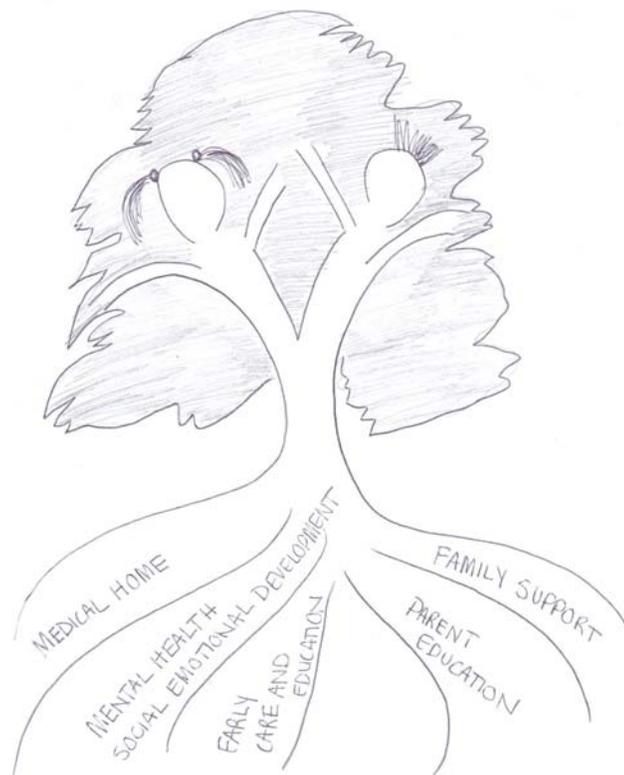




2009-2012
Maryland Early Childhood
Comprehensive Systems
State Plan of Implementation

Growing Healthy Children



Giving Maryland children roots to grow...
strong and healthy minds and bodies.

SUMMARY:

This executive summary provides a comprehensive framework and description of the Maryland Early Childhood Comprehensive System state plan. The introduction briefly describes the purpose of the Maryland Early Childhood Comprehensive Systems project as well as the background of the present proposal.

Introduction

The early childhood years, ages 0 to 5, are a critical stage of growth and development. Maryland's Early Childhood Comprehensive Systems (ECCS) Building Initiative, is a statewide effort to strengthen Maryland's system of services for young children and families. This opportunity ensures the infusion of quality health systems throughout every Maryland state program and agency working with young children. Collaborations and partnerships between public, private, and community agencies are essential to ensuring that all children enter school healthy and ready to learn. Partners of Maryland's State Plan include all the state departments that administer programs serving young children, community based agencies, childcare providers, health care and mental health professionals, child advocates and parents of young children. These partners continue to work together to improve outcomes for children and families by building a coordinated, comprehensive system which addresses five critical components: access to health insurance and medical homes, social-emotional development/mental health, early care and education, and family support and parent education.

Health of Maryland Children

In Maryland, there are 786,253 families, with 1,370,586 children (NCCP, 2007). There are 449,749 children between the ages of zero and five, 8% of the total population living in the state of Maryland (The Annie E. Casey Foundation, 2007). A long-standing policy of focusing on the well-being of young children has recently expanded to include readiness for entry to school. As one of the wealthiest states, measured by per capita income, Maryland has too many children entering school both unhealthy and unprepared to succeed at learning. The estimated population of Maryland in 2007 was 5,618,344, a slight increase from the 2006 estimate of 5,615,727 (Vital Statistics, 2007 & The Annie E. Casey Foundation, 2007). The distribution of the 2007 Maryland population was as follows: White (64.2%), Black or African-American (30.0%), Asian or Pacific Islander (5.3%) and American Indian (< 1%) (Vital Statistics, 2007). Over six percent of the population (6.3%) was comprised of individuals of Hispanic origin (Vital Statistics, 2007).

Several positive health factor improvements were seen in the last Title V needs assessment, namely a decrease in child death rates, decrease in child abuse (except in the rural areas of the eastern shore), more new mothers initiating breastfeeding, more children immunized on schedule and having access to health insurance. However, by 2007, nearly 80% of live births were to women who began prenatal care during the first trimester of pregnancy, and 4.7% were to women who received late (third trimester) or no prenatal care. These figures indicate a decrease from 2000, when 86% of pregnant women initiated care in the first trimester. Additionally, the percentage of women receiving late or no prenatal care has been increasing among white and Hispanic women in recent years. (Vital Statistics, 2007). These fluctuating data points further support the need for preventative health services for woman of childbearing age, whether or not a pregnancy is planned.

Health disparities that have a negative impact exist between Caucasians and African Americans. Selected statistical data (Table 2. Maryland's Indicators of Healthy Children- page 10) describe Maryland's early childhood population and identify unmet needs that could negatively impact school readiness. These indicators include infant mortality, low birth weight, poverty, asthma, lead poisoning/exposure, homelessness, abuse and neglect, and mental health concerns and psychosocial issues.

Statewide, about 13.4% of Maryland adults and 13.1% of children have a history of asthma. [About 8.9% of adults and 9.1% of children currently have asthma.] (Asthma in Maryland, 2006). In 2006, there were approximately 9,700 asthma hospitalizations and approximately 44,000 emergency department (ED) visits in Maryland for asthma (Asthma in Maryland, 2006). Asthma caused an average of 81 deaths per year in Maryland over the past 5 years. In 2006, hospitalization expenditures due to asthma totaled nearly \$57 million (Asthma in Maryland, 2006). Charges for emergency department visits due to asthma totaled an additional \$27 million (Asthma in Maryland, 2006). Many disparities can be seen in the morbidity and mortality from asthma. Persons at increased risk for asthma and its complications include the very young, the elderly, African-Americans, low-income persons, and individuals in some jurisdictions— particularly Baltimore City. Recent prevalence data also indicates high asthma rates for Maryland Hispanics (Asthma in Maryland, 2006). In Maryland, African-Americans adults have a 1.3 times higher asthma prevalence than Caucasian adults (Asthma in Maryland, 2006). Black children are more likely to be affected than other children, and are more likely than White children to be brought to the ED because of asthma complications or other respiratory disease (Maryland's Children and the Environment, 2008).

Emergency department visits, hospitalizations, and mortality demonstrate a failure to properly manage asthma. These events are preventable (Asthma in Maryland, 2006). African Americans are more likely to have asthma and chronic conditions associated with asthma due to a lack of access to quality health care, poverty, and increased exposures to environmental factors associated with developing asthma. African-Americans have a 4.3 times higher rate of emergency department visits, a 2.4 times higher rate of hospitalization, and a 2.4 times higher rate of mortality than Caucasians (Asthma in Maryland, 2006). Asthma may interfere with all aspects of daily life, including work, sleep, and daily activities. Consequently, adults with asthma perceive their general health less favorably than those without asthma.

Exposure to lead is an important public health problem, particularly for young children. Blood lead levels are highest for younger children, who play and crawl on the ground and frequently put their hands in their mouths. Within the larger population, blood lead concentrations differ by race and family income and are useful in identifying communities at greatest risk (Maryland's Children and the Environment, 2008). Eliminating blood lead levels (BLL) >10 $\mu\text{g}/\text{dL}$ in children is one of the 2010 health objectives from the U.S. Department of Health and Human Services (DHHS). Maryland is actively working to eliminate lead poisoning by 2010 through the combined efforts of the Maryland Department of the Environment (MDE), the Lead Coalition, and the Center for Maternal and Child Health (CMCH). There is strong emphasis on increase screening and testing by health care providers, as well as, home visiting and case management by the local health departments (LHDs) for children with blood lead levels >10 $\mu\text{g}/\text{dL}$.

The National Health and Nutrition Examination Survey (NHANES) survey, 1991-1994, 1999-2002, and 2001-2004 revealed that among subpopulations, non-Hispanic blacks (aged 1-5 years) had the highest prevalence of elevated blood lead (EBL) levels (51%). Although NHANES is a nationally representative survey, the low prevalence of elevated BLLs does not allow stratification by more than one factor that might be related to exposure, such as race, ethnicity, or age of residence. Preliminary work to determine the most sensitive indicators of childhood lead poisoning in Maryland show that the percentage of children less than five years of age, who are from families with annual incomes low enough to be included in the Federal Government's definition for poverty (US Bureau of Census) are at increased risk. Thus, poverty is the second most significant risk factor, after pre-1950 housing. In Baltimore City and the Maryland lower Eastern Shore, there are high percentages of households with annual incomes at or below the poverty level, especially in older communities.

The majority of children with lead exposure, at high enough levels mandating case management in the state, are African-Americans (“Maryland Plan to Eliminate Childhood Lead Poisoning by 2010”, MDE, 2008). Lead poisoning can affect many systems in a child’s body including neurological impairment and ability to learn. Testing rates of young children increased statewide from 13.2 percent in 1996 (59,700 children) to 22.2 percent in 2006 (103,000 children) (Maryland’s Children and the Environment, 2008). The number of children statewide with blood lead levels greater than 10 µg/dL has declined steadily from 17.2 percent in 1995 to 1.2 percent in 2006 (Maryland’s Children and the Environment, 2008). In order to reach the Healthy People 2010 goal, Maryland plans to continue programs to identify lead hazards and children at risk for lead exposure, increase the number of children screened and tested at one and two years of age, and refer children for timely treatment and follow up.

The National Center for Children in Poverty (2006) identified several factors that impede the assurance that all children enter school health and ready to learn. These factors entail major social issues, including poverty, the inequitable distribution of societal resources, racism, substance abuse, homelessness, and changes in the family structure, unplanned pregnancies, and health disparities. In Maryland, 29% (129,927) of children under 5 live in low-income families, 34% are African American and 36,599 families were served in Maryland shelters in 2007 (the most recent data available). The Title V Agency recognizes the need to broaden and integrate the role of health in child development and school readiness across the five critical components that form the basis of the state plan for early childhood comprehensive systems.

Through the continuation of Maryland’s state plan, the Maryland Center for Maternal and Child Health seeks to further strengthen the numbers and types of collaborative partners and to integrate comprehensive early childhood health systems through the earliest years. Data from the original needs assessment, focus groups and planning activities have all identified factors impeding the development of a comprehensive early childhood system in Maryland and the capacity of CMCH to address these issues in the state plan. In the 2009 updated needs assessment, trend data was reviewed based on key indicators of health. These findings were then applied to the larger state plan so that it could be reviewed and updated. The Early Care Advisory Council (ECAC) served as the reviewer committee to keep the plan focused and directed toward child and family health. By identifying issues that limit the state’s ability to ensure all children enter school healthy and ready to learn, Maryland is better positioned to know how to continue to allocate resources and develop more effective intervention strategies. Additionally, the ongoing collaboration and support of state and private

agencies and stakeholders will ensure that comprehensive health services are a cross cutting component of all early childhood support systems.

Maryland's early childhood health, education and child social service partners have worked together for over ten years to build early childhood systems that promote school readiness for all Maryland children. The following efforts and activities have helped boost school readiness from 49% to 68%:

- Increase resources to identify and treat children exposed to lead
- Infusing health into all committees and advisory councils working on issues surrounding young children
- Head Start
- Early Head Start
- Judy Centers
- Mandatory pre kindergarten programs
- Established all day kindergarten
- Increased resources to help English language learners
- Countdown to Kindergarten initiative to increase kindergarten readiness
- Decrease service gaps between preschool and kindergarten by moving the Office of Child Care to MSDE.

Despite these efforts, the advances in Maryland's school readiness are fewer than anticipated when compared to the Action Agenda's plan for 75% of all Maryland children to be fully ready for school. Maryland has averaged about 2-3 % increase in school readiness per year (as indicated by the work sampling system scores from 2002-2003 through 2007-2008).

School Readiness

In the Action Agenda for School Readiness, Maryland defines school readiness as “the state of early development that enables an individual child to engage in, and benefit from, primary learning experiences.” For the past seven years, every Maryland public school kindergartener has taken part in a work sampling system that measures and rates school readiness. This system has been tested for reliability and consistency. School readiness reflects all the conditions and practices a child has experienced from prenatal to school entry that affect the likelihood of successful school skills. Utilizing this data helps determine what perinatal and early childhood practices and behaviors work and where gaps still exist.

The kindergarten work sampling from 2007-2008 indicates that the early childhood community and other partners are successfully reaching a larger number of young children and building the skills they need for kindergarten. The effect of their efforts is 68% of children are entering kindergarten fully ready to learn and better prepared to achieve a successful kindergarten experience. However,

disparities in school readiness still exist. The school readiness scores indicate that more girls than boys enter school ready to learn (74% to 63%). Further disparities exist with a >13% difference between Caucasian and African American boys. Immigrant children with limited English proficiency have advanced beyond children in special education by 14% but still lag behind both Caucasian and African American entry level children. The results further indicate that low-income families still lag far behind their standard income classmates.

There is a strong correlation between the health of young children and their ability to enter school ready to learn. The National Education Goals Panel states that in order to be ready for school all children need to: “experience high quality learning; have enough to eat and the ability to live in safe and stable neighborhoods; be able to see a doctor under any circumstance; have parents who are caring and attentive, armed with the support they need to be strong and capable caregivers; and attend schools prepared to receive children at school age.” (National Education Goals Panel 2000)

School Readiness data for 2007-2008 reveal that only three of five Maryland children enter kindergarten ready to learn. National and federal efforts in the area of health education and welfare have called for providing integrated, comprehensive, and culturally competent, targeted services to children. The Early Childhood Comprehensive Systems plan aims to integrate services, and establish multi-service early childhood and family support systems, and achieve the goal of “children entering school ready to learn.” Health indicators for Maryland’s children reveal areas of critical need that could benefit from additional financial and social resources, partnership collaboration, and public awareness:

Maryland’s Vital Statistics Administration reports in 2007 that of all infant deaths, 59.3% were African American compared to 34.2% Caucasians and 6.4% Hispanics. The incidence of low birth weight (birth weight <2500 grams) was 9.1% in 2007. This figure was 7.1% for white infants, 12.9% for black infants and 7.3% for Hispanic infants. The incidence of very low birth weight (birth weight <1500 grams) was 1.9% overall: 1.2% for whites, 3.2% for blacks and 1.3% for Hispanics (Vital Statistics, 2007).

Childhood lead exposure further declined in 2007. There was 33.3% decline in both prevalence and incidence. The reduction has occurred both statewide and in areas of highest risk, such as Baltimore City. Despite this decrease, of the 105,708 children 0-72 months tested for lead statewide in 2007, 892 (0.8%) were found to have an (EBL) level ≥ 10 $\mu\text{g/dL}$ (prevalent cases) of whom 654 had their very first EBL test (incident cases) in 2007.

The 2005-2006 National Survey of Children with Special Health Care Needs reports that 50.4% of children with special health care needs (CSHCN) who had private insurance, received coordinated, ongoing, comprehensive care within a medical home. Only 37.1% of CSHCN who had public insurance, had access to a medical home in 2006.

The American Academy of Pediatrics recommends that all children and adolescents have a primary care professional (or a multidisciplinary team for children with severe chronic illnesses) whose practice serves as a medical home to help ensure that needed services are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective (The Commonwealth Fund, 2008). A medical home may be especially important to children and youth with special health care needs and their families, who often need help to access and integrate services from a complex web of providers and programs (The Commonwealth Fund, 2008).

In 2006, a total of 10% of children 0-5, (45,000 children) in Maryland are without any health coverage because: their family income exceeds 200% of the FPL (M-CHP eligibility- 250% for pregnant woman and infants) and their employer does not provide health insurance, immigration status prevents them from eligibility for governmental programs, the families do not know they are eligible or “pride” prevents them from enrolling their children (The Annie E. Casey Foundation, 2008). 13.7% Children aged <5 are overweight (CDC PedNSS, 2007). In 2007, the percentage of Maryland children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile was 33% (HRSA, 2009).

Health and School Readiness: A Blended Partnership

Ages 0 to 5 are critical stages of growth and development. *Growing Healthy Children*, Maryland’s Early Childhood Comprehensive Systems (ECCS) Building Initiative, is a statewide effort to strengthen Maryland’s system of services for young children and their families. The Maryland Title V Program is using this process to strengthen partnerships with agencies that serve children and to develop new collaborations/partnerships with public, private, and community agencies that play an essential role in preparing all children healthy and ready to learn before they enter school. These partners include all the state agencies that administer programs for young children, community agencies, childcare providers, health care and mental health professionals, child advocates and parents of young children. We continue to work together to improve outcomes for children and families by building a coordinated, comprehensive system, which addresses the five critical components. Each of the five critical components of early childhood systems development is part of the MCHB Strategic Plan and has become solidly blended into Maryland’s state ECCS plan.