



Essentials for Childhood
POLICY GUIDE



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Acknowledgments

This report was made possible through funding from CDC’s National Center for Injury Prevention and Control under cooperative agreement U38OT000161. ASTHO is grateful for this support. The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Introduction

Public health leaders and their partners can make the greatest impact on population health by focusing on early childhood. As several decades of research show, early childhood experiences and environments profoundly influence health and well-being throughout a person's life.¹ Healthy brain development from an early age creates the building blocks for educational achievement, economic productivity, responsible citizenship, positive parenting, and lifelong health and well-being.

State and territorial health departments can take steps to promote safe, stable, and nurturing relationships and environments for children and ensure a foundation for health into the next generation. Evidence-based programs and services that address specific needs have greater impact when they are coupled with policies that help working families, such as those that provide economic support, expand access to quality early care and education, and promote family-friendly workplaces. This resource presents an overview of the state health department's role in informing policy and lays out several policy options for states and other partners to consider when working to create the context for healthy children and families.

Policy Options to Promote Safe, Stable, and Nurturing Relationships and Environments

The following policy options, divided into three categories, reflect the best available evidence for what works to promote safe, stable, and nurturing relationships and environments, ones that prevent child abuse and neglect and reduce risk factors for child abuse and neglect (e.g., parental stress or parental mental health).

Economic Supports to Families

Policies that increase economic self-sufficiency for lower income families and streamline complicated application processes for public assistance programs may reduce parental stress associated with child abuse and neglect.² Policies that promote access to affordable, high-quality childcare enable parents to work and support a family and help ensure that all children feel safe and comfortable in their surroundings as they learn, play, and grow.

- Minimum wage
- Earned Income Tax Credits and Child Tax Credits
- TANF benefits
- Child support pass-through
- Enrollment in federal nutrition safety net programs
- Housing assistance programs
- Childcare access



Quality Care and Education Early in Life

Policies that promote high-quality early childhood programs and services that are designed to meet the needs of children and families can help ensure that every environment provides learning opportunities for young children, whether at home, in childcare, or other preschool settings.

- Early Head Start
- High-quality preschool education

Policies to Support Working Families

Policies that provide employees with the flexibility to spend time away from work caring for a child or other family member without the worry of losing their jobs or income encourage both stronger family bonds and increased productivity when employees return to work.³

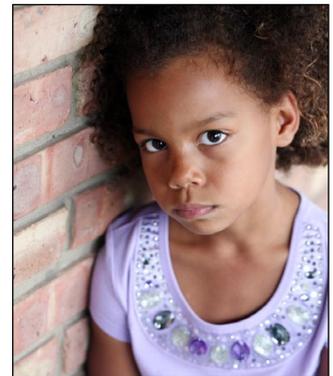
- Paid leave: family, parental, and medical leave
- Paid sick leave

Impacts of Early Childhood Experiences and Environments

Health is shaped by a number of determinants, including environmental and social exposures, education and economic opportunities, health behaviors, access to and quality of healthcare, and genetics. The health outcomes of young children are particularly affected by early life experiences. Early experiences, especially within the first three years of life, transform the architecture of the brain.⁴ Having consistent, stable, reciprocal interactions with caring people at home and in the community are important for building a strong foundation for future health and wellness.

Adverse Childhood Experiences (ACEs)

Some children are exposed to conditions or events that are so severe and persistent that they produce toxic stress responses that damage the brain's developing architecture. Adverse childhood experiences (ACEs) are incidents that harm social, cognitive, and emotional functioning and dramatically upset the safe, nurturing environments children need to thrive. As the number of ACEs increases so does the risk for asthma, depression, smoking, diabetes, and a number of other negative health and well-being outcomes across a lifespan.⁵



Adverse childhood experiences include:

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Emotional abuse• Physical abuse• Sexual abuse | <ul style="list-style-type: none">• Emotional neglect• Physical neglect | <ul style="list-style-type: none">• Mother treated violently• Household substance abuse• Household mental illness• Parental separation or divorce• Incarcerated household member |
|---|--|--|

Early exposure to these traumas become programmed into the physiological system and can lead to difficulties in learning, memory, and self-regulation. Since cognitive, emotional, and social capacities are closely intertwined, children who are abused or neglected early in life can develop an exaggerated stress response that, over time, weakens the body's defense system against diseases and other health problems.⁶

Experiencing abuse or neglect as children can negatively affect how adults develop parenting skills. Adults who encountered ACEs at an early age are at higher risk for experiencing mental health issues, substance abuse, and intimate partner violence themselves⁷, all of which can diminish the quality of the parent-child relationship. Many parents may not recognize how early trauma can affect their parenting and their reactions to stressful situations. Helping parents and caregivers understand how ACEs and trauma affect health, relationships, and parenting is an important step in preventing ACEs from becoming part of an intergenerational cycle.

Many states are collecting information about ACEs through the Behavioral Risk Factor Surveillance System (BRFSS).⁸ BRFSS is an annual, state-based telephone survey that collects data on general demographics, health status, health behaviors, risks for chronic diseases and injuries, and access to healthcare. Since 2009, 32 states and the District of Columbia have added a module to the survey consisting of 11 questions related to ACEs to measure cumulative childhood stress in a large, representative sample of adults.⁹

Data from the BRFSS surveys show that roughly two-thirds of adults have experienced at least one ACE, creating a sense of urgency around understanding trauma and its effects on brain development. ACEs data has been used by health departments, national organizations, advocacy groups, and others to inform public policy and primary prevention efforts, as well as to educate the public and specific sectors about the prevalence of ACEs in states and communities. State health officials and their partners are often called to inform and educate the public, policymakers, and others about the scientific evidence related to the impact of policy on health outcomes. In doing so, they frequently use data, including ACEs data, to communicate with decisionmakers and partners about the potential effects of a policy intervention on a public health issue.

CDC'S ESSENTIALS FOR CHILDHOOD

To prevent child abuse and neglect and improve short- and long-term health, CDC promotes safe, stable, and nurturing relationships and environments for all children. The [Essentials for Childhood](#) framework proposes steps communities can consider to promote the types of relationships and environments that help children grow to be healthy and productive adults. The framework is organized around four goals and related steps to promote safe, stable, and nurturing relationships and environments for children and families.¹⁰

Four Goal Areas:

- #1:** Raise Awareness and Commitment to Promote Safe, Stable, Nurturing Relationships and Environments and Prevent Child Maltreatment
- #2:** Use Data to Inform Actions
- #3:** Create the Context for Healthy Children and Families through Norms Change and Programs
- #4:** Create the Context for Healthy Children and Families through Policies

A wide range of policies are important for promoting children's health, especially policies that prevent child abuse and neglect from happening in the first place. This supplement explores Goal #4 in-depth, with a menu of policy options that support strong families and communities.



Role of the State Health Department and Partners in Informing Policy

Policy approaches can shape the social environments in which children grow up in ways conducive to better health and well-being. There is no one-size-fits-all approach to informing policy. In addition, effective policies are not the sole responsibility of any one agency or group. They result from collaboration among many different types of partners at the federal, state, and local levels. State agencies, county and city governments, businesses, healthcare professionals, school administrators, childcare providers, community- and faith-based organizations, and individual families, youth, and community members are all essential partners in advancing policy.

A comprehensive policy agenda encourages better linkages across sectors to address the health and developmental needs of young children, particularly among children with special needs and low-income families. State health departments can exercise their authority as regulators, conveners, and educators to inform smart policies that facilitate coordination and engagement across multiple sectors, including education, labor, agriculture, human services, housing, public safety, parks and recreation, and child welfare. An increasing number of private partners, such as businesses, faith-based and civic organizations, primary healthcare providers, universities, foundations, cultural arts centers, and sports clubs and athletic associations, are also coming together in the interest of supporting safe, stable, and nurturing relationships and environments.

Many states are already integrating what is known about the health impacts of early childhood experiences into cross-cutting policy efforts.^{11,12}

Policy: Organizational, Regulatory, and Legislative

CDC defines “policy” as a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions. There are different types of policies and each plays an important role in improving the public’s health, including the following:

- **Organizational policies** (also known as internal policies) – rules or practices established within an agency or organization.
- **Regulatory policies** – rules, guidelines, principles, or methods created by government agencies with regulation authority for products or services (government agencies receive authorization to make regulations through state laws).
- **Legislative policies** – laws or ordinances.

State health departments participate in all aspects of the policy change process, which includes:

- **Problem identification** – analyze and communicate challenges and obstacles.
- **Policy analysis** – identify possible interventions.
- **Strategy and policy development** – prioritize interventions.
- **Policy enactment** – provide evidence as requested by decisionmakers.
- **Policy implementation** – support implementation through education, training, technical assistance, and guidance.

For more detailed information on the policy process, see: [The State Health Department’s Role in the Policy Process: A Tool for State Health Department Injury and Violence Prevention Programs.](#)



Examples of State Initiatives

Connecticut's Two-Generation Approach

In 2015, Connecticut passed a provision in the state budget establishing what it calls a “two-generational” school readiness and workforce development pilot program¹³ to foster family economic self-sufficiency in low-income families. The program delivers early education and workforce services concurrently across generations (i.e., parent and child or caregiver). Six pilot communities located in New Haven, Greater Hartford, Norwalk, Meriden, Colchester, and Bridgeport are beginning to coordinate children’s school readiness and academic achievement services with parents’ job readiness and support services. State and local governments are working together to align funding, programming, and other systems so that community-based programs can more easily provide these and other types of two-generation services.

To oversee the program, the legislation (PA 15-5, Section 401) established an interagency workgroup co-chaired by two leaders representing the appropriations and human services committees and managed by the Connecticut Commission on Children. The interagency workgroup is comprised of commissioners of the departments of social services, early childhood, education, housing, transportation, public health, labor, and corrections, as well as the chief court administrator, nonprofit and philanthropic organizations, and other business and academic professionals.

Oregon's Child Fatality Review Teams

The Oregon Health Authority and the Department of Human Services bring together child fatality review teams from across the state to identify trends and work together on prevention strategies.¹⁴ A major focus of this work is on increasing family stability and child safety by strengthening the integration of mental health and addiction, housing, and employment services and other systems.



While federal funds cannot be used to lobby at the federal, state, or local level, these prohibitions do not prevent state health departments from participating in the policy process. Importantly, health departments can educate elected officials and the public about evidence-based policy options that will improve health outcomes. Partnerships are vital throughout the process, from collecting data to policy development to implementation.

Anti-lobbying Restrictions for CDC Grantees

Language included in Section 503 of Division F, Title V, of the FY 12 Consolidated Appropriations Act reinforces and expands statutory and other provisions governing the use of appropriated funds by CDC and its grantees for advocacy, lobbying, and related activities.

What is prohibited?

No appropriated federal funds can be used by CDC grantees for grassroots lobbying activity directed at inducing members of the public to contact their elected representatives to urge support of, or opposition to, proposed or pending legislation or appropriations or any regulation, administrative action, or order issued by the executive branch of any federal, state or local government.

What is allowed?

State and local agencies funded by CDC are permitted to work directly on policy-related matters across their equivalent branches of state or local government. This derives from language in Section 503 permitting communications through a normal and recognized executive-legislative relationship, and permitting a grantee to participate in policymaking and administrative processes within the executive branch of their state or local government, if within these boundaries:

Allowable activities using CDC appropriated funding include:

- Educating the public on personal health behaviors and choices.
- Research on policy alternatives and their impact.
- Working with other agencies within the executive branch of their state or local governments on policy approaches and on implementation of policies.
- Educating the public on health issues and their public health consequences.
- Educating the public on the evidence associated with potential policy solutions to health issues.
- Working with their own state or local government’s legislative body on policy approaches to health issues, as part of normal executive-legislative relationships.
- Development of model laws, templates, and menu of options, which could include various state and local laws that serve as models.

These joint efforts in Oregon have resulted in:

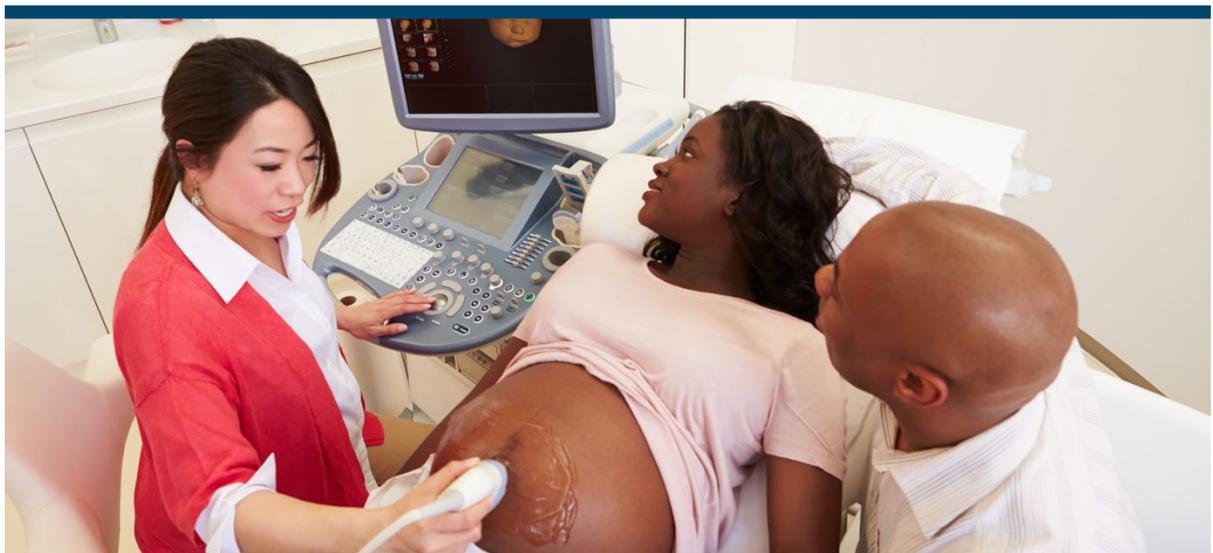
- A coordinated child fatality data collection and reporting system that uses surveillance data from outside the child welfare system.
- Improved partnerships with drug and alcohol treatment providers and efforts to expand family-based treatment.
- Co-location of domestic violence advocates in the state’s child welfare and self-sufficiency offices. After working with an advocate, clients were more likely to access services provided by the health department’s offices.

Minnesota’s Prenatal to Three Policy Framework

In Minnesota, the Children’s Cabinet, which includes commissioners of the departments of health, education, and human services, charged the Minnesota Department of Health with developing a statewide policy framework that addresses the health of children beginning with prenatal mothers through age three. The framework focuses on outcomes for children and families in five key areas: prenatal health, general health, education, well-being, and service area coordination for children from before birth to age three. During the initial planning phases, the department of health convened a workgroup to identify potential outcomes across these key areas, as well as metrics to determine success. The second phase involved building partnerships with external stakeholders to identify policy recommendations to promote healthy development and early learning, and raise awareness of the importance of infant and toddler development. Minnesota is continuing to build community capacity for reducing health inequities and promoting safe, stable, and nurturing relationships and environments, as well as social and economic security for pregnant and parenting families with very young children.¹⁵

New Jersey’s Centralized Intake System

In New Jersey, a centralized intake system helps families access services, such as home visiting, pediatric and adult primary care, and social services, all through a single entry point.¹⁶ The model began with a focus on linking infants and pregnant women to the state’s home visiting programs and has since expanded, with intake hubs in every county that provide referrals and linkages to other programs, including Head Start and Early Head Start and high-quality childcare centers. Central intake is part of a larger interagency collaboration across four state departments—health, children and families, human services, and education—to build a comprehensive pregnancy to age 8 early learning plan for New Jersey.



Policy Options to Promote Safe, Stable, and Nurturing Relationships and Environments

Research shows that the domains of child development are interconnected. As our understanding of these connections and their collective influence continues to evolve, states can explore policy options that are most likely to have a positive impact on the first years of a child's life. The following policy options represent strategies to prevent and reduce risk factors for child abuse and neglect.

Economic Supports to Families

Poverty makes it harder for parents to meet a child's most basic needs, including food, shelter, and medical care. Economic hardship also creates significant stress and can lead to changes in parental mental health, caregiving behaviors, or family dynamics. Research shows that children living in families with limited economic resources are at greater risk for abuse and neglect than children from higher socioeconomic groups.¹⁷ Children in low socioeconomic status households experience some type of abuse or neglect at more than five times the rate of other children.¹⁸

The adverse health effects of low family income also accumulate over time. Children from poorer families often enter adulthood with worse overall health, which affects their future earnings ability and keeps their socioeconomic status low.^{19,20} Many states have used county-level data to show that average life expectancy varies considerably across different zip codes. Areas where residents have a shorter life expectancy are often characterized by much higher rates of poverty and lower family incomes.²¹

Policy options to support more stable, economically secure families are discussed below.

Minimum Wage

OVERVIEW

One way to improve economic sufficiency is to consider policies that directly address low-wage workers and low family income. Proposals to raise the minimum wage have gained momentum among policy-makers as a strategy to address widening income inequality. States and some local government entities, such as cities and counties, have the authority to set their own minimum wages above the federal level. Currently, 29 states and the District of Columbia have minimum wages above the federal minimum wage of \$7.25 per hour.²² Fourteen states have tied increases in pay to the Consumer Price Index to ensure the minimum wage will keep pace with increases in the cost of living. One adult working full-time at the minimum wage with two children earns roughly \$14,500 a year, well below the 2015 U.S. poverty threshold of \$19,096 for a family of this size. Childcare is virtually out of reach for many workers who earn minimum wage to support their families, since full-time care for children up to age four in childcare centers in the United States averages roughly \$9,500 per year.

A recent study in the *American Journal of Public Health* found that a higher minimum wage may yield significant health benefits and that increasing the minimum wage could be a potential strategy for addressing health disparities. The study examined community-level income and mortality data from New York City between 2008 and 2012 to estimate the impact of a minimum wage of \$15 per hour over a five-year period. The analysis suggests that a \$15 minimum wage would reduce premature deaths in New York City by as many as 5,500 deaths over five years.²³

Although the relationship between income and health has been well-documented, there are studies^{24,25} to support positions on both sides of the minimum wage debate. Research on the employment effects of minimum wage increases, for example, has yielded mixed findings.²⁶ Increasing the minimum wage has

proven to be a divisive issue. Proponents of minimum wage increases consider it a moral imperative to achieve greater fairness and believe it will stimulate the economy. Opponents say increases will cost businesses too much, leading to increased prices and fewer jobs.

■ ROLE OF THE HEALTH DEPARTMENT

State health officials can educate policymakers on the well-established health consequences associated with poverty. They can also stay informed about efforts to study how poverty rates change in states where the minimum wage is increased, and ultimately how it affects health in those states. Participating in an exchange of ideas with policymakers around this issue serves as an opportunity for health departments to explore the feasibility of other approaches, complementary to raising the minimum wage, which may also benefit low-wage workers, such as policies to ensure paid sick time, more consistent work schedules, and protections against wage theft. State health departments may also consider conducting health impact assessments (HIAs) to quantify the impact of changes to the minimum wage on mortality and other health outcomes.

■ SELECTED STATE EXAMPLES

In 2014, the **Health Officers Association of California** and Human Impact Partners conducted a rapid health analysis using the California Health Interview Survey to assess a legislative proposal to raise the state's minimum wage. The analysis found that raising the minimum wage to \$13 per hour would result in almost 400 fewer premature deaths annually among working-age Californians.²⁷ In April 2016, California's governor signed Senate Bill 3 into law, increasing the minimum wage to \$15 per hour by 2022 and indexed thereafter annually for inflation.

A similar analysis found that for San Francisco families, increasing the minimum wage to \$11 per hour would result in a 22 percent decrease in the risk of early childbirth and a greater likelihood of completing high school. San Francisco approved a ballot initiative that will raise the minimum wage to \$15 by 2018. The city's current minimum wage of \$12.25 has been in effect since May 1, 2015.

Earned Income Tax Credit (EITC) and Child Tax Credit (CTC)

■ OVERVIEW

The Earned Income Tax Credit (EITC) both provides income support and incentivizes work. The EITC is explicitly tied to work—an individual or family without earned income is not eligible for the credit. Because it increases after-tax wages for some workers, the EITC creates incentive for individuals to enter the workforce. Under the federal EITC, families with two children receive a 40 percent subsidy to their earnings up to a maximum of \$5,548, which phases out as incomes rise. The gradual phase-out keeps families from abruptly losing the credit and reinforces the incentive to keep working and earning more. The Child Tax Credit (CTC) provides a similar benefit, giving families a \$1,000 credit for each child under 17 to help offset the costs of raising a child.

Twenty-six states and the District of Columbia supplement the federal credit by offering a state EITC, but the amount provided varies dramatically by state. In California, the EITC is equal to 85 percent of the federal EITC (for families and individuals with wage income below \$7,000 to \$14,000) and in a few states it is worth 30 percent or more. In other states, however, the state EITC is worth less than 10 percent of the federal credit.²⁸



Research shows that EITCs can contribute to improvements in children’s health, academic performance, and future earnings.²⁹ Increased income may allow the family to purchase more nutritious foods, seek preventive medical and dental care, and improve the safety of their home environment.

The EITC is an important component of state and federal efforts to reduce poverty. Poverty during pregnancy can have lasting effects on child health and cognitive development. One study found that \$1,000 in income from the EITC was associated with a 6.8 percent to 10.8 percent decrease in rates of low birth weight for single mothers with a high school education or less and up to a 15 percent decrease in low birth weight in high-poverty neighborhoods.³⁰ The Child Tax Credit was significantly associated with decreases in maternal depression³¹, a risk factor for child physical abuse and neglect.³²

■ ROLE OF THE HEALTH DEPARTMENT

States can support outreach efforts to maximize the number of families taking advantage of the credit, regardless of whether the state has an EITC that piggybacks on the federal EITC credit or not. Due to the way the EITC is calculated and claimed, administrative costs are minimal and as a result, in some states, there is no single agency charged by statute to promote public awareness of the credit or its eligibility requirements. To assist low-income individuals who may qualify for, but be unaware of, the credit, state health departments can provide public education and free tax preparation services to help families claim financial assistance. Informational materials can be included with public assistance checks, tax forms, and utility bills, or advertisements can be placed on public transportation. State health departments can also take steps to ensure that licensed childcare providers, home visiting programs, community health workers, and other professionals who serve low-income working families can offer clear and concise information about how to claim the EITC.

■ SELECTED STATE EXAMPLES

The **Texas Workforce Commission** and local workforce development boards assist TANF recipients who become employed to apply for the federal EITC.³³ **Washington’s Department of Social and Health Services** created a toll-free hotline to provide eligibility information and referrals to tax providers. The **Virginia Department of Social Services** mailed and called potential EITC-eligible recipients to encourage them to claim the EITC. The department spent roughly \$42,000 on outreach via mailings and phone calls, resulting in a \$2.4 million increase in EITC benefits claimed.³⁴

TANF Benefits

■ OVERVIEW

Temporary Assistance for Needy Families (TANF) provides income assistance and wage supplements, childcare, education and job training, early childhood home visiting programs, transportation, and other services to help low-income families with children. TANF benefits are funded through block grants to states, and each state has some flexibility in determining how it implements the program. TANF plays an important role in the range of income supports for low-income families because it is the only widely available source of cash assistance, usually a benefit paid monthly to help meet a family’s ongoing basic needs.

A family’s eligibility for TANF and the amount of cash assistance they receive depend on the state. States that set higher TANF benefits, allow longer lifetime limits, and eliminate family caps have documented decreases in the number of children in foster care.³⁵ Nine states and the District of Columbia raised TANF benefit levels between July 1, 2014 and July 1, 2015.³⁶

In addition, TANF connects families to other services that support positive long-term health outcomes for both children and parents, including health and nutrition programs, early childhood education, and quality employment and training opportunities.

■ ROLE OF THE HEALTH DEPARTMENT

State health departments can work with TANF agencies to both coordinate and serve as active partners in statewide, tribal, regional, and local efforts to promote family economic security. Many families are eligible for TANF benefits but do not receive them due to a lack of knowledge about their eligibility or the difficulty of the application processes. Online tools designed to streamline multiple benefit applications have been developed in states, including Colorado and California, where child welfare and income support specialists are co-located in one office, creating a single point of entry for accessing services. States can also support the co-location of parent and child services by sponsoring a job skills class in a childcare center, for example, making it easier for families to access both services.

■ SELECTED STATE EXAMPLES

Washington created a private-public partnership called Thrive Washington to better allow evidence-based home visiting programs to serve TANF families. Several types of funds, including state TANF and federal Maternal, Infant, and Early Childhood Home Visiting block grant funds, as well as private donations, are being used to provide TANF families with slots in home visiting programs, focusing on pregnant women and families with infants. The home visiting model bring a whole-family lens to working with TANF clients and supporting parents in their role as caregivers. Partners in this work include the Department of Early Learning, the Department of Social and Health Services, and the Department of Commerce. Thrive Washington also sits on Washington's *Essentials for Childhood* Steering Committee.

In **North Carolina**, the Division of Social Services, Economic and Family Services, which houses NC Work First, the state's TANF program, partnered with the North Carolina Office of Early Learning to improve collaboration between Head Start and Early Head Start programs and programs that administer TANF and work with TANF families. With funding from the state's Head Start program, the two agencies issued a competitive grant to incentivize partnerships between local Head Start and Early Head Start programs and county social services offices. As a result, more children of TANF participants accessed Head Start or Early Head Start slots through referrals from NC Work First.³⁷



Child Support Pass-Through

OVERVIEW

Consistent emotional and financial support from both parents benefits children's well-being. The child support system is meant to mediate the potentially negative consequences that children living apart from one of their parents experience by requiring noncustodial parents to contribute financially to their upbringing.

Under federal law, families receiving TANF benefits assign their rights to child support payments to the state in order to keep receiving income assistance under TANF. When a state collects child support on behalf of a TANF recipient, the state is permitted to keep the money to recoup its own costs or to allow some or all of the child support payment to be "passed through" to the custodial parent. Pass-through programs encourage noncustodial parents to pay child support because they know their money will directly benefit their children.³⁸

States can also disregard some or all of the child support payment when calculating the recipient's monthly TANF benefits; otherwise, benefits can be reduced dollar-for-dollar depending on the amount of child support received. Pass-through and disregarded dollar amounts vary by state. In recent years, states have experimented with child support pass-through policies, and currently about half of states allow some portion of the child support payments to pass-through to the families.

Child support payments can make a difference in the financial security of single parents and their children, as well as reduce the risk of child abuse and neglect. A recent study showed that a pass-through policy allowing 100 percent of child support to reach custodial parents is associated with a 10 percent decrease in child abuse and neglect reports.³⁹

ROLE OF THE HEALTH DEPARTMENT

Each state designates an agency to implement child support enforcement (CSE) efforts, such as the department of health, department of revenue, or the attorney general's office. TANF and CSE programs often serve an overlapping population and both systems share a common mission of ensuring the well-being of children and families. States can promote cross-training between TANF and CSE staff so they better understand each other's program goals, services, and policies and to recognize their shared objectives in supporting families. States can also support improved coordination across all programs and organizations involved in CSE, including legislators, courts, local and state bar associations, district and state attorneys, local child support directors, local law enforcement officials, and family and child support advocacy groups.

SELECTED STATE EXAMPLES

Research demonstrates that child support pass-through and disregard policies benefit both states and families. In **Wisconsin**, where all child support collected by the state is passed through to families receiving TANF cash assistance and disregarded as income, a widely-studied demonstration project showed that:⁴⁰

- Fathers were more likely to pay child support and make higher payments.
- Rates of paternity establishment increased.
- Overall costs for increased collections and distribution were relatively small, with a cost savings to the state.⁴¹

In addition, because many noncustodial parents have a limited ability to pay due to unemployment or other barriers to finding or maintaining a job, states are working to establish income-based child support orders. Determining child support payment based on income helps parents pay their child support more regularly over time. To address these underlying issues, states have implemented work-oriented

programs for unemployed noncustodial parents who are behind on their child support payments. As of February 2014, at least 30 states and the District of Columbia have work-oriented programs that serve noncustodial parents.⁴² Georgia, Maryland, and North Dakota have statewide programs.

North Dakota's Parental Responsibility Initiative for the Development of Employment (PRIDE) program provides case management, skills training, and job placement services to help noncustodial parents find employment.⁴³ Referrals to the program come from the court system and child support workers. PRIDE was expanded statewide in 2009 and is a collaborative effort involving Job Service North Dakota (the designated state workforce agency), the courts, and the Department of Human Services' regional human service centers, TANF, and child support enforcement programs.

In 2006, the **District of Columbia** used a Section 1115 Medicaid demonstration waiver to test a service delivery change to increase the number of child support orders by improving collaboration between the Department of Human Services' Child Support Services Division (CSSD) and the TANF agency. Three CSSD intake workers were colocated at one TANF office, so that clients could complete their child support interviews—the first step in establishing a child support order—on the same visit. By colocating staff, the project streamlined the child support order establishment process and increased child support payments to TANF families over time. There was limited interagency collaboration prior to this demonstration project but, because of the overlap in clients and their goals, as well as the potential for child support to contribute meaningfully to low-income families' resources, collaboration between the agencies yielded many benefits.⁴⁴

Enrollment in Federal Nutrition Safety Net Programs

■ OVERVIEW

Nutrition influences health at every stage of life, and many families living in poverty do not have access to healthy foods. Part of creating a nurturing environment is having adequate food. Household food insecurity has been associated with maternal depression, and family stress can undermine children's well-being.⁴⁵ Health problems associated with hunger and malnutrition can have permanent, negative effects on a child's immune system, cardiovascular system, and developing brain. Participation in federal nutrition safety net programs, such as the Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Program for Women, Infants, and Children (WIC), provides vital nutrition and health benefits to low-income families to ensure that young children have what they need for healthy development.

SNAP is designed primarily to assist eligible low-income households by providing monthly benefits that can be used to purchase food. To increase SNAP participants' access to fresh fruits and vegetables, states have created incentive programs to allow people to use Electronic Benefits Transfer cards and redeem benefits at farmers' markets and other fresh produce retailers.

WIC provides nutrient-rich foods, healthcare and social services referrals to low-income women, infants, and children, along with breastfeeding promotion and support. Breastfeeding has been shown to reduce the risk of child maltreatment.⁴⁶

Receiving WIC or SNAP benefits is associated with fewer child maltreatment reports.⁴⁷ Additionally, children who receive WIC and SNAP benefits experience lower levels of food insecurity.⁴⁸ While not directly aimed at preventing abuse and neglect, participation in programs such as SNAP and WIC, which offer a range of services and supports, may enhance protective factors, alleviate financial stress, and help caregivers meet their children's needs during critical developmental stages.

■ ROLE OF THE HEALTH DEPARTMENT

States play a critical role in maximizing the effectiveness of the federal nutrition safety net. Through a variety of policy options, states have the ability to adapt SNAP and WIC programs to meet the needs of their low-income populations.

WIC's funding is discretionary, and state agencies use formula grants to operate the program through local WIC agencies and clinics. While federal WIC guidelines provide a framework for delivering nutrition education programs, state and local agencies have significant flexibility to design programs that are culturally appropriate and responsive to the needs of their clients.

In 2014, about three-quarters of households receiving SNAP benefits also had at least one member enrolled in health insurance coverage through Medicaid or the Children's Health Insurance Program.⁴⁹ As states are implementing new eligibility systems and policies under the Affordable Care Act, this overlap presents an important opportunity to reduce duplication of effort and retain eligible families in these programs. States can use SNAP data to determine Medicaid eligibility without requiring eligible participants to complete a new application and submit supporting documentation to prove their income. In this way, states can simplify the application and eligibility determination processes and coordinate their renewal policies to improve administration, customer service, and program participation.

Similarly, the process of demonstrating eligibility for WIC can be time-consuming and complicated. States often use adjunctive eligibility to simplify the WIC application process. Under adjunctive eligibility, applicants who show proof of participation in SNAP, TANF, or Medicaid are automatically considered income-eligible for WIC.

Because WIC is often housed within state health departments, there is a natural bridge to other public health programs. State health departments can coordinate program operations and foster positive relationships with community partners and other entities that interface with clients, including childcare centers, shelters and food pantries, faith-based organizations, and educational institutions that train nurses and dietitians. Some states have designated WIC "referral days," where the WIC clinic might temporarily suspend services or change its hours of operation to allow local agency staff to physically visit other community partners to learn about other programs so that they, in turn, can make better referrals.

■ SELECTED STATE EXAMPLES

To better understand the referral process in WIC clinics, the **Maryland Department of Health and Mental Hygiene's** Office of Population Improvement started a quality improvement project to learn more about how clients were referred to, or educated about, lead testing, immunizations, smoking cessation, and comprehensive women's healthcare services.⁵⁰ WIC staff make referrals in these four areas, to either the local health department or to community health partners. Each month, more than 10,000 of these public health service referrals are given to Maryland WIC clients statewide with no systematic process of determining or tracking those who ultimately participate in or receive a service to which they were referred. WIC offices and other public health entities had very limited data-sharing capabilities. This project helped not only connect WIC clients to these services, it made the referral process more effective.



Maryland tested several strategies over a period of 10 months to identify ways to help ensure that WIC clients received the services to which they were referred. Health department staff conducted site visits of all the WIC clinics located in Prince George's and Montgomery counties and met with local health department coordinators to map out the procedures and steps taken at each stage of the referral process to identify the root causes of some of the issues within each process that could be made more effective or efficient.

The quality improvement team found that referral rates to family planning services were very low, in part because WIC staff are not trained on comprehensive women's issues. To address this educational gap, the team developed a module in partnership with the health department's maternal and child health program and the WIC training staff. The partnership focused on domestic violence prevention and response, smoking cessation, postpartum depression, and contraception methods. Of all pilot WIC clinic staff, 100 percent completed the module on comprehensive women's health and reported that they felt more comfortable talking with clients about family planning and postpartum depression. As a result, the state WIC program plans to standardize and implement this comprehensive women's health training module statewide.

Housing Assistance Programs

OVERVIEW

A safe, stable, nurturing environment for children starts with secure and affordable housing. Housing is considered an important social determinant of physical and mental health. High-quality, stable housing has been linked with improved health, educational, and economic outcomes.⁵¹ Without affordable housing options, families are often forced into substandard living arrangements, which puts them at risk for lead exposure, asthma, and unintentional injury.

Impoverished communities often lack the businesses, employment opportunities, and other institutional resources that help families thrive. Concentrated poverty limits opportunities for people living in these communities, and social disadvantage perpetuates a cycle of crime, health, and education problems. Without social cohesion, limited neighborhood resources can exacerbate stress. Affordable housing programs are a platform for helping families become self-sufficient.

Housing assistance reduces homelessness,⁵² homelessness increases the likelihood that a child will be placed with relatives or in foster care.⁵³ Housing voucher programs may reduce child abuse and neglect by decreasing children's exposure to crime and violence, and by allowing families to rent properties in safer, more stable, and higher opportunity neighborhoods.⁵⁴

ROLE OF THE HEALTH DEPARTMENT

Some state and local governments offer housing assistance programs for low-income families and individuals who qualify for, but do not receive, federal rental assistance programs.

The most common housing assistance programs include:

- Housing vouchers that allow people to live in private rental housing.
- Public housing, which consists of affordable housing developments managed by public housing authorities.
- Project-based rental assistance, which contracts with private building owners to make apartments affordable.

Linking housing to health, education, workforce programs, and other supportive and case management services may improve outcomes for low-income families and children. State health departments can work with public housing agencies to explore colocating or coordinating health, behavioral health, and



safety and wellness services with housing. State Medicaid agencies can leverage funds to test innovative strategies for bringing housing and Medicaid-reimbursed services together, since homelessness is a major driver of healthcare costs among vulnerable populations.

Racial and economic segregation affects how different groups of people access educational, transportation, healthcare, and employment resources. Opportunity mapping uses a variety of data sources to reveal patterns of segregation and can help policymakers understand how these trends influence access to services that promote economic and physical well-being. State health departments can use local data from public housing authorities, education and transportation agencies, and nonprofit organizations to supplement the U.S. Department of Housing and Urban Development's national data sources to create a more relevant, meaningful picture of local conditions that represent what is actually happening. States can conduct an opportunity mapping analysis and study a variety of different indicators to create an opportunity index for each community in a selected county, for example.

State health departments can also make housing voucher programs easier for families to navigate. Sometimes families who rely on housing vouchers can face discriminatory practices among landlords who refuse to allow voucher holders to rent from their properties, either to circumvent the administrative requirements of the program or because of negative stereotypes of families who participate in a voucher program. States can raise awareness about housing discrimination and enact local laws to prohibit property owners' discrimination against families who use housing vouchers.

■ SELECTED STATE EXAMPLES

In 2012, **New York** used a Section 1115 Medicaid demonstration waiver to overhaul its Medicaid system, and later, in 2014, the state was awarded a Centers for Medicaid and Medicare Services (CMS) State Innovation Model grant to help support its planning and implementation efforts. Part of a larger Medicaid redesign effort, one of the state's priorities under the Supportive Housing Initiative⁵⁵ is expanding supportive housing units and providing rental subsidies for high-risk homeless and unstably housed Medicaid recipients. Supportive housing dovetails with other interventions, providing subsidies for housing providers to offer supportive services to high-risk patients, including older adults and persons living with HIV. Supportive housing providers in New York can use Medicaid funds to expand the supply of permanent supportive housing in the state and better address the health needs of homeless and other individuals. These efforts are coordinated across a variety of state agencies, including the Office of Addiction Services and Supports, the Office of People with Developmental Disabilities, the Office of Mental Health, and the AIDS Institute.

In December 2015, CMS approved a five-year renewal of **California's** Section 1115 Medicaid Waiver, Medi-Cal 2020. Included in the waiver was the Whole Person Care pilot program⁵⁶, a new initiative that allows participating counties to test local strategies to better coordinate physical health, behavioral health, and social services for Medicaid beneficiaries who are high users of multiple healthcare systems

and have poor health outcomes. One of the project's main goals is to improve integration among county agencies, housing authorities, health plans, providers, and other entities within the participating counties so that they can develop an infrastructure that will ensure local collaboration to identify and secure housing for people with medical needs who are experiencing, or are at risk of, homelessness.

Childcare Access

OVERVIEW

Providing high-quality childcare can be one of the biggest challenges for families with young children, yet it is essential to giving their children a strong start. Quality childcare allows parents to work or go to school while also providing young children with the early educational and developmental opportunities they need to be ready to learn and succeed. For parents to take advantage of other vocational training programs or classes intended to help lift them out of poverty by entering the workforce, they first need access to childcare. Quality childcare is an essential support for working families, but, without subsidies, it can be prohibitively expensive.

Childcare subsidies help parents enter and remain in the workforce so that they may provide financially for their families. Parents receiving childcare subsidies tend to choose better quality⁵⁷ and more stable childcare.⁵⁸ Research suggests that state policies improving access to subsidized childcare are associated with decreased child abuse and neglect rates.⁵⁹

The Child Care and Development Block Grant (CCDBG) is the major federal childcare assistance program that provides childcare assistance for low-income families so they can work or participate in education and training. States contribute matching resources for a portion of the CCDBG block grant funding they receive. Although states have different childcare subsidy policies, practices, financing approaches, and administrative structures, they typically use the grants to subsidize childcare for low-income working families, administered through vouchers or certificates, which can be used by parents for the care provider or program of their choice. The vouchers pay part of the fee based on a sliding scale.

The CCDBG was reauthorized in November 2014 with several new measures aimed at improving the continuity and quality of childcare. The CCDBG reauthorization sets out a number of policy changes designed to reduce barriers for families trying to access and maintain childcare assistance. It includes several statutory changes and defines requirements related to the health and safety of childcare settings, improved transparency of information for consumers and providers, new family-friendly eligibility parameters, and quality improvement efforts. As states are developing childcare plans in response to new federal rules, there is a critical opportunity to consider how these programs support both child development and address a broader set of family needs, either directly or by helping parents access other types of services.

ROLE OF THE HEALTH DEPARTMENT

States operate their childcare subsidy programs by creating policies that set income eligibility limits, waitlists, copayments and fees, and provider reimbursement rates. Coordination across state agencies is necessary to ensure that the childcare subsidy program is being administered alongside other state quality improvement initiatives and early childhood systems. While parents always have the option to receive a voucher to use with a childcare provider of their choice, states may also establish direct contracts with providers. In continuing to emphasize quality, above minimum childcare licensing standards, states can require that providers, as a condition of receiving a direct contract, meet national accreditation standards or higher levels of a state quality rating and improvement system (QRIS).



Regardless of whether they are the lead agency for administering the CCDBG, state health departments can conduct outreach to potentially eligible families who participate in programs such as TANF or WIC. Additionally, by creating and maintaining an active, centralized waitlist to illustrate the need for subsidies, particularly in underserved areas, or communities with high levels of poverty or unemployment, states can also make the case for additional resources to support access to childcare for low-income working families.

Many families receiving childcare assistance are also eligible for other benefits and services, but these programs often have separate and cumbersome eligibility and renewal requirements, which can make it difficult for families to stay actively enrolled in all of the programs that are integral to supporting their child's health and well-being. States are increasingly aligning eligibility criteria and other policies across Medicaid, SNAP, and childcare assistance to reduce duplication and more effectively connect families to the services provided through these programs.

■ SELECTED STATE EXAMPLES

In **New Hampshire**, eligibility is coordinated across SNAP, Medicaid, childcare, and TANF, with state offices using a single application for all four programs and aligning documentation and verification practices across programs.⁶⁰ Families receive 12-month eligibility for childcare, and when they receive multiple benefits, the period of time until the family must verify their eligibility again is the same across SNAP, TANF, and Medicaid. The state also created an online portal to allow families to apply for and track multiple benefits, including childcare.

In **Oregon**, the Department of Human Services recommends a budget for establishing subsidy policies. Directed by the legislature, the department implemented policy changes in 2007 by substantially increasing the maximum rates paid to providers, decreasing parents' copays, increasing income eligibility, and increasing the length of time between required redeterminations of eligibility. More recently, in July 2015, the legislature passed HB 2015, making additional reforms to Oregon's childcare subsidy program. It creates financial incentives for families and childcare providers to use the state's QRIS. Families who voluntarily choose a QRIS childcare provider get a reduced copay, and providers with a 3-, 4- or 5-star rating through Oregon's QRIS receive a monthly incentive payment on top of their set reimbursement rate.⁶¹

Quality Care and Education Early in Life

Quality early education programs can positively influence a child's approach to learning and promote social, emotional, physical, cognitive, and language development. Children who have access to high-quality early care and education experiences tend to have better outcomes across these developmental domains.⁶² In addition to addressing children's early learning needs, comprehensive early education programs also engage parents, creating a network of support that centers on strong children, families, and communities and better outcomes.

Policy strategies to promote quality care and education early in life are discussed below.

Early Head Start

OVERVIEW

Early Head Start provides early, continuous child development and family support services to low-income infants and toddlers and their families, and also to pregnant women and their families. The primary goal of the program is to support child development, but it has also shown positive impacts on parenting and family well-being.⁶³ Early Head Start has the potential to serve as a hub for a variety of services for the most vulnerable children and families. It is delivered through several program options, including programs that are center-based, home-based, or a combination of the two.

Children in the very young age group served by Early Head Start are in a critical period where nurturing environments are especially important, and adverse experiences can be especially harmful. The focus that Early Head Start places on increasing positive parenting and decreasing corporal punishment might play a role in reducing child abuse and neglect. Parents of children who participate in the program are more likely to enroll them in other early childhood education programs, such as Head Start or state pre-K classes.⁶⁴

In May 2013, data collection and analyses were completed on a joint project between the Early Head Start Research and Evaluation Project, the Administration for Children and Families (ACF) and the CDC to examine child protective service reports among Early Head Start research participants. For the study, researchers matched data on child protective services reports from seven pilot sites. The data show that children in Early Head Start had significantly fewer child welfare encounters between the ages of five and nine years than children in the control group. Additional findings suggest that the program may be effective in reducing child physical and sexual abuse among low-income children.⁶⁵

ROLE OF THE HEALTH DEPARTMENT

While the federal Office of Head Start administers the program by awarding grants directly to local grantees across the county, state health departments can consider how to better integrate Early Head Start with other state early childhood services to prioritize healthy child development and learning. States can work with local grantees to help coordinate training and technical assistance, use resources efficiently, and provide guidance on continuous quality improvement. For example, states may have existing networks of public health nurses or home visiting staff who can collaborate and provide additional training and professional development for Early Head Start providers. In lieu of providing direct services, states can use their expertise to improve both the quality of and access to the program and childcare programs, and help create the infrastructure and management systems to support young children and families.

Because state agencies often have administrative and fiduciary responsibility to oversee childcare licensing and subsidy funds, food assistance programs, state pre-kindergarten programs, and early childhood home visiting grants, they can help connect Early Head Start providers with other systems and services

that touch the same families. States can commit to helping local agencies with less organizational capacity use data and information systems to help track longitudinal trends and health outcomes among children and families served by these programs.

■ SELECTED STATE EXAMPLES

In 2014, Congress appropriated \$500 million for Early Head Start-Child Care Partnerships (EHS-CCP)⁶⁶ to expand high-quality, comprehensive early learning opportunities for young children through greater coordination of childcare and Early Head Start services and, at the same time, create a continuum of care from birth through kindergarten. By layering funding, the program integrates Early Head Start comprehensive services and resources into traditional childcare and family care environments, (i.e., by combining existing childcare operating subsidies with Early Head Start funds for both comprehensive and individual child services).

Alabama, California, Delaware, Georgia, Pennsylvania, the District of Columbia, and the Northern Mariana Islands received state-level EHS-CCP grants.



Alabama’s Department of Human Resources is partnering with other state agencies and existing Head Start programs to better align state and local early learning system efforts. For example, the department created a memorandum of understanding with the Alabama Department of Health to coordinate healthcare for all families participating in the EHS-CCP initiative statewide. The state’s childcare subsidy program is also aligning its eligibility policies with EHS-CCP to streamline the process and better meet the needs of families who are eligible and receiving services through both programs. A state-level Parent Policy Council also serves as an advisory body to the EHS-CCP program.⁶⁷

High-quality Preschool Education

■ OVERVIEW

High-quality preschool education, including pre-kindergarten and Head Start, is increasingly seen as laying a solid foundation for children to acquire school readiness skills and be exposed to rich learning opportunities that promote brain development, healthy behaviors, and relationships with peers and adults. Children who attend high-quality preschool programs are more likely to arrive at kindergarten with social-emotional skills and academic experiences that put them on a path for success. States often prioritize or target enrollment to those children and families living in poverty. Still, only 41 percent of four-year-olds nationwide are enrolled in publicly funded preschool programs, like pre-k and Head Start.⁶⁸

Pre-k and Head Start program models differ in several ways. Head Start is a comprehensive child development program that provides children with preschool education, health screenings and examinations, nutritious meals, and opportunities to develop social-emotional skills. Head Start programs work with families to ensure they have the means to obtain health insurance, services for children with disabilities, adequate housing, and job training. Pre-k programs are funded locally and designed for children ages 3 or 4 to provide one or two years of education prior to kindergarten. These programs focus on children’s pre-academic skills to prepare children to enter a school environment. Pre-k programs often operate in conjunction with public school districts, whereas Head Start contracts with local agencies to provide early education and social services for low-income families. Head Start is similar to pre-k, but it serves a broader age group (from newborns to 5-year-olds), as well as pregnant women.

■ ROLE OF THE HEALTH DEPARTMENT

Consistent, meaningful family engagement is an important component of preschool and all early childhood programs that promote children’s development, learning, and wellness, and states play an important role in setting the foundation for effective family engagement. Increased participation in these programs by family members and other caregivers in these programs has been linked to stronger social and emotional skills among young children, and reductions in child maltreatment⁶⁹ and youth violence.⁷⁰ State health departments can work to ensure that family engagement is integrated across early



childhood and education agencies and programs by adopting a unified vision that will enable the state to better coordinate its efforts, and by supporting partnerships with community-based organizations and employers who are in a position to strengthen outreach efforts to parents.

States implement and operate pre-k programs in many different ways and, while access to pre-k is important, the quality of programs is paramount to delivering long-term, positive benefits. Many states are working to establish statewide quality systems for pre-k, and implement policies to ensure continuous improvements and high standards. Quality rating and improvement systems (QRIS) are a major initiative in many states that can be used to align standards and address transi-

tions for infant and toddler development to ensure a continuum of early learning.⁷¹

It lays out quality standards for programs and practitioners, infrastructure to meet these standards, monitoring and accountability systems, plans for ongoing financial assistance that is tied to meeting quality standards, and engagement and outreach strategies.

Through QRIS, states establish tiers of early care and education program quality and programs voluntarily participate in order to receive a quality rating. QRIS is a common framework that creates and links standards across the early childhood system, including childcare, Head Start and Early Head Start, and pre-k. Leveraging QRIS, state health departments might, for example, request that participating providers conduct a systematic assessment of their policies and practices related to referrals for family support services, or they might simply include information on child abuse and neglect prevention in the set of materials and resources that programs participating in QRIS receive.

Collaboration between Head Start and state pre-K programs requires strong partnerships and often involves revisiting how to establish or improve relationships among state and regional education agencies, school superintendents, Head Start providers, teachers, and parents. Federal and state government officials can model collaboration and encourage school districts and Head Start grantees to work together to identify and overcome the barriers that exist. States can explore intergovernmental agreements that would spell out regional, state, and local level strategies for improving the integration of education and services along the early childhood continuum.

■ SELECTED STATE EXAMPLES

Oregon is taking steps to increase equitable access to high-quality learning experiences for all young children and promote family engagement. Members of Oregon’s philanthropic community, and ardent supporters of family engagement and parent education programs, launched the Oregon Parenting Education Collaborative, which has brought Parenting Hubs to nearly every county in the state. The collaborative provides parent workshops, family events, classes, and home visiting services. In 2013, Oregon restructured its early childhood programs, moving several agencies into the Department of Education to form the Oregon Early Learning System.⁷²

Inspired by the Parenting Hubs, the state also created Early Learning Hubs, which began operating in 2013, to coordinate and foster collaborations across sectors that serve children and families. All 16 hubs across the state share common goals, including making families a central part of the state’s Early Learning System. While Parenting Hubs serve a universal population, Early Learning Hubs target underserved families and children in the state—yet both are focused on integrated approaches that promote children’s kindergarten readiness by teaching and building positive parenting skills. Communities are responsible for identifying the backbone organizations that will support the work of each hub. As a result, hubs have many different kinds of partners serving as their backbone organizations, including education service districts, county governments, community colleges, coordinated care organizations, and non-profits such as the United Way.

In the 2015 legislative session, the Oregon Legislature enacted HB 3380 creating Preschool Promise, a new, mixed delivery preschool model that recognizes that early learning happens in a variety of settings, giving families the ability to choose the preschool setting that works best for them and their child, such as elementary schools, Head Start programs, licensed center- and home-based childcare programs, and community-based organizations.⁷³ Hubs also are working to align their services with the coordinated care organizations that are being established in the state, with some of the organizations providing additional funding to expand parent education and support to families and children in their region.

HB 3380 directs the Early Learning Hubs to coordinate and contract with local preschool providers in the hub’s service area to bring new and expanded preschool opportunities throughout Oregon.

Policies to Support Working Families

The way that families live and work has changed. Increasing numbers of children are growing up in single-parent homes or households in which both parents work. Public and private sector family-friendly policies allow working parents to more easily balance family and work priorities and help them earn a living without compromising their ability to give the emotional and developmental support children need in their early, formative years. Family-friendly policies can also help alleviate poverty by making it possible for more people to remain in the workforce.

Policy strategies to support parents and positive parenting are discussed below.

Paid Leave: Family, Parental, and Medical Leave

OVERVIEW

Paid leave is time away from work that helps people take care of important life events without jeopardizing their economic security. While paid leave is a relatively common benefit employers provide employees, only 12 percent of private sector workers have access to paid parental and family leave benefits through their employer.⁷⁴

Paid family leave is particularly important for low-income workers, who are often less able to bounce back from a significant loss of income when they need to take leave from work when they have a new child, experience a personal medical emergency, or have a family member who is ill. The high cost of infant care is prohibitive for many families and often forces parents, typically new mothers, to leave the workforce, which can have profound consequences on their lifetime earnings.⁷⁵

There is evidence linking paid leave to better maternal and child health outcomes. Using paid leave following the birth of a child is associated with mothers and fathers taking longer periods of leave, which results in strengthened parental bonding over a child’s life, with long-term benefits for brain development and overall well-being. Paid family and medical leave programs can have a positive effect on the financial and physical health of working families, and are associated with reductions in parental

depression and stress,⁷⁶ both of which are risk factors for child physical abuse and neglect.⁷⁷ Paid family leave to care for a newborn has also been associated with reductions in abusive head trauma (i.e., shaken baby syndrome).⁷⁸

There is no national law in the United States that provides paid leave to employees to care for their families. Although the Family and Medical Leave Act (FMLA) mandates that companies provide leave, the law does not require that it be paid. Therefore, unpaid leave is most common, while paid parental leave (beyond paid sick or vacation days) is limited. Without paid family or medical leave, families often cobble together shorter leaves using bits and pieces of earned vacation or sick time.

There are several types of paid leave policies, including:⁷⁹

- Parental leave for mothers (maternity leave) and fathers (paternity leave) for bonding with a new child after birth, adoption, or foster placement.
- Family leave for parents taking care of a child with a serious health condition, or for workers who need to care for ill or disabled adult family members, such as their spouse, parents, or adult children.
- Medical leave for workers with a serious health condition needing time for self-care, including medical leave for women around pregnancy and childbirth.



The federal Family and Medical Leave Act (FMLA) allows people to take up to 12 weeks of unpaid medical, parental, or family leave with the legal right to return to their jobs, but roughly 40 percent of American workers are not eligible for the FMLA benefits because they work for smaller businesses or have not been employed long enough to be eligible.⁸⁰

Several state legislatures are considering bills to establish paid leave programs to build upon the FMLA. California, New Jersey, and Rhode Island have created insurance programs that provide paid family and medical leave to workers. In April 2016, New York became the fourth state with paid family leave, which will go into effect in 2018. Under these state laws, employees continue to receive a portion of their wages while

they are on leave.⁸¹ Other states are adding on to the FMLA's unpaid leave benefits by adopting statutory provisions that expand the definition of family, for example, or apply the law to smaller businesses.

■ ROLE OF THE HEALTH DEPARTMENT

One of the biggest challenges for states that want to implement paid family leave programs is the absence of appropriate, cost-effective state-level financing or administrative structures needed to run these programs. California, New Jersey, and Rhode Island implemented paid family leave programs on top of pre-existing temporary disability insurance programs. While they provide a solid infrastructure for building on paid leave programs, only five states have disability insurance programs.

State health officials can work with partners at the state department of labor and with legislators to explore alternative financing structures, such as looking at existing unemployment and workers' compensation programs, which are often financed through employee or employer payroll taxes, to determine if this method of tax collection could be used to generate enough revenue to fund a new paid leave program in the state.

In states that have paid family leave, state health departments can partner with other agencies, coalitions, and local businesses to disseminate accurate, clear, and comprehensive information about available leave options. To encourage low-income working families to use paid leave benefits, states can work with healthcare professionals who interact with pregnant women and parents of young children, including pediatricians and community health workers, to pass information on to their patients. States can urge

leadership and staff at other organizations that interact with families, such as childcare providers, daycare centers, Head Start programs, WIC offices, and schools, to also provide information to their clients.

State health departments can also support data collection efforts to better illustrate who has access to paid leave benefits and where disparities in access may exist. Expanding data collection and producing annual reports can help educate policymakers and increase public awareness, particularly among low-income workers. Finally, states can formally recognize champions in the business community who are educating their employees about paid leave and encouraging them to take advantage of the benefits that paid leave offers. Commending businesses that actively support their employees demonstrates a commitment to moving toward a broader culture of family-friendly business practices.

■ SELECTED STATE EXAMPLES

By the time it is fully phased-in, **New York State's** paid family leave law will make virtually all employees in the state eligible for 12 weeks of paid leave to care for an infant or a family member with a serious health condition, or to relieve family difficulties when a spouse, domestic partner, child or parent is called to active military service. The law, enacted earlier this year as part of the state budget, will provide job-protected paid family leave to workers in New York regardless of the size of their employer.

New Jersey's Family Leave Insurance (FLI) program is funded through an employee payroll tax and provides up to six weeks of paid leave to bond with a new child or care for a sick family member. Benefits are paid at two-thirds of the worker's average wage, up to a maximum weekly benefit of \$615 in 2016. To make information about paid family leave more accessible, state lawmakers passed a law in January 2016 requiring the New Jersey Department of Labor and Workforce Development to create a one-stop website containing information for the public about paid and unpaid leave benefits available to New Jersey workers. The department also provides an online filing option for individuals wishing to claim paid leave benefits, allowing them to submit required documents online, rather than by mail or fax.

In addition, a yearlong, qualitative study involving low-income parents in New Jersey found that, on average, working mothers who took time off using paid leave reported breastfeeding for one month longer, compared to those who did not use paid leave.⁸²

Paid Sick Leave

■ OVERVIEW

More than 80 percent of low-wage workers do not have paid sick days.⁸³ There are also racial and ethnic disparities in access to paid sick leave. In a survey of a nationally representative sample of U.S. adults, black and Spanish-speaking Hispanic workers were found to be more vulnerable to H1N1 transmission than whites because of a lack of paid sick leave, reliance on public transportation, and fewer options for childcare separate from other children.⁸⁴

Earned, paid sick leave helps working families take time off to recuperate from illness or seek medical care without putting their economic security at risk. Unlike paid family and medical leave, paid sick leave is designed for short-term illnesses or injuries and to support preventive healthcare. Access to paid sick leave promotes public health by reducing the spread of illness.⁸⁵ By allowing employees to seek care during regular business hours, it also reduces healthcare costs by curbing unnecessary visits to the emergency department.⁸⁶ Lastly, paid sick leave supports child and family well-being by helping parents meet their caregiving responsibilities.

There are no federal laws that require employers to provide paid sick leave for their employees. All states provide paid sick leave to at least some state employees, and the federal government provides 13 paid sick days that employees to care for themselves or their families.



In the United States, California, Connecticut, Massachusetts, Oregon, Vermont, and the District of Columbia currently have laws that require employers to provide paid sick leave benefits, along with 26 cities and one county.⁸⁷ As more states and jurisdictions consider similar legislation, there is a growing body of evidence demonstrating that providing access to paid sick leave has positive outcomes for businesses, local economies, and public health.

■ ROLE OF THE HEALTH DEPARTMENT

Nationally, several cities and states have performed health impact assessments (HIAs) on paid sick leave policies, and have developed case studies to describe the implementation of paid sick leave policies. State health departments have an opportunity to lead or serve as experts and key contributors to HIAs. Health departments have access to data sources, such as hospital discharge data, that could be used to monitor indicators associated with paid sick leave over time in order to study whether these policy changes can be linked directly to health outcomes. Health departments could also consider adding a question about paid sick leave to the Behavioral Risk Factor Surveillance System and perform an analysis on access to paid sick leave and preventive care services.

Since there are disparities in access to paid sick leave in the U.S., particularly with respect to socio-economic status, states can take steps to ensure that policies are thoughtfully crafted and implemented to help create systems and cultures that are inclusive of all workers, including a strong communication plan to help spread awareness about the policy. Health departments can play a role in supporting such public information campaigns and in reviewing the results of periodic surveys of employers to assess the impact on small businesses and on families.

■ SELECTED STATE EXAMPLES

In 2016, **Vermont's** governor signed House Bill 187 into law, enacting a statewide paid sick leave law. The requirements will be phased-in starting in January 2017, when Vermont employers must allow employees to accrue and use at least 24 hours (or three days) of earned sick time in a 12-month period. For more than 10 years, getting a paid sick leave law had been a priority for the Vermont Paid Sick Days Coalition, as well as other advocacy groups and grassroots supporters of child health and welfare, workforce and civil rights reform, and domestic violence prevention. Over the years, the coalition worked with Vermont lawmakers, businesses, and the public to educate stakeholders, hear and address concerns, and collect stories about the urgent need for paid sick leave from communities across the state.

The Vermont Department of Health and key stakeholders conducted a health impact assessment to study the possible effects of a statewide paid sick leave policy that was re-introduced during the 2015 legislative session.⁸⁸ A year earlier, having committed to pursuing a Health in All Policies approach to policy development, the department considered several topics for an HIA, but chose paid sick leave because the legislative proposal made it immediately relevant and it had widespread health and health equity implications. Health department staff with HIA experience volunteered to lead the paid sick leave HIA and invited a group of stakeholders to help complete the assessment, including the Vermont Commission on Women, as well as representatives from childcare centers, schools, hospices, trade organizations, and the restaurant industry. Other partners included the Vermont Medical Society, the Vermont Department of Labor, the Lake Champlain Regional Chamber of Commerce, and the Vermont Health Care Association.

Results from the HIA indicated that a paid sick leave law in Vermont would significantly increase access to paid sick leave among low-wage, part-time workers, and employees of small businesses. While empirical evidence demonstrated the link between the availability of paid sick leave and preventable hospitalizations, Vermont data showed that approximately \$6 million in healthcare costs could be saved if implementing a paid sick leave policy reduced avoidable hospitalizations by 10 percent.

State health departments can use HIAs on paid sick leave and other policy proposals as tools to engage the public health and business leaders on issues that affect not only the economy, but also the health and prosperity of individual workers, families, and communities.

Conclusion

Preventing child abuse and neglect is a public health imperative to help all children reach their potential. Adverse experiences in early childhood are associated with poor health and mental health outcomes in children and families, and these negative effects can last a lifetime. Federal, state, and local governments, communities, early childhood professionals, businesses, parents, and other stakeholders share in the responsibility of ensuring child and family well-being. Research has shown what children and their families need to thrive today and into adulthood, at home, in school, at work, and in the community. Because child abuse and neglect affects entire communities, multiple sectors—including medical and behavioral health, law enforcement, judicial, businesses and employers, social services, and nonprofit agencies—need to be involved in systematically implementing policies and services that best meet the needs of children and their families. Policies that help families meet their basic needs and access supportive services in the community can ease the stress that sometimes gives rise to child abuse and neglect. As the examples provided in this guide demonstrate, state health departments and other partners are well-positioned to align programs and policies to link parents to economic resources, such as job training and social services, and create access points for healthcare, childcare subsidies, and other benefits.

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Association of State and Territorial Health Officials
2231 Crystal Drive, Suite 450
Arlington, VA 22202

202-371-9090 tel | 202-371-9797 fax
www.astho.org