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Policy Options to Support Children From Birth to Age Three

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www.crcmich.org

Science and the First Years of Life

A growing scientific consensus has documented the critical importance of the first years of a child's life:

- Early brain development sets the stage for future life
- Relationships and experiences affect that brain development
- Early intervention promotes development and avoids costly remediation

"What happens in the first months matters a lot… Compensating for missed opportunities, such as the failure to detect early difficulties of the lack of exposure to environments rich in language, often requires extensive intervention, if not heroic efforts, later in life. Early pathways, though far from indelible, establish either a sturdy or fragile stage on which subsequent development is constructed."

- Neurons to Neighborhoods: The Science of Early Childhood Development

Purpose of the Report

Goal: Assist state policymakers in targeting resources for early intervention most effectively by answering key questions

- How many children in Michigan need early intervention?
- What specific programs offer the greatest promise for additional investment?
- How much will these investments cost and what will be the return to the state?

Report Sponsors

The report would not have been possible without the generous support of the following organizations and individuals:

- Center for Michigan
- Alliance for Early Success
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Estimating the Need: At-Risk Children in Michigan

Who is At-Risk?

At-Risk Population: children with a heightened risk of falling behind their peers before they reach kindergarten. Research suggests key risk factors include:

- Children from low-income families
- Children with developmental delays or disabilities
- Children of parents with low educational attainment
- Children in non-English speaking homes
- Children experiencing severely adverse situations

Methodology

Analysis drew on both survey research as well as other empirical research regarding the incidence of risk factors:

American Community Survey: 3-year sample covering surveys from 2010 to 2012; represents 3% of all households. Data extracted from University of Minnesota's "Integrated Public Use Microdata Series" (IPUMS) interface. Data included:

- Federal poverty level for household
- Spoken language indicators for adults in household
- Educational attainment indicators for adults in household

Empirical Research: Since the ACS did not contain information on the incidence of developmental issues or adverse situations, we looked to outside research on these factors

American Community Survey Data:
Defining Poverty

Michigan Population, Children Aged 0 to 3: 465,283

Percentage of Poverty Line	Program Using This Threshold	Children Aged 0 to 3 Living in Poverty	
		Number	Percent
100%	Head Start	126,373	27.2%
130%	Food Assistance / Free Lunch	158,865	34.1%
150%	State Emergency Relief	181,896	39.1%
185%	Medicaid / Reduced Lunch	218,599	47.0%

American Community Survey Data:
All Risk Factors

Non-English Speaking: No parent or head of household reports speaking English "well"

Low Educational Attainment: No parent or head of household has earned a high school diploma or GED

	Based on 100% FPL	Based on 185% FPL
Poverty	126,373	218,599
Non-English Speaking	6,774	6,774
Low Educational Attainment	40,635	40,635
Unduplicated Count	**139,485**	**223,436**
Percentage of All Children	30.0%	48.0%

Adverse Experiences ("Toxic Stress")

Growing body of research has documented the negative long-term impacts of early exposure to severely adverse experiences. Examples include:

- Death of a parent
- Divorce or separation of a parent
- Parent served time in jail
- Persistent economic hardship
- Household member with mental illness or substance abuse
- Violence in the home or neighborhood
- Experiencing racial/ethnic discrimination

Research: Toxic stress has enormous lifelong costs as manifested in adverse impacts on learning, behavior, and health

Source: Shonkoff and Garner, The Lifelong Effects of Early Childhood Adversity and Toxic Stress, *Pediatrics,* 2012.

Incidence of Toxic Stress Among Children

A 2013 report from non-partisan Child Trends research organization examined data from 2011/2012 National Survey of Children's Health to estimate the incidence of adverse childhood experiences.

Percentage of Children Having 3 or More Adverse Experiences, By Age and Income

Age	Percent	Family Income	Percent
0 to 5	5.2%	100% FPL or less	13.8%
6 to 11	13.0%	101% - 200% FPL	11.6%
12 to 14	15.3%	above 200% FPL	5.9%
15 to 17	18.0%		

Development Delays and Disabilities

Two recent research reports provide estimates on the incidence of developmental issues in children:

- Trends in the Prevalence of Developmental Disabilities in US Children, 1997-2008, *Pediatrics,* May 2011
  - Data from 1997-2008 National Health Interview Surveys
  - Parent-reported responses for children aged 3 to 17
  - Overall prevalence of disability was 13.8 percent
  - Age 3-10, 11.8 percent; children in poverty, 16.1%

- Prevalence of Developmental Delays and Participation in Early Intervention Services for Young Children, *Pediatrics,* 2008
  - Data drawn from Early Childhood Longitudinal Study, Birth Cohort
  - Children evaluated at 9 months and 24 months
  - Incidence of developmental delays was 13.8 percent at 24 months
  - Children in poverty, 17.9 percent; above poverty, 12.7 percent

Estimating the At-Risk Population

Combining the Data

Depending on the poverty threshold used in the estimation, between 40 and 56 percent of young Michigan children are experiencing at least one of our key risk factors.

At-Risk Children Aged 0 to 3 in Michigan
Experiencing at Least One Risk Factor

	Based on 100% FPL	Based on 185% FPL
One of more ACS Factors (poverty, education, non-English)	139,485	223,436
Toxic Stress	19,383	19,383
Developmental Issues	65,616	65,616
Unduplicated Count	**190,454**	**259,933**
Percentage of All Children	40.9%	55.9%

Prevalence of Multiple Risk Factors

The majority of at-risk young children are experiencing multiple risk factors. Using the 185% poverty threshold, over 160,000 children would be defined as facing multiple risks.

	At-Risk Children (At or below 185% poverty)	
	Number	% of all children
Total At-Risk Children	259,933	55.9%
One Risk Factor	98,982	21.3%
Two Risk Factors	107,522	23.1%
Three Risk Factors	44,790	9.6%
Four Risk Factors	8,046	1.7%
Five or More Factors	593	0.1%

What Should We Do?: Options for Policymakers

Identifying Promising Programs

- Guidance from state and national experts
- Programs supported by a solid research base
- Models that are replicable and can be evaluated
- Opportunities to serve the neediest children first
- Parent engagement
- Demonstrated rate of return

Areas for Strategic Investment

- Home visiting programs: trained service providers assist families in addressing challenges and risks
- Access to medical homes: programs can help parents and providers overcome barriers to quality care
- Promoting high-quality child care: structure subsidized care to promote quality
- Piloting subsidized pre-school for three-year olds

Home Visiting Programs

What are Home Visiting Programs?

- Link parents with trained service providers (e.g. nurse, social worker) for regular home visits
- Programs are voluntary
- Various models support families with array of different needs
- Substantial research documenting program effectiveness

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program

- $300 million in grants to states and territories in FY2013; $34.4 million to Michigan to expand home visiting to high-need areas
- 75 percent of funding restricted to federally-approved “evidence-based programs”
- Mathematica Policy Research conducted independent assessment to determine models that qualified

Evidence-Based Models in Michigan

Federal evidence-based models must:

- Be supported by research with study design rated high- or moderate-quality (e.g. randomized control trials, matched comparison groups)
- Demonstrate favorable, statistically significant impacts on one or more of eight domain outcomes (e.g. health, school readiness, self-sufficiency)

Models meeting the federal "evidence-based" criteria:

- Early Head Start – Home Visiting
- Healthy Families America (HFA)
- Nurse Family Partnership (NFP)
- Parents as Teachers (PAT)

Model meeting the state "evidence-based" criteria:

- Maternal Infant Health Program (MIHP)

Home Visiting: Evaluating the Evidence

Studies rated high-quality have found that evidence-based programs have had positive impacts across a wide range of child and family outcomes, including:

- Gains in reading, math and vocabulary for children as well as improved school attendance
- Improved health outcomes for both mothers and children and reduced mortality rates for children
- Improvements in parenting skills and parent-child interaction
- Reductions in the incidence of reported and of confirmed abuse/neglect in the home
- Reduced arrest and conviction rates as adults for children receiving services
- Reduced reliance on public assistance

Home Visiting: Unmet Need and Costs

- Current services: data is limited on the number of children currently served by home visiting programs in Michigan; estimates suggest around 40,000

- Home visiting programs vary significantly in cost:

Annual Costs Per Family of Home Visiting Services

	Program-Reported		Mathematica	
	Average	Range	Weighted Avg	Range
Nurse Family Partnership	$4,500	$2,914 - $6,463	$7,596	$4,228 - $13,692
Healthy Families America		$3,214 - $3,892	$5,270	$2,848 - $10,502
Parents as Teachers	$2,652		$2,415	$2,122 - $2,622
Early Head Start - Home Visiting		$9,000 - $12,000		

Home Visiting Program

Effective Options for Policymakers

- Provide grant funding to implement evidence-based home visiting models
  - Estimated cost: $50 million for each additional 10,000 children served
- Fund technical assistance: best practices, screening to find most appropriate model, leveraging federal dollars (e.g. Medicaid)
- Serve neediest children first
- Assist communities with outreach: Program so voluntary and different models focus on different needs

High-Quality Child Care

- Old view: impact of child care ambiguous at best; and at worst, care is correlated with negative social outcomes
- Recent research: High-quality care can improve outcomes for children
- National Institute of Child Health and Human Development (2010): impact of high-quality child care (birth to 4 ½)
  - Improved cognitive achievement at age 15
  - Higher quality -> greater cognitive gains
  - Fewer behavioral/emotional problems with high-quality care
- Burchinal (2010), Early Childhood Research Quarterly: pre-K programs in 11 states serving low-income children. High quality programs demonstrated:
  - Higher levels of social skills and fewer behavioral problems
  - Improved reading, math, and language skills

Child Care in Michigan

Child Development and Care (CDC) Program

- Child Care and Development Program: provides child care subsidies to primarily low-income households on behalf of children up to 12 years of ago
  - Average monthly caseload: 43,246
  - FY2013 total cost: $135 million

- Maximum subsidy amount for children 2 ½ years or younger: $3.75/hour for child care centers; $2.90/hour for group/family homes; $1.35/hour for unlicensed care

- Income threshold: family of three with income above 122% of federal poverty guideline ($23,880) is not income-eligible

Reimbursement and Eligibility

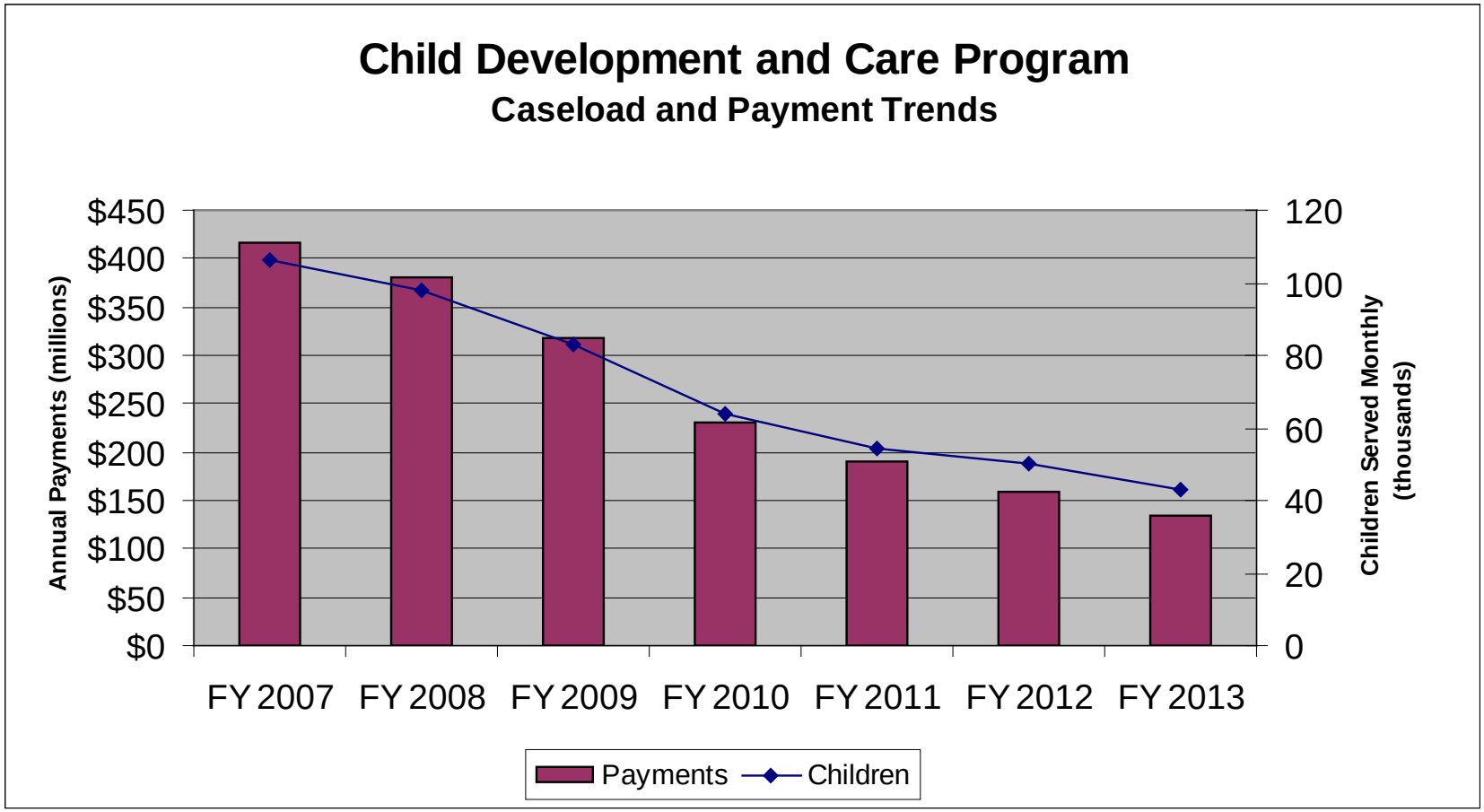
Michigan less generous than other states

	Reimbursement			Income Limit	
	Center Care 1 year old	Percent of benchmark	Rank	Family of Three	Rank
Pennsylvania	$902	99.2%	1	$38,180	1
Indiana	$814	89.9%	2	$24,240	5
Wisconsin	$955	82.9%	3	$36,131	2
Illinois	$1,007	77.5%	4	$35,328	3
Minnesota	$1,126	76.9%	5	$33,786	4
Ohio	$713	73.8%	6	$23,172	7
Michigan	$650	65.0%	7	$23,880	6

Source: Schulman and Blank, *Pivot Point: State Child Care Assistance Policies 2013,* National Women's Law Center, 2013.

CDC Caseloads Have Plunged

Spending Down 67% from FY2007



Child Care: Unmet Need

- Current caseload: Department of Human Services data indicate 19,292 children from birth to age three received subsidy support in April 2014

- ACS data: children aged zero to three that are both "at-risk" and have all available parents engaged in employment
  - Using 100% FPL threshold: 108,000
  - Using 185% FPL threshold: 145,000

- Raising reimbursement to federal 75th percentile benchmark for currently served children aged 0 to 3: up to $73 million

- Raising reimbursement and restoring caseload to peak 2005 levels: up to $397 million

High-Quality Child Care

Effective Options for Policymakers

- Continue to expand investment in quality-based tiered reimbursement: access for children and incentive to providers
  - Estimated cost: $15-20 million initially if reimbursement rate increases up to federal benchmarks are limited to programs rated three-star or higher
- Evaluate and validate the "Great to Start to Quality" child care rating system
- Fund an awareness campaign for "Great Start Connect"

Medical Homes for Children

Expert interviews and research: critical link between early experiences and lifelong health outcomes

What is a "medical home" for young children?

- Ongoing relationship with personal, primary care physician
- Coordination and integration of needed specialty care
- Whole person orientation covering all patient's health needs
- For children, "two generation focus" that supports parents in being child's first health care provider

Challenge: supporting both medical providers and families in creating and maintaining a medical home relationship.

- Difficulty navigating the health care system
- Access to providers
- Other barriers to access (e.g. transportation, language)

Evidence on Medical Homes

Research demonstrates that patient-centered medical homes have benefits for both patients and the health care system in general:

- Reductions in emergency room use; increase in well-care
- Improved patient outcomes (e.g. diabetes, blood pressure control)
- Reductions in overall health care expenditures
- For children in particular:
  - Improved rates of vaccination
  - Reduction in unmet health and dental needs
  - Increase in healthy behaviors (e.g. reading, bike helmets)

Children's Healthcare Access Program (CHAP)

- Kent County program initiated in 2008: partnership between health plans, local providers, and other local partners focusing on improving health of Medicaid-enrolled children
- Three levels of focus:
  - Family: parent education, care management, community services
  - Provider: assistance to provide components of medical home
  - System: health plans provide enhanced reimbursement, incentives
- CHAP team: nurse, community health workers, social workers, behavioral health patient navigator; English and Spanish
- Expansion: Wayne County CHAP began in 2011; planning ongoing in 9 other counties, but funding for MI-CHAP collaborative through Early Childhood Investment Corporation was discontinued

CHAP: Costs and Unmet Need

Between 2009 and 2011, the Kent County CHAP program:

- Covered 18,000 children and provided direct services to around 2,000 children per year, 55% of whom were five years old or younger
- Incurred annual costs of around $558,000 for direct services (about $224 per child who received tangible services)

Unmet Need

- 2011/12 National Survey of Children's Health: 36.5 percent of children (birth to 5 years) lack medical home
- Those data suggest that 95,000 at-risk children aged 0 to 3 are without a medical home statewide
- Kent and Wayne County CHAP programs cover an estimated 10,750 children in the 0 to 3 age range

Medical Home for Children

Effective Options for Policymakers

Expansion of the CHAP program would effectively increase the number of children with access to medical homes.

Policymakers should consider:

- Providing matching grant funding to assist communities in creating and running CHAP programs
  - Estimated cost: $10 million to cover all Medicaid-eligible children
- Creating a resource center to provide technical assistance
- Investing in long-term evaluation on effectiveness and return on investment

Preschool for Three-Year Olds

- Great Start Readiness Program: provides subsidized preschool opportunities for at-risk 4-year olds in Michigan; recent program expansion designed to cover virtually all eligible children

- Policy question: What about 3-year olds? Would an additional year of high-quality preschool be beneficial?
  - Research is mixed: initial benefits, but no consensus on persistence
  - 2013 National Institute of Early Education Research: Fifth grade follow up on participants in Abbott preschool (New Jersey) showed increased cognitive achievement scores; more persistent benefits for those who started at age three

Preschool for Three Year Olds

Effective Options for Policymakers

- Unmet Need: Our data analysis estimates that around 65,000 3-year olds meet at least one of our risk factors; around 16,400 are likely already covered by publicly supported preschool programs (e.g. Head Start)

- Given the lack of concrete evidence, policymakers should consider piloting a preschool program for 3-year olds and carefully evaluate results from a cost-benefit standpoint

- Assuming a per-student cost of $3,625, subsidized pre-school could be provided for 5,000 3-year olds at an annual cost of $18.1 million.

Thank you for joining us!

Questions?

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