Scope Child Observation Record – COR Advantage	https://highscope.org/assessment/child
PALS (Phonological Awareness Literacy Screening)	https://pals.virginia.edu/public/tools-prek.html
Teaching Pyramid Observation Tool (TPOT)	https://www.brookespublishing.com/product/tpot
The Pyramid Infant Toddler Observation Scale (TPI T OS)	https://childhealthanddevelopment.files.wordpress.com/2011/06/tpitos.pdf

Systems	Website
Child Plus (e.g., used in Early Head Start and Head Start)	https://www.childplus.com/schoolreadiness
COMET	http://www.comet4children.com
RECAP	https://www.childrensinstitute.net/programs-and-services/recap

Participants identified the following barriers and challenges to using these systems:

- Cost of data systems and assessment tools;
- Cost of training around how to use assessment tools, which can be complex;
- Lack of time to complete assessment tools (especially for family providers who are with children all day);
- Insufficient technology (e.g., for recording data electronically; some are recording by hand);
- Lack of follow-up options when needs are identified, due to a dire lack of providers; and
- Perceived difficulty in following up with parents if screening identifies a need for services (see description of provider-parent communication above).

Funding Recommendations from Key Stakeholders

Participants recommended the following for future funding:

Recommendation #1: Use funding to expand promising programs and practices, especially those focused on:

- **supporting children with intensive behavioral, social-emotional, mental health, cognitive, and physical needs (e.g., mental/behavioral health consultants and on-site pediatric nurses);**
- **supporting parents (e.g., parent support staff, parent training, and emergency/back-up care); and**
- **supporting legally exempt providers (e.g., Staffed Family Child Care Networks).**

- Noting that there is no need to "reinvent the wheel," key informants, administrators, and frontline staff suggested expanding the programs and practices in Appendix 3. While some suggested funding could go towards programs that cover multiple areas, others suggested it might need to be funded in pieces (i.e., multiple programs that touch upon specific whole child health components).
- In particular, participants across groups suggested approaches focused on:
  - **Supporting children with intensive behavioral, social-emotional, mental health, cognitive, and physical needs**, such as:
    - Mental health/behavioral health specialists/consultants, including specialists who work directly with children and families, and not just those who consult with the teacher. Both administrators and direct care staff strongly emphasized this point, noting it is best when the specialists can model strategies in the classroom, in the moment and over time, rather than provide a checklist of strategies. Some suggested that specialists with a clinical/therapy background would be best (including those trained in play therapy). An administrator emphasized that this is especially important when staff and children experience trauma. They also noted that this should include specialists who work with children ages 0-3, as many only work with children ages 4-5; and
    - On-site pediatric nurses (and ideally physical, occupational, and speech therapists).

- **Supporting parents**, such as:
  - Parent support staff (like Head Start Family Service Assistants);
  - Parent education/training (and sharing information) on child development;
  - Field trips with parents, as this provides an opportunity for teachers, children, and parents to connect;
  - Back-up and emergency care, for example when family childcare providers are sick or on vacation, when staff are taking professional development days, or when parents need last-minute care during non-business hours (all of which parents reported is extremely difficult to find); and
  - Dissemination of information on the quality of child care programs (which parents reported is difficult to obtain).
- **Supporting legally exempt providers**, such as:
  - Providing Staffed Family Child Care Networks (see Appendix 4).

"I would fund a project that incorporates all of this… to fund something literally around the whole child… There are things already going on… so it wouldn't be recreating the wheel, but if we wanted to do this project of the whole child, some things could be new, but there could be things in the community that are already happening that could be part of it." – Key Informant

Recommendation #2: Fund the training and coaching of ECE staff, including trauma-informed care, provider-parent communication, and Infant Mental Health/reflective supervision.

- Provide training to providers, especially around **trauma-informed care** and **provider-parent communication**;
- Increase training opportunities for legally exempt providers;
- Increase trainings that include an in-home or in-center component (the Child Care Council is working toward this), but also a group component where providers can connect with others;
- Increase alternative training options, for example web-based trainings (due to staff's limited time and availability);
- Increase coaching/mentoring opportunities, including **Infant Mental Health reflective supervision**; and
- Consider adapting and utilizing the Greater Rochester Health Foundation's whole child health graphic as a training tool, to show staff how these components fit together.

"In early childhood you get a lot of education on here's the appropriate toys, here's the NAEYC appropriate practices, here's the environmental rating scale… but there is very little on 'how do I relate to a parent'… there's a lot of training on environments … this is not just about taking care of the child, it's about taking care of the parent as well." – Key Informant

Recommendation #3: Support advocacy efforts, including those to increase staff pay, subsidies, and reimbursement rates for service providers.

- **Wide-reaching advocacy efforts:**
  - Increase **staff pay** (which was an overwhelming recommendation across groups);
  - Increase **subsidies for parents** and spread UPK across the county to make ECE more affordable for all parents;
  - Increase screening and assessments *and* **reimbursements for service providers** who can work with children when needs are identified through these screens, as there is currently a dire need for providers;
  - Increase federal funding of Head Start, which is very strong in supporting all of the whole child health components, especially through its engagement of parents;
  - Increase information on high-quality programs for parents searching for child care;
  - Improve the transition to kindergarten by better aligning kindergarten with preschool curriculums and practices (participants noted that many ECE programs are now solely focused on play-based practices, and transitioning to the often heavy focus on academics in kindergarten classrooms is extremely challenging); and
  - Support multidisciplinary efforts that go beyond ECE – reaching home visitors, child welfare workers, pediatricians, therapists, etc.

"The next frontier of our federal policy is about how to support parents of infants and toddlers in early care learning settings – parents are still the frontline for their early development… You can go the really narrow route because God knows we need more high-quality early childhood programs for infants and toddlers, so you could go the program route, but you could also think about how can we better identify the gaps in the community and support parents."
– Key Informant (Policy Expert)

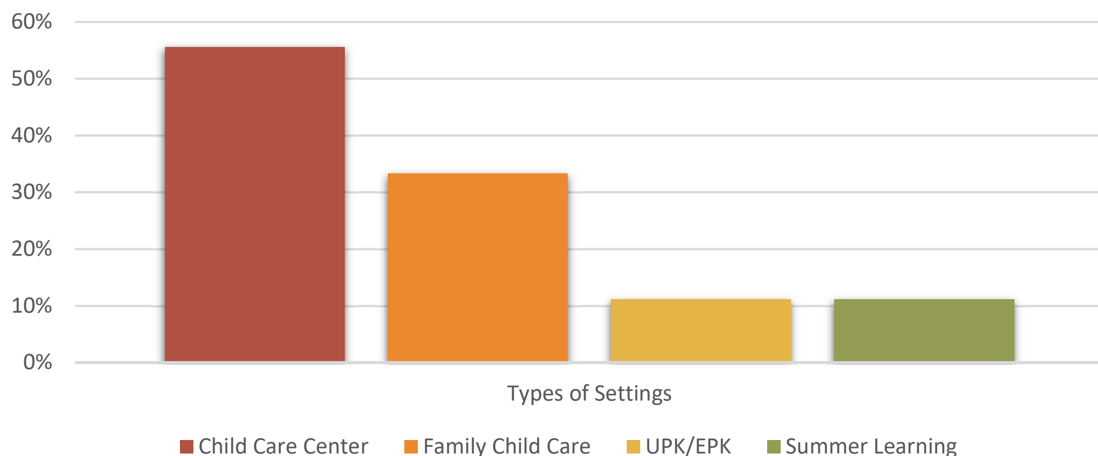
- **Regarding regulations:**
  - Create consistency in how regulations are interpreted by different licensors from OCFS (participants described a "culture of fear" that negatively impacts their teaching practices);
  - Focus more child care regulations on programming/curriculums (not just safety);
  - Actively seek input from parents and providers on child care regulations (e.g., could more publicly broadcast comment periods; a participant reported that in California, providers are required to share regulations with parents);
  - Make it less onerous to develop a continuity of care plan (to implement the continuity of care practice described in Appendix 3);
  - Clarify the restrictions placed on mental health consultants (if any) when they work with children with an IEP (due to the concern regarding this issue described above, see page 22);
  - Allow providers to show licensors documents electronically as the OCFS requirement to have all documents in hard copy creates a burden for providers moving toward electronic record-keeping systems; and
  - Make it easier to vet and screen substitute staff to cover absences (staff must be cleared for each site).

- **Additional policy changes mentioned:**
  - Consider requiring providers in Monroe County to participate in CACFP (although some providers did note concerns with the strict requirements and the "paperwork" this program demands as noted above);
  - Consider requiring legally exempt providers to complete more training (although these providers face challenges in participating in trainings, as described above); and
  - Consider requiring all staff (family providers, and all staff in centers) to have a Child Development Associate credential (CDA) (currently only required of centers' lead staff) (although participants expressed differing opinions regarding the credentialing of providers and its benefits).

Parent Survey

We received an overwhelming response to our call for parents to participate in focus groups. Eighty-two parents responded to an online form or called to express interest in participating in a focus group. Since we were unable to accommodate all interested parents, we sought their feedback via a five-minute online survey. We emailed the 60 parents that did not participate in in-person focus groups and for whom we had email addresses, and 18 completed the survey (30% response rate).

Figure 4. Early Care Settings Represented by Survey Participants (*n* = 18)



Percentage of early care settings represented adds up to greater than 100% because participants were able to identify having experience with multiple settings (e.g., parents with multiple children in various levels of care, and settings that provide multiple types of care).

The inclusion of this brief survey was meant to capture the voice of parents we were unable to accommodate in our focus groups. This survey was only administered electronically, as all of the parents had responded to our electronic recruitment methods. These responses may therefore reflect the perspective of a limited group of parents based on demographics (e.g., education level, internet access) and are not intended to be a representative sample of Monroe County parents. Rather, it provides a supplement to the information gathered through the focus groups described above.

In the survey, parents were asked to:
(1) describe the type of setting that their child attends;
(2) rate how well the setting supports whole child health components (broken down, e.g., healthy habits around nutrition, healthy habits around physical activity, etc.) (based on a 5-point Likert Scale rating: Excellent, Very Good, Good, Fair, Poor, and Not Sure); and

(3) identify things the provider does particularly well and ways the provider could improve.

We incorporated parents' qualitative responses in the findings described above. Here, we provide information on how they rated the support of whole child health components.

Overall, responses were favorable with over 50% rating each component "Excellent" or "Very Good." Respondents believed their providers were "Excellent" or "Very Good" at providing support for physical safety (78%), positive relationships with their child (89%), developing cognitive skills (72%), and healthy habits around physical activity (67%). Supporting healthy habits around sleep (22%) and nutrition (17%) had the highest percentages of respondents rating "Poor" or "Fair."

Figure 5. Parent Survey Ratings of Whole Child Health Components (*n* = 18)

How well does the child care support the following?

	Excellent	Very Good	Good	Fair	Poor	Not Sure
Physical safety for your child	61%	17%	11%	6%		6%
Positive relationships between your child and their caregivers/teachers	56%	33%	6%		6%	
The development of your child's cognitive skills (e.g., problem-solving and decision-making).	39%	33%	17%		6%	6%
Healthy habits around physical activity	39%	28%	17%	6%	6%	6%
The development of your child's social-emotional skills (e.g., their ability to express and manage their emotions).	39%	22%	17%	6%	6%	11%
Healthy habits around sleep	39%	17%	17%	11%	11%	6%
Healthy habits around hygiene (e.g., hand-washing, cleaning up)	39%	17%	17%	6%	6%	17%
The development of your child's literacy skills.	39%	17%	11%		11%	22%
Healthy habits around nutrition	28%	33%	22%	17%		

RECOMMENDATIONS

As the Foundation seeks to support whole child health in children ages 0-5, we recommend three primary strategies. Ideally, the Foundation would support all three.

1. **Fund large-scale expansions of *existing* approaches, for *extended* periods of time, to under-resourced providers across Monroe County. Fund approaches rather than pilot programs.**
   - Through this scan, we identified many practices that exist to support whole child health both within Monroe County and across the country (see Appendix 3). As participants described, there is no need to "reinvent the wheel." There is simply a lack of funding. We recommend funding a large-scale expansion of existing evidence-supported approaches across Monroe County.
   - We also identified the length of time programs are funded is a challenge for providers. Funding for pilot programs is often short, and providers spend a great deal of money, time, and energy training and implementing programs for which funding ends. We recommend providing long-term and sustainable funding, helping providers to fully implement initiatives with fidelity and giving time for children to reap the benefits.
   - The scan also uncovered a need for additional resources for providers who do not benefit from federal or state funding streams but serve children from low-income families and children who have experienced trauma – and for whom the additional resources would improve the quality of services. This includes home-based/legally-exempt providers located in the City of Rochester as well as some providers in rural/suburban areas. This should include supports for children ages 0-3, as much focus is on programs for children ages 3 and older (e.g., Head Start and UPK).

2. **Increase the accessibility of training and coaching opportunities.**
   - Through the scan, we identified the need for training and coaching opportunities – for example, around trauma-informed care, provider-parent communication, and Infant Mental Health/reflective supervision. Training opportunities are limited not only based on expense, but also the ability for staff to attend. Participants identified strategies such as providing training components on-site with providers or web-based modules. We recommend that any funding of training and coaching focuses on accessibility for all providers.

3. **Support advocacy efforts that value early care.**
    - Through the scan, we identified several policy issues to support, such as increasing staff pay, subsidies for families, reimbursement rates for service providers, and availability of UPK and Head Start programs. These advocacy efforts would support whole child health; for example, increasing staff pay is essential to building healthy relationships: staff need to feel valued, and low turn-over improves the bond between children and their caregivers. We recommend that funding include support of these advocacy efforts in addition to support for programming and practices.

Additional recommendations to successfully engage these strategies, include the following:

4. **Engage community coalitions, seeking their input, buy-in, and support for these efforts.**
    - It is crucial to engage key stakeholders in this work every step of the way. This can include attending their regular meetings to present information and seek input. We recommend obtaining ongoing communication in this way to reduce burden and optimize engagement.
    - It is important to be mindful to reach beyond the City of Rochester, as private, suburban centers and home-based providers may not be at these tables. We recommend reaching these providers through provider groups and the Child Care Council.
5. **Look beyond child care settings toward other systems that serve young children ages 0-5 (e.g., home visiting, child welfare, pediatrics, etc.).**
    - While children spend a great deal of time in child care settings, it is key to work across the child-serving systems. Integration of existing supports for young children will be essential for a whole child health approach to take root and flourish in the community.

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APPENDICES

Appendix 1: Monroe County Data Tables

Table 1. Demographic Information of Parents Who Requested Referrals in the Past 12 Months in Monroe County (*n* = 1,788)

Demographic Variable	N	(%)
Race (n = 1,776)		
White	457	25.7%
Black or African American	311	17.5%
Asian (i.e., Indian, Chinese, Filipino, Vietnamese)	13	0.7%
Did Not Identify	946	53.3%
Hispanic/Latin Ethnicity (n = 1,776)		
No, not Spanish/Hispanic/Latino	622	35.0%
Yes, Spanish/Hispanic/Latino (e.g., Puerto Rican, Mexican/Chicano, Cuban, Other)	126	7.1%
Did Not Identify	1,028	57.9%
Income Category (n = 1,783)		
Above NYS 200% of Poverty	958	53.7%
Below NYS 200% of Poverty	825	46.5%

Note: The above tables were out of 1,788 records, some of which had missing data (e.g., the referral form was incomplete, not distributed).

Appendix 2: Participant Settings

Table 1. Early Care Settings Represented by Focus Group Participants (*n* = 38)

	Total Sample (n = 38)		Administrators (n = 12)		Parents (n = 17)		Direct Care Staff (n = 9)	
Child Care Setting	N	%	N	%	N	%	N	%
Child Care Center	24	63.2%	10	83.3%	9	52.9%	5	55.6%
Family Child Care	3	7.9%	0	0.0%	3	17.6%	0	0.0%
UPK/EPK	19	50.0%	9	75.0%	4	23.5%	6	66.7%
Preschool or Nursery School	14	36.8%	6	50.0%	6	35.3%	2	22.0%
Head Start/Early Head Start	9	23.7%	2	16.7%	3	17.6%	4	44.4%
Legally Exempt Care	1	2.6%	0	0.0%	1	8.3%	0	0.0%
Summer Learning Program	6	15.8%	4	33.3%	2	16.7%	0	0.0%
Other	2	5.3%	0	0.0%	2	16.7%	0	0.0%

Note: Percentages of early care settings represented add up to greater than 100% because participants were able to identify having experience with multiple settings (e.g., parents with multiple children in various levels of care, and settings that provide multiple types of care).

Table 2. Size of Focus Group Participants' Early Care Settings (*n* = 38)

	Total Sample (n = 38)		Administrators (n = 12)		Parents (n = 17)		Direct Care Staff (n = 9)	
Size of Setting	N	%	N	%	N	%	N	%
1-2 children	1	2.6%	0	0.0%	1	5.9%	0	0.0%
3-6 children	2	5.3%	0	0.0%	2	11.8%	0	0.0%
7-12 children	2	5.3%	0	0.0%	2	11.8%	0	0.0%
13-80 children	13	34.2%	3	33.3%	8	47.1%	2	22.2%
81 or more children	20	52.6%	9	66.7%	4	23.5%	7	77.8%
Unsure	2	5.3%	0	0.0%	2	11.8%	0	0.0%

Note: Some percentages add up to greater than 100% because participants were able to identify having experience with multiple settings (e.g., parents with multiple children in various levels of care).

Appendix 3: Promising Programs and Practices in Monroe County

Name of practice, program, or model	Description	Reach in Monroe County	Evidence
Healthy Relationships			
Continuity of care	Practice where children and caregivers remain together for more than one year	Used in Head Start and only a few private centers (per focus groups)	Based on child development research; No Randomized Controlled Trials (RCTs) or other outcome-based research
Primary caregiving	Practice where one teacher is assigned the primary responsibility of caring for a small group of children, rather than having a lead and assistant teacher	Used in Head Start and only a few private centers (per focus groups)	Based on child development research; No RCTs or other outcome-based research
Infant Mental Health	Practice that focuses on the development of 0-5-year-olds within the context of parent/caregiver-child relationships	The New York Association for Infant Mental Health recently created an endorsement process; Local community (e.g., Early Childhood Development Initiative's Social-Emotional Wellness Committee) aims to build capacity	Based on child development research; No RCTs or other outcome-based research
Reflective Supervision	Practice of supervision that focuses on reflection and the influence of relationships to support staff working with young children	Local community (e.g., Early Childhood Development Initiative's Social-Emotional Wellness Committee) aims to build capacity	Based on child development research; No RCTs or other outcome-based research
Incredible Years	Program used in schools and mental health centers to prevent and treat young children's behavioral challenges	Was used as part of BASIC (per focus groups)	Rated as Effective for parenting skills, child externalizing behaviors, hyperactivity, inattention, and oppositional behaviors, child emotion regulation, social skills, positive coping, and school readiness by National Registry of Evidence-Based Programs
Positive Solutions for Families	Program for parent training, developed by Center on the Social and Emotional Foundations for Early Learning (CSEFEL) to promote children's development	Was used in Head Start; Used in some large private child care centers (per focus groups)	Based on child development research; No RCTs or other outcome-based research

Name of practice, program, or model	Description	Reach in Monroe County	Evidence
Rochester Area Parent Program (RAPP)	Program for parents of young children, which includes 12 sessions of video and group-based training	Used in ABC Head Start, Ibero Early Childhood Services, Rochester Childfirst Network, and the Rochester City School District	Based on the Chicago Parent Program, which is supported by research evidence; Shown to strengthen parenting confidence/skills and reduce behavior problems in young children
Safety/Security			
Compliance with safety standards	Practice/regulations around staff ratios, screening, qualifications and training; food safety, facilities, supplies, environmental health, play areas, immunizations etc.	All required to comply with the NY State OCFS regulations	N/A
Healthy Habits			
Promoting healthy eating, physical activity, screen time reduction, and breastfeeding support	Practices based on national guidance around serving healthy food and drinks; promoting physical activity; reducing screen time; and supporting breastfeeding		N/A
Child and Adult Care Food Program (CACFP)	Program, funded and administered by the New York State Department of Health, that provides nutrition education and meal reimbursement	In June 2018, 423 family and group providers and 143 centers[11]; 97 legally-exempt providers as well (per correspondence with the Child Care Council)	Evidence-supported; Five comparative studies; Greater offering of healthy beverages, fruits, & vegetables, more healthy weights, more likely to have written nutrition policies, more likely to have nutrition practices, particularly for low income children
Eat Well Play Hard	Program, funded by the New York State Department of Health, that provides funding to grantees to implement a nutrition and physical activity curriculum for children and parents	5 "Champion Centers"; Child Care Council grant allows them to create 13 new Champion Centers each year in low-income centers in Monroe County (per correspondence with the Child Care Council)	Evidence-supported; 1 single-group study; Associated with building community capacity for healthy child goals

[11] CACFP participation data available at: https://health.data.ny.gov/Health/Child-and-Adult-Care-Food-Program-Participation/dmn7-mpa8

Farm to Preschool	Program, funded through SNAP-Ed (Supplemental Nutrition Assistance Program Education), that connects settings to local food producers; includes educational activities around nutrition	A limited number of centers are currently participating (per correspondence with the Child Care Council)	Evidence-supported in other states; Not yet evaluated in NY; One implementation study—programmatic infrastructure, admin support, and family support helps sustain it; One quasi-experimental pilot study-associated with greater willingness to try and liking target fruits/vegetables
Hip Hop to Health	Program that includes diet and activity programming for low-income families, including obesity prevention curriculum for young children	No longer being implemented in Monroe County (per correspondence with the Child Care Council)	Mixed Evidence; Large 4-year RCT, large comparative effectiveness trial, pilot of family-based version, ongoing comparative effectiveness study; Prevention of increases in BMI in Latino preschoolers, less screen time; Low participation by parents
Healthy Way to Grow	Program of the American Heart Association and Nemours that provides technical assistance to providers around nutrition, physical activity, screen time, and infant feeding	Offered in 52 locations (e.g., YMCAs, Head Starts, centers)	Based on child development research; No RCTs or other outcome-based research
Cornell Cooperative Extension of Monroe County	Program that includes free nutrition education classes through two federally funded grant programs	Classes available in Rochester; online wellness education materials freely available	Evidence-supported; Quasi-experimental design-CCE coordination efforts lead to increased use of Farmer's Market Nutrition Program by WIC participants over time
Creating Breastfeeding Friendly Communities	Statewide initiative that promotes breastfeeding and seeks to address racial disparities in exclusive breastfeeding; Providers can get a breastfeeding-friendly designation through CACFP	University of Rochester is a grantee; As of June 2018, 5 child care centers and 58 home providers with this designation (per correspondence with the Child Care Council)	Based on child development research; No RCTs or other outcome-based research
Legally Exempt Activity and Nutrition (LEAN)	Pilot program of the Child Care Council, funded by the Greater Rochester Health Foundation, focused on enrolling legally exempt providers in CACFP	Previously (and no longer) funded	See evidence for CACFP above

Pediatric Nursing Consultation	A national health and performance standard dictates that facilities work with a licensed health professional	As of June 2018, 101 providers using Child Care Council's Registered Nurses as their consultant in county (per correspondence with the Child Care Council)	Based on child development research; No RCTs or other outcome-based research
Skills			
Developmentally appropriate practice	Practice that is grounded in research on how children develop and learn		Based on child development research
High Scope	Infant/preschool curriculum, with tools for assessments, family engagement, and professional learning; focused on positive interactions and learning through exploration/play	Used in Head Start and City of Rochester UPK programs (per focus groups)	Evidence-supported; Comparative study improved home literacy behaviors, adult earnings, crime, employment, high school graduation rate
Pyramid Model	Model using a positive behavioral intervention and support (PBIS) framework to support caregiving relationships, positive learning environments, and social-emotional skills-building; Practice-Based Coaching is an evidence-based model used to implement Pyramid Model strategies	Used by 10 local programs. Teachers in the Rochester City School District and ABC Head Start have been trained in the modules. Rochester is leading the statewide effort to bring Pyramid Model practices to the community.	Evidence-supported; One RCT; Teachers more likely to implement EBP, greater emotional support in classroom, and higher social skills compared to usual teaching
BASIC (Behavioral and Social Interventions for Children)	Model, previously funded by the United Way and overseen by the Children's Institute, integrating several programs/curriculums: Incredible Years; Promoting Alternative Thinking Strategies; Primary Project; behavioral health consultation; and child parent psychotherapy and trauma-focused cognitive behavioral therapy	Previously (and no longer) funded	Evidence-based programs included in model (i.e., Incredible Years); Focus group participants reported that the United Way stopped funding because evaluations did not support improved child outcomes; however, this information is not published
Early Childhood Mental Health Consultation (ECMHC) / Behavioral health consultation	Practice whereby consultants work with early care professionals to address and prevent challenging behaviors by sharing strategies and modeling approaches	Children's Institute and Mt. Hope Family Center provide consultation; Head Start and some UPK providers utilize this (per focus groups)	Based on child development research; No RCTs or outcome-based research

Early Literacy Connections	Program of the Child Care Council, previously funded by the United Way, that provides training/mentoring, a literacy curriculum, and materials/activities for child care providers	Started in Steuben County; no longer funded to implement, but the Child Care Council served 20 providers in the county last year (per correspondence with the Child Care Council)	Not yet evaluated ; No RCTs or outcome-based research
Whole Child Health			
Head Start / Early Head Start	Program (federally-funded) for children in low-income families that promotes school readiness through four components: Education, Health, Parent Involvement, and Social Services	Local Head Start programs include Action for a Better Community (ABC) Head Start, Ibero Early Childhood Services, and the Volunteers of America Children's Center	Based on developmental research; Mixed support for educational, social, and behavioral outcomes
Montessori	Method of education focused on the whole child; children initiate learning in multi-age classrooms with teachers trained in the Montessori approach	Two Montessori child care centers	Evidence-supported; Naturalistic studies; Better academic achievement, social understanding, mastery orientation, academic outcomes, and social problem solving than public/conventional PreK/K
Reggio Emilia	Philosophy of early childhood education developed in Reggio Emilia, Italy, with guiding principles focused on respect and community	A few "Reggio Emilia-inspired" centers that incorporate aspects of this approach (per correspondence with the Child Care Council); Rochester NYAEC chapter has Reggio Study Group	Based on developmental research; No RCTs or other outcome-based research
Waldorf	Method of education that focuses on children's development ages 0-7, and the community (including healthy relationships with parents, teachers, and children)	One Waldorf center	Based on developmental research; No RCTs or other outcome-based research

Appendix 4: Promising Programs and Practices Outside Monroe County

Name of practice, program, or model	Description	Location	Evidence
Educare	Model that focuses on: data, professional development, high-quality teaching, and family engagement	National; No schools in New York State	Evidence based; Randomized Controlled Trial (RCT); Improved English language skills, problem behaviors, parent-child interactions vs. care as usual; Ongoing implementation study and three follow-up single-group studies
Help Me Grow	Model in which communities utilize existing resources to identify and connect children with needed services and empower families; Funded by the Health Foundation for Western & Central New York, Help Me Grow Western New York provides information, referrals, and questionnaires for families	National – in 28 States; Help Me Grow Western NY covers Erie and Niagara Counties	Well-validated screening and assessment
Kids in Transition to School (KITS)	Program, developed at the Oregon Social Learning Center, focused on increasing school-readiness through positive teaching and behavior change strategies; includes programing for children and families	Oregon	Evidence-based; Rated as Promising for disruptive behavior problems, academic achievement, parenting skills, and self-regulation by National Registry of Evidence-Based Programs
Staffed Family Child Care Networks	Program in which Family Child Care providers receive supports such as individualized/customized technical assistance, professional development, and screenings for children from network staff	National	Based on child development research; No RCTs or other outcome-based research
Trauma Smart	Model, developed by the Crittendon Children's Center in Kansas City, that assists schools and professionals working with children 0-12 to address the impact of violence and trauma (by including parents, improving environments for staff, etc.)	National; None in NY State outside of NYC	Evidence-based; Single-school design; Significant decreases in attention problems, externalizing problems, attention deficit/hyperactivity problems, and oppositional defiant problems over time

Appendix 5: For More Information on Promising Programs and Practices

Whole child health component and name of practice/program/model	For more information…
Healthy Relationships	
Continuity of care	Sosinsky, L., Ruprecht, K., Horm, D., Kriener-Althen, K., Vogel, C., & Halle, T. (2016). Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy. A Research-to-Practice Brief, OPRE Report # 2016-46. Zero to Three. (2010). Primary Caregiving and Continuity of Care. Retrieved from https://www.zerotothree.org/resources/85-primary-caregiving-and-continuity-of-care https://www.theounce.org/wp-content/uploads/2017/03/NPT-Continuity-of-Care-Nov-2015.pdf
Primary caregiving	Sosinsky, L., Ruprecht, K., Horm, D., Kriener-Althen, K., Vogel, C., & Halle, T. (2016). Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy. A Research-to-Practice Brief, OPRE Report # 2016-46. Zero to Three. (2010). Primary Caregiving and Continuity of Care. Retrieved from https://www.zerotothree.org/resources/85-primary-caregiving-and-continuity-of-care
Infant Mental Health	New York State Association for Infant Mental Health (2018). About Babies. Retrieved from http://www.nysaimh.org/about-babies Cardenas, J. & Tanco, I. (2016). Elevating the Field of Early Childhood Education through Endorsement: An International Standard of Excellence in Infant Mental Health. *Early Years, 37*(2).
Reflective Supervision	Zero to Three. (2018). Reflective supervision. Retrieved from https://www.zerotothree.org/resources/407-reflective-supervision
Incredible Years	The Incredible Years. (n.d.). Retrieved from http://www.incredibleyears.com/ Research evidence: https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=311
Positive Solutions for Families	Center on the Social and Emotional Foundations for Early Learning. (n.d.). Facilitator's guide: Positive solutions for families. Retrieved from http://csefel.vanderbilt.edu/resources/trainings/facilitator_guide.pdf Child Development Inc. Retrieved from http://childdevelop.org/positive-solutions-for-families
Rochester Area Parent Program (RAPP)	Children's Institute. (2018). Retrieved from https://www.childrensinstitute.net/about-us/parent-corner/rapp The California Evidence-Based Clearinghouse for Child Welfare. (2017). Chicago Parent Program. Retrieved from http://www.cebc4cw.org/program/chicago-parent-program/detailed

Safety/Security	
Compliance with safety standards	American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. (2011). Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. NY State Office of Children and Families regulations available at: https://ocfs.ny.gov/main/childcare/daycare_regulations.asp
Healthy Habits	
Promoting healthy eating, physical activity, screen time reduction, and breastfeeding support	American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. (2011). Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.
Child and Adult Care Food Program	New York State Department of Health. (2018). Child and Adult Care Food Program Participation. Retrieved from https://health.data.ny.gov/Health/Child-and-Adult-Care-Food-Program-Participation/dmn7-mpa8 United States Department of Agriculture. (2017). Child and Adult Care Food Program (CACFP). Retrieved from https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program Murphy, S. P., Yaktine, A. L., Suitor, C. W., Moats, S. (Eds). (2011). Child and Adult Care Food Program: Aligning Dietary Guidance for All. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK209819 Research Evidence: Bruening KS, Gilbride JA, Passannante MR, McClowry S. Dietary intake and health outcomes among young children attending 2 urban day-care centers. J Am Diet Assoc. 1999;99:1529-1535. Erinosho, T., Vaughn, A., Hales, D., Mazzucca, S., Gizlice, Z., Treadway, C., & ... Ward, D. (2018). The quality of nutrition and physical activity environments of child-care centers across three states in the southern U.S. Preventive Medicine, 11395-101. Liu ST, Graffagino CL, Leser KA, Trombetta AL, Pirie PL. Obesity prevention practices and policies in child care settings enrolled and not enrolled in the Child and Adult Care Food Program. Matern Child Health J. 2016;20:1933- 1939. Ritchie LD, Boyle M, Chandran K, et al. Participation in the child and adult care food program is associated with more nutritious foods and beverages in child care. Child Obes. 2012;8:224-229. California Food Policy Advocates. (2017). Early Access to Healthy Foods. Trends in California's Child and Adult Food Program 2010 – 2016. Retrieved from https://cfpa.net/ChildNutrition/ChildNutrition_CFPAPublications/CFPA-CACFPTrends-2017.pdf

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