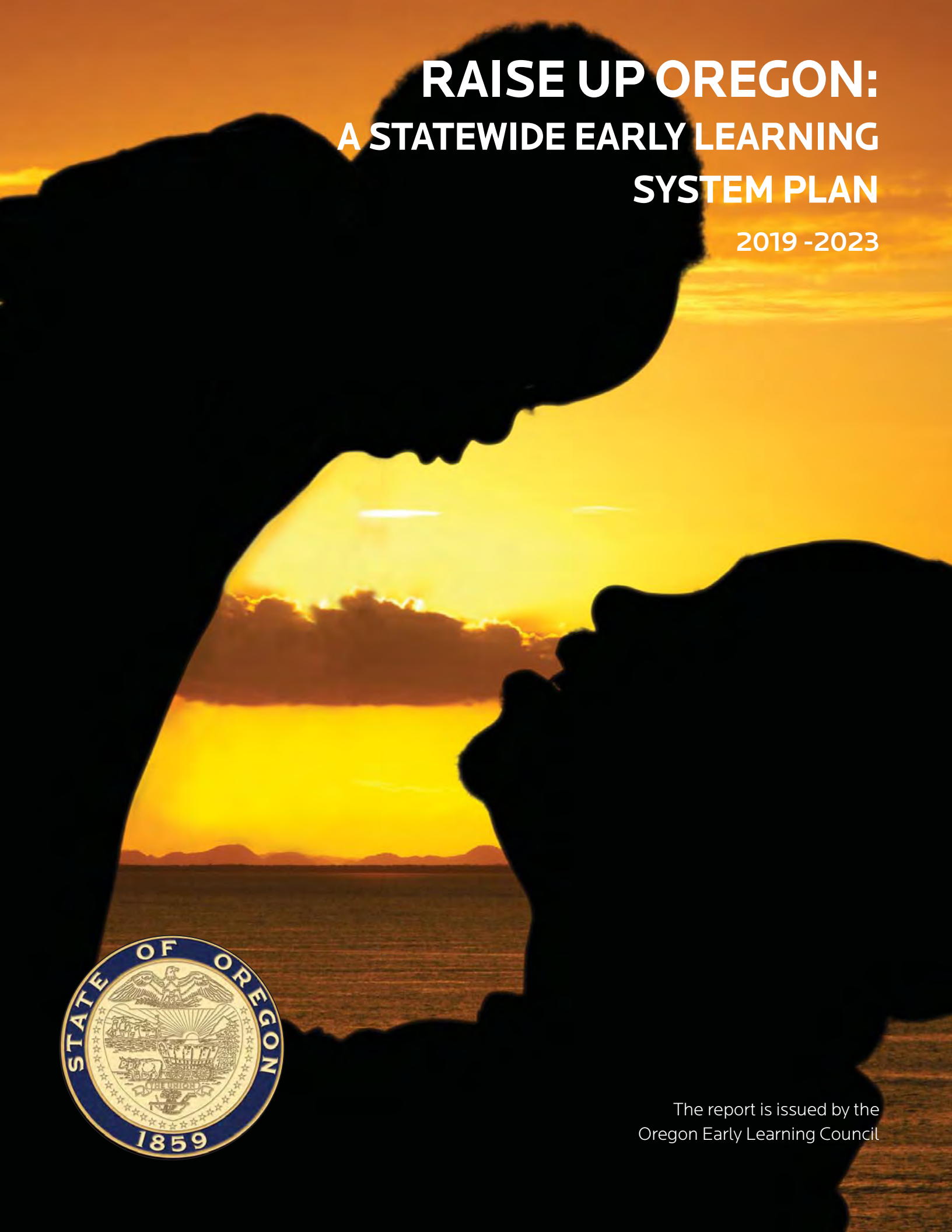
RAISE UP OREGON:
A STATEWIDE EARLY LEARNING SYSTEM PLAN
2019 -2023



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Oregon Early Learning Council

Acknowledgements

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For more information

Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023,
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OREGON DEPARTMENT OF EDUCATION
EARLY LEARNING DIVISION

CONTENTS

EXPLANATION OF SYMBOLS

This symbol is next to strategies with a focus on infants and toddlers.

Existing state plans and *Raise Up Oregon* have shared strategies, as indicated by the following symbols:

Aligns with Department of Human Services 2016-2019 Self Sufficiency Programs (SSP) Strategic Plan, SSP Fundamentals Map and Child Welfare Action Plan

Aligns with Oregon Department of Education 2017-2019 Strategic Plan.[i]

Aligns with Early Learning Division's Child Care Supply and Quality; Preschool and Kindergarten Readiness; Community-based and Family Supports; and Workforce Quality, and with ELD Policy Option Packages (POP) and Legislative Concepts (LC) 2019-2021.

Aligns with Oregon Health Authority State Health Improvement Plan,[ii] the Public Health Division Maternal and Child Health Section 2018 Strategic Plan,[iii] and CCO 2.0 Recommendations of the Oregon Health Policy Board.[iv]

Aligns with Oregon Housing and Community Services 2019 Statewide Housing Plan.

Aligns with Governor's Agenda, e.g., Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management; Education Policy Agenda: Every Oregon Student Engaged, Empowered, and Future Ready; Housing Policy Agenda: Housing Stability for Children, Veterans, and the Chronically Homeless and Increased Housing Supply for Urban and Rural Communities; Child Welfare Policy Agenda: Protecting Children, Supporting Families and Ending the Cycle of Poverty; and The Children's Agenda: Pathways Out of Poverty for Children to Achieve Their Full Potential.[v]

KATE BROWN
GOVERNOR

January 1, 2019

Dear Early Learning Stakeholders:

As you know, the first few years of a child's life have a powerful impact on their future, and, as a result, the future of our state. It is essential for the state and local communities to do all that we can to provide support for the more than 43,000 children born each year in Oregon and their families.

That is why, over a year ago, I asked Miriam Calderon, Early Learning System Director, and Sue Miller, Early Learning Council Chair, to prepare a statewide prenatal to age five early learning plan. I envisioned this plan as a roadmap to ensure all children enter school ready to learn, especially those children who have been historically underserved, including those living in rural areas, communities of color, and low-income communities.

I am pleased to share that plan with you today, entitled *Raise Up Oregon: A Statewide Early Learning System Plan*. To create this plan, the Early Learning Council engaged hundreds of diverse stakeholders over the past year. Council members listened to families and received input from professionals working in early learning across our state. They have delivered a plan that demonstrates a solid understanding of our challenges and the best path forward to ensure a brighter future for our youngest Oregonians. This plan responds to what we know from science, economics, and experience about how to best address root causes and meet the needs of Oregon's youngest children and their families.

Raise Up Oregon: A Statewide Early Learning System Plan builds on our successes, calls for bolder action in the areas where we must do more, and, importantly, it recognizes that it takes collaborative problem solving across sectors to do better by our youngest children. The plan is bolstered by the expertise and commitment of families and of those working in early care and education, health, housing and community development, human services, and K-12 education, and its solutions engage all of these sectors to take action.

I commend the members of the Early Learning Council for the development of this plan. In addition, the development of this plan would not have been possible without the support of key philanthropic partners in early learning. My thanks to The Ford Family Foundation, Bill & Melinda Gates Foundation, Lora and Martin Kelley Family Foundation, Oscar G. & Elsa S. Mayer Family Foundation, Meyer Memorial Trust, James F. and Marion L. Miller Foundation, Oregon Community Foundation, J.B. and M.K. Pritzker Family Foundation, and Thrasher Family Fund of the Oregon Community Foundation for their financial support and for their ongoing commitment to early childhood.

I am proud to share this plan with you, and I look forward to working together to move it from plan to reality.

Sincerely,

Governor Kate Brown

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RAISE UP OREGON AT-A-GLANCE

SYSTEM GOAL 1: CHILDREN ARRIVE READY FOR KINDERGARTEN

OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Strategy 1.1 Expand parenting education and family supports.

Strategy 1.2 Scale culturally responsive home visiting.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

Strategy 2.3 Strengthen child care assistance programs.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/Early Childhood Special Education services.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice among early care and education and K-3 that supports all domains, including social-emotional learning.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

SYSTEM GOAL 2: CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

- **OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.**

  Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

  Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- **OBJECTIVE 8: All families with infants have opportunities for connection.**

  Strategy 8.1 Create a universal connection point for families with newborns.

  Strategy 8.2 Provide paid family leave.

- **OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.**

  Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

  Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

  Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

  Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

- **OBJECTIVE 10: State-community connections and regional systems are strengthened.**

  Strategy 10.1 Ensure family voice in system design and implementation.

  Strategy 10.2 Ensure family-friendly referrals.

  Strategy 10.3 Further develop the local Early Learning Hub system.

- **OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.**

  Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

  Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- **OBJECTIVE 12: The alignment and capacity of the cross-sector early learning workforce is supported.**

  Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

  Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- **OBJECTIVE 13: The business and philanthropic communities champion the early learning system.**

  Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

  Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

- **OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.**

  Strategy 14.1 Strengthen data-driven community planning.

  Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

  Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

  Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

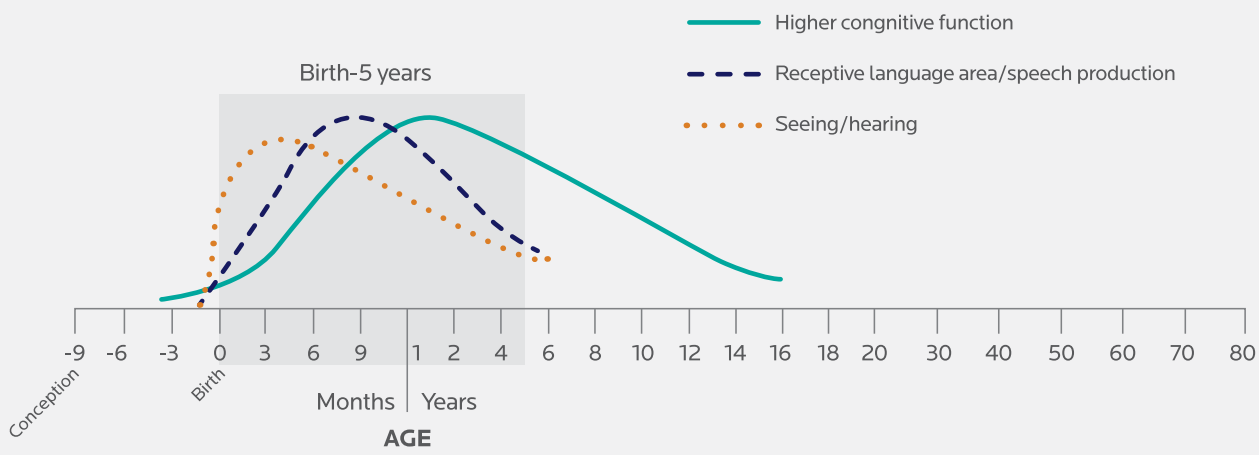
INVESTING IN OREGON'S YOUNG CHILDREN: MULTI-SECTOR SOLUTIONS GROUNDED IN SCIENCE AND EQUITY

Oregon is home to over 275,000 children, birth to kindergarten entry.[vi] Our state has an opportunity to change how it supports these children and their families and, in doing so, put itself on the path to an even brighter future. Overwhelming evidence tells us that investing in young children and their families has a lasting, positive impact across their lifetime. *Raise Up Oregon: A Statewide Early Learning System Plan* is grounded in the science of child development, equity, and a firm understanding that it takes leaders from early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—to work together during this critical period of children's lives.

Brain science makes clear that the first 2,000 days of a child's life – the time between birth and kindergarten entry – represent the most consequential period in human development. From birth to age three, a child's brain makes one million new neural connections every second. The rapid pace of synapse formation in the brain sets the architecture for future health and learning. During this time, children are establishing critical attachment to caregivers as well as learning to communicate with others and regulate their emotions. The quality of their relationships, experiences, and interactions matters greatly.

The science of child development underscores the importance of the first 2,000 days of childhood.

Figure 1. Synapse formation in the developing brain[vii]

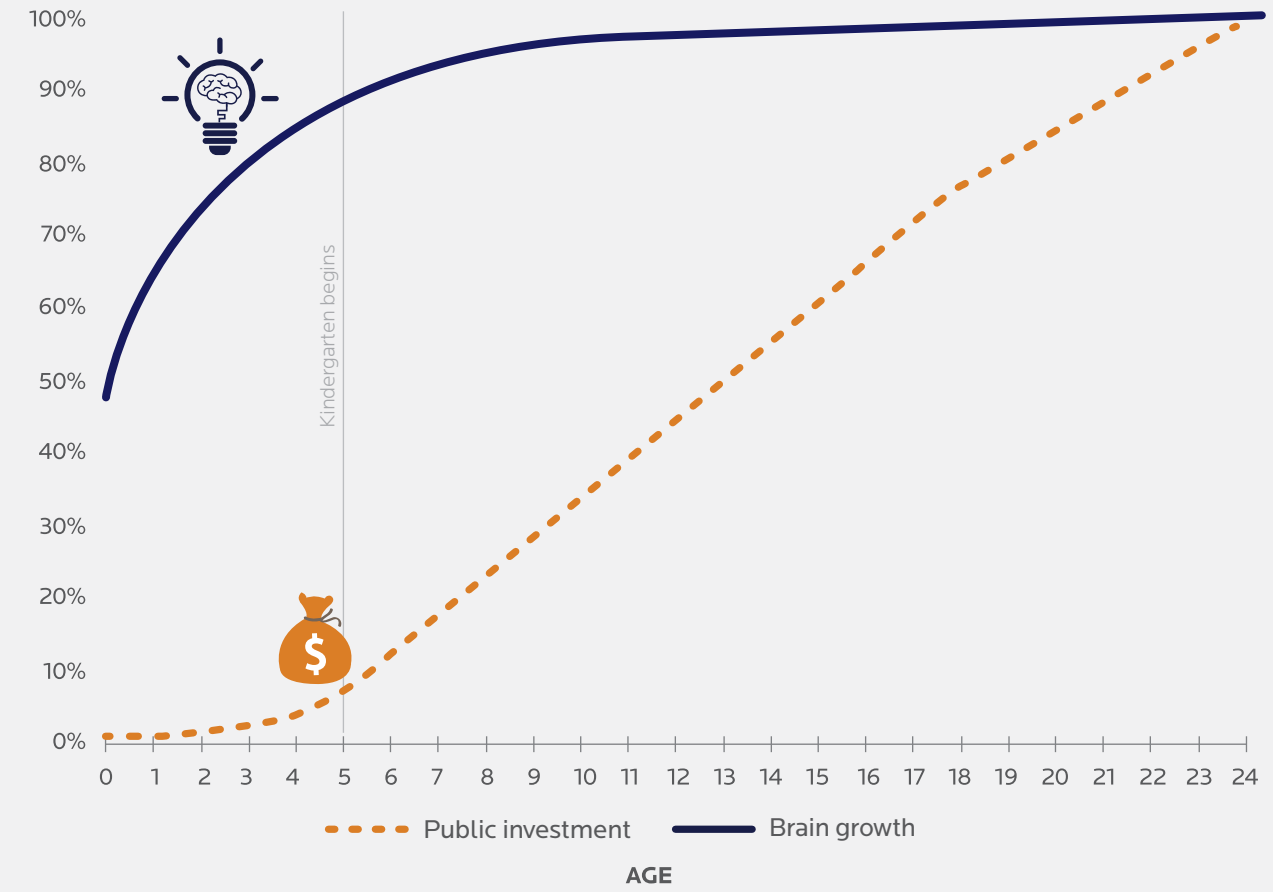


When we address the learning and development needs of young children, the economic returns not only benefit children and families, but society at large. Scientists at the RAND Corporation reviewed 115 early childhood programs, and 102—or nearly 90%—had a positive effect on at least one child outcome, such as behavior and emotion, language, cognitive achievement, child health, and kindergarten readiness. Researchers also found a reduction in child welfare involvement and crime-related behaviors.[viii] The RAND review showed that among programs with an economic evaluation, the typical return is $2 to $4 for every dollar invested. These findings are associated with improved adult outcomes, including higher likelihood of high school and college completion, increased earnings and workforce participation, and better health.

The evidence notwithstanding, less than 10% of Oregon's combined federal and state investment in children's education occurs before age five. The state investments from cradle to career accrue gradually in the first five years and increase rapidly once a child enters kindergarten. This is the antithesis of an approach that would be consistent with the brain science. By kindergarten entry, the brain has matured, reaching 90% of its adult size; however, most of the public investments in education are made after this point.

Invest early to get the best return on public investment.

Figure 2. Oregon's cumulative per child public education investment compared to child brain growth[ix]



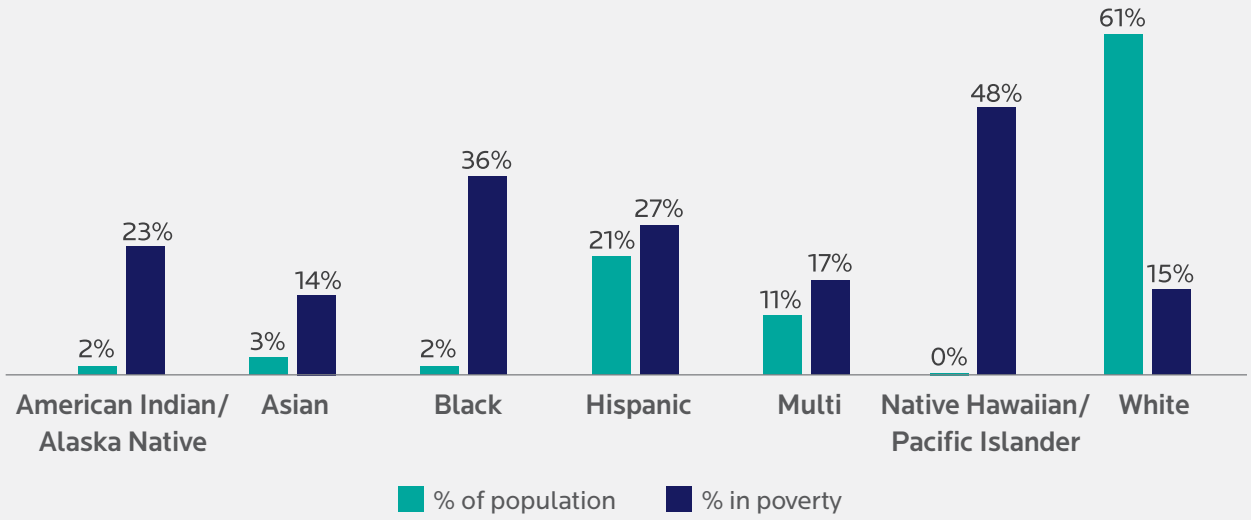
While these years represent a remarkable period of opportunity, they are also a period of intense vulnerability. Adverse conditions, such as inadequate nutrition and housing, exposure to toxic substances, poor maternal health, or a lack of appropriate early experiences and nurturing relationships have a lasting detrimental effect on the developing brain, even if a child's circumstances are improved later in childhood.

Oregon's equity lens helps us understand that adversity in early childhood is rooted in chronic and persistent opportunity gaps. Income, race, and zip code are powerful predictors of whether children and their families experience the conditions that are optimal for young children's development, including access to high-quality child care and preschool. Breaking the link between these inherited factors and life outcomes can only happen if we change the circumstances of families, which means changing the distribution of opportunities in those years.

This will require addressing the economic well-being of families with young children, and recognizing that income is closely linked with race and geography. Nearly 50,000 young children in Oregon live in poverty, which means their families earn below $20,780 for a family of three. More than one in five children in rural Oregon live in poverty, with children of color disproportionately represented among them.

Racial and economic disparities emerge early.

Figure 3. Oregon children under 5: percent of population and percent in poverty by racial/ethnic groups[x]



In order to address early adversity and opportunity gaps, we must develop comprehensive solutions that recognize that the lives of young children and families are influenced by many factors, including stable housing, consistent health care, and affordable, high-quality early care and education. We must also find new ways to work with community partners and – particularly – communities of color, as well as adequately fund the programs in our state that are designed to support these communities that have been historically marginalized and underserved. Early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—are all needed to drive positive change for Oregon's youngest children and families.

DEVELOPING *RAISE UP OREGON:* THE APPROACH TO STRATEGIC PLANNING

The Early Learning Council serves as the governing body for Oregon's comprehensive early learning system at the state level. Its composition includes the directors of the five state agency partners and key early learning professionals representing the diversity of the state. The Early Learning Council is statutorily charged with overseeing the early learning system and the services it delivers for children and families in order to make progress toward three system goals outlined in statute:

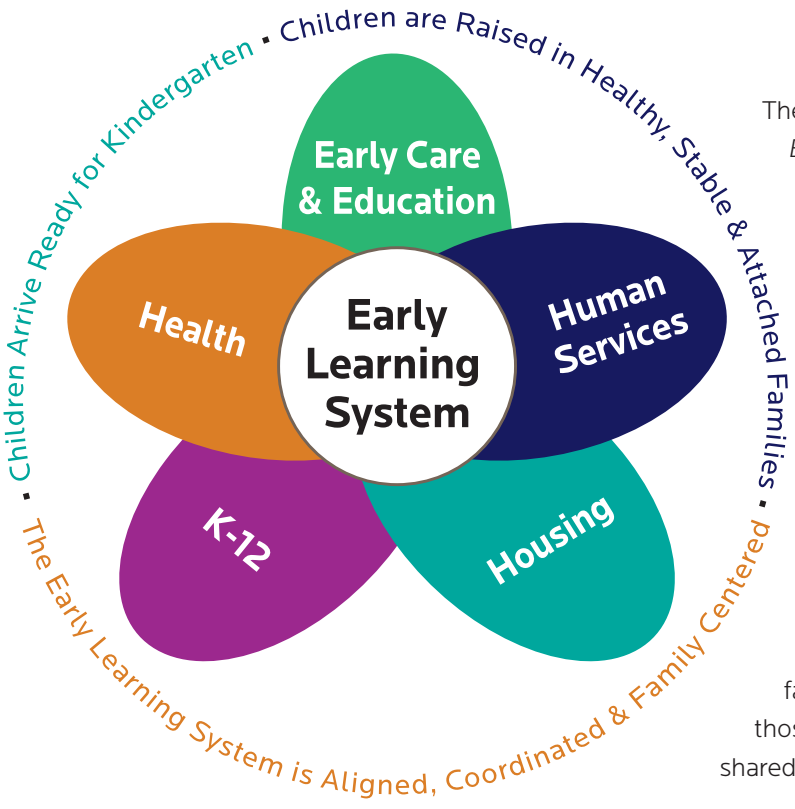
Children Arrive Ready for Kindergarten

Children are Raised in Healthy, Stable, and Attached Families

The Early Learning System is Aligned, Coordinated, and Family Centered

In developing *Raise Up Oregon: A Statewide Early Learning System Plan*, the Early Learning Council focused on the most strategic ways to make progress over the next five years (2019-2024) toward the vision embodied by the three system goals. The Council spent a year working with cross-agency partners— Department of Human Services, Oregon Department of Education, Oregon Early Learning Division, Oregon Health Authority, and Oregon Housing and Community Services– and hearing from communities, partners, parents, and providers.

Figure 4. *Raise Up Oregon* goals and sectors



The Council framed *Raise Up Oregon: A Statewide Early Learning System Plan* using the Council's guiding principles, which are rooted in equity, community and family engagement, and evidence-based practices in all decision-making processes within the early learning system. In order to engage diverse voices throughout the state, outreach included partners and providers representing children and families in historically underserved communities. The Council was particularly interested in: parents' and providers' experiences with services during the early childhood years; each sector's key goals and priorities for children prenatal to five and their families; strengths for and barriers to reaching those goals and priorities; and opportunities for shared interests and work across sectors.

The purpose of the five-year *Raise Up Oregon: A Statewide Early Learning System Plan* is to share a vision of where we as a state intend to go and to identify actionable, concrete strategies for working together across traditional boundaries to make this vision a reality. All of Oregon's young children deserve the best start. Zip code, race, and family income should not predict the health, educational, and life outcomes of Oregon's children.

Implementing *Raise Up Oregon: A Statewide Early Learning System Plan* requires that all five sectors are connected to the early learning system. This plan aligns with the governor's agenda and the strategic plans of cross-agency state partners, and provides an opportunity to intervene early and be more successful in the individual missions of each agency. This systems approach will make certain that children and families are receiving the services and supports they need to ensure that children enter kindergarten learning, thriving, and healthy.

DEVELOPING *RAISE UP OREGON: A STATEWIDE EARLY LEARNING SYSTEM PLAN*

OVER 200 PEOPLE

including state agency representatives, program administrators and providers, families, and all four Early Learning Council committees engaged in the development of *Raise Up Oregon*.

7 EARLY LEARNING COUNCIL MEETINGS

Presentations and discussions with state agency leadership, program administrators, Early Learning Hubs and other regional entities, providers and families across early care and education, health, housing and community supports, human services, K-12, and public health.

12 PARENT ENGAGEMENT SESSIONS

Parent discussions throughout the state.

16 EARLY LEARNING HUB Governance Board Meetings

Early Learning Hub Governance Boards discussed the strengths and barriers within each Hub community, provided input on cross-sector strategic planning themes, and explored the potential role for Hubs.

4 EARLY LEARNING COUNCIL COMMITTEES

All four Council committees—Best Beginnings, Equity Implementation, Child Care and Education, and Measuring Success—contributed to plan development.

VIA SURVEY

60 PEOPLE

Partners representing Child Care Resource & Referral entities, Early Learning Hubs, Early Learning Division staff, local Public Health offices, and members of the nine federally recognized tribes of Oregon provided feedback on the objectives and strategies most related to their work.

8 CHILDREN'S CABINET MEETINGS

4 Meetings with top state AGENCY LEADERSHIP

The Department of Human Services, Oregon Department of Education, Oregon Health Authority, and Oregon Housing and Community Services met with the Early Learning Council chair and the Early Learning System Director.

SYSTEM GOAL 1:
CHILDREN ARRIVE READY FOR KINDERGARTEN

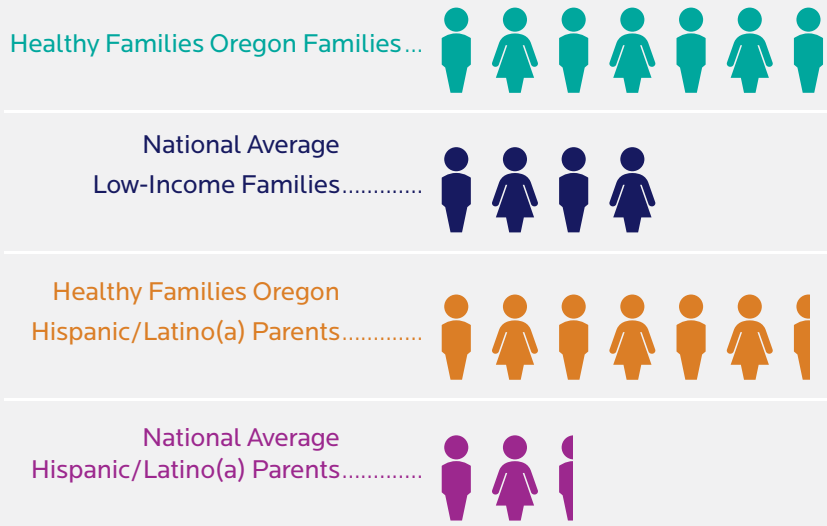
OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Parents have the greatest impact on their children's learning and development, especially when they can access programs that support them. For example, 70% of parents who participated in the Healthy Families Oregon (HFO) home visiting program for at least six months reported reading to their children on a daily basis, compared to the national average of just 40%.

Yet, only 20% of eligible families in Oregon have access to a home visiting program[xi] and only 3% have access to parenting education programs.[xii]

Furthermore, culturally specific organizations that have some of the strongest and most trusting relationships with families often lack access to available public resources needed to serve their communities.

Figure 5. Percentage of parents reading to children 0-5 daily[xiii]



Strategy 1.1 Expand parenting education and family supports.

- Expand availability and access to community-based parenting education by building on the philanthropic investment in the Oregon Parenting Education Collaborative (OPEC).
- Create an Equity Fund to support community-based, culturally specific organizations to extend their reach in providing culturally specific parenting and early learning supports in their communities.

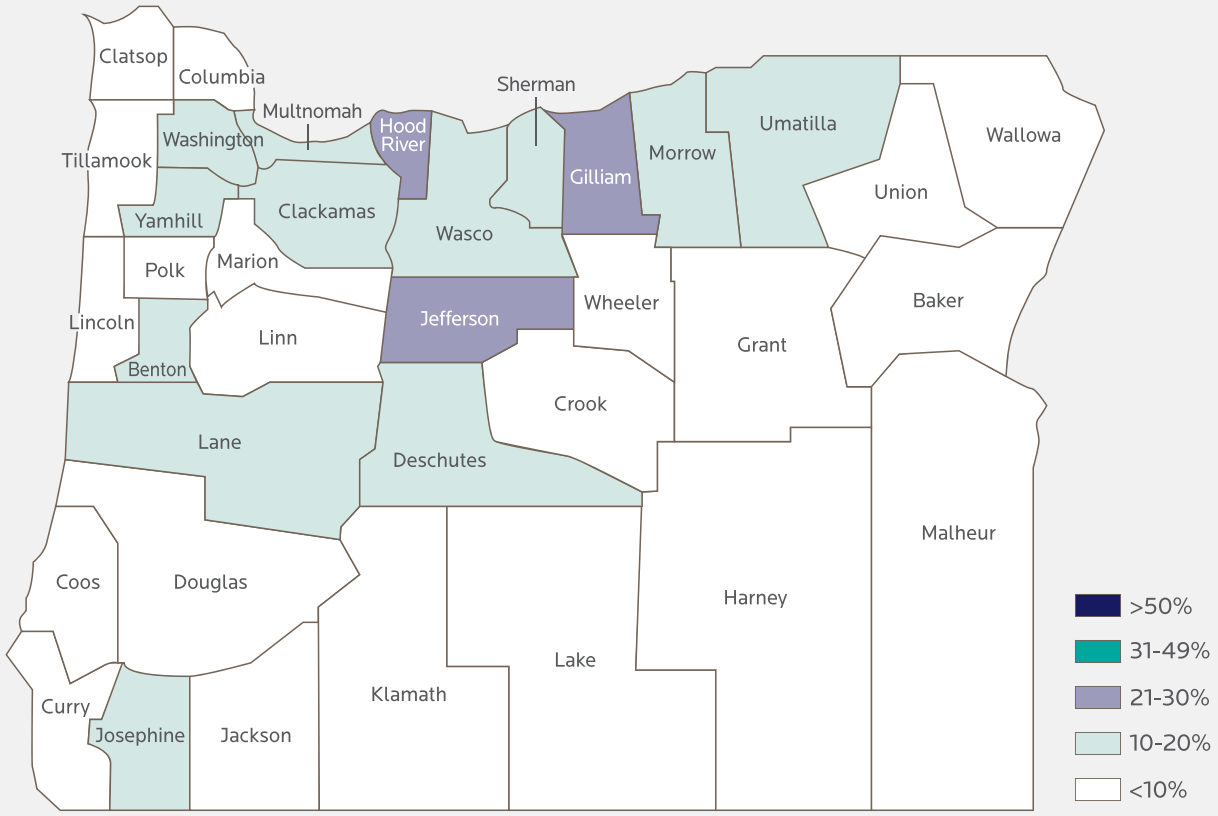
Strategy 1.2 Scale culturally responsive home visiting.

- Expand access to Oregon's current array of evidenced-based and evidence-informed targeted home visiting programs so that more families have access to these supports, prioritizing those families in historically underserved communities.
- Expand access to professional learning opportunities and address compensation for home vsitors in order to build a strong, culturally diverse workforce and increase retention.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Oregon families face significant barriers to accessing early care and education (ECE), including finding programs that are high-quality, affordable, culturally or linguistically responsive, and meet their scheduling needs. All but one of Oregon's counties are infant and toddler child care "deserts"[xiv] and over 30,000 three to five year olds in low-income families lack access to publicly funded preschool.[xv] A national report ranking states on infant child care affordability lists Oregon in the bottom three for center-based care.[xvi] Achieving a supply of accessible, affordable, high-quality ECE takes sound policy, resources, and the engagement of families and communities.

Figure 6. Percent of Oregon young children 0-3 with access to regulated child care[xvii]



Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

- Create, scale, and sustain a statewide, high-quality infant and toddler child care program with a focus on children in historically underserved communities.
- Create shared service networks within rural and urban communities to better scale infant and toddler care.
- Increase state investments in Early Head Start by expanding Oregon Prekindergarten as a prenatal-to-five program.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

- Expand preschool programs (i.e. Oregon Prekindergarten, Preschool Promise, Early Childhood Special Education) to serve more children, especially those in historically underserved communities.
- Align policies across Oregon's three state preschool programs (Early Childhood Special Education, Oregon Prekindergarten, and Preschool Promise) to facilitate blended funding models.
- Expand use of child care assistance contracts for wraparound care for preschool programs so they meet the needs of working families.
- Support Early Learning Hubs to create coordinated preschool enrollment processes.

Strategy 2.3 Strengthen child care assistance programs.

- Unify policymaking and policies across all child care assistance programs (Employment-Related Day Care (ERDC), Temporary Assistance for Needy Families (TANF) child care, and contracted child care assistance).
- Increase resources for child care assistance programs so that: 1) reimbursement rates meet the cost of delivering quality care across all types of care and ages, and 2) participating families pay no more than 7% of their income on care.
- Ensure child care assistance policy results in continuity of care, particularly for infants and toddlers.
- Ensure child care assistance policy reflects the scheduling needs of families.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

- Improve child care licensing standards.
- Improve child care licensing implementation by strengthening technical assistance and monitoring.
- Coordinate investigations into serious violations in child care at the state and local level.
- Identify and address gaps in current licensing authority, including who is subject to licensing.

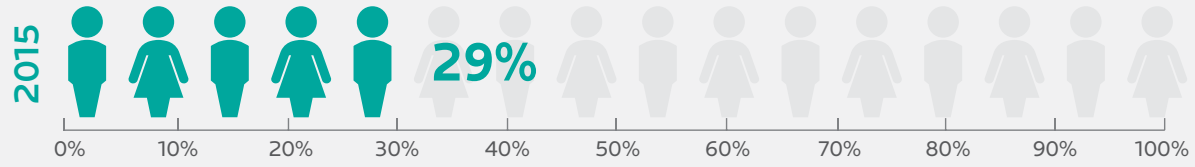
Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

- Conduct a statewide facilities needs assessment to identify communities with a dearth of ECE facilities and invest accordingly.
- Identify how to open high-quality family child care and child care centers within affordable housing units and housing developments.
- Create a regional plan for expanding access to and supply of high-quality infant, toddler, and preschool early care and education, available at times that meet the needs of families, especially to infants, toddlers, and preschoolers in historically underserved communities, under the leadership of the Early Learning Hubs.
- Use the state's licensing and Spark programs to recruit and support providers, especially in rural communities and communities of color, to become licensed and implement foundational health, safety, and quality practices.
- Expand resources for Spark to support additional ECE providers, including family, friend, and neighbor caregivers, in implementing best practices in ECE.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

A supply of high-quality, culturally responsive ECE programs requires a diverse, knowledgeable, skilled, and fairly compensated workforce. Yet Oregon's early childhood educators typically make between $25,000 and $35,000 annually.[xviii] In addition to fair compensation, educators also need pathways to early childhood degrees, ongoing professional learning supports, and positive, supportive work environments in order to implement best practice. These conditions can ensure that Oregon retains the workforce it needs, rather than continue to see a quarter of the workforce leaving the field each year.

Figure 7. Oregon ECE teacher and provider annual workforce turnover[xix]



Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

- Implement a competency-based professional learning system that is culturally and linguistically relevant for educators, educational leaders, professional development, and training personnel.
- Tailor and scale supports for family, friend, and neighbor caregivers, especially for those participating in child care assistance programs.
- Create competencies and professional learning opportunities that speak to the unique role of infant and toddler educators.
- Ensure communities have data needed to design and evaluate effectiveness of professional learning for the diversity of the workforce – including across different settings.
- Increase the relevance and effectiveness of professional learning through job-embedded supports and the inclusion of culturally responsive pedagogy.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

- Fully implement all steps in the career pathway.
- Partner with higher education institutions to ensure degree programs reduce barriers to higher education and meet the needs of the current workforce, equitably addressing cultural, language, learning, and access needs.
- Partner with higher education institutions to ensure degree programs include curriculum that addresses the prenatal-to-5 continuum.
- Build upon existing scholarship programs to support more educators in entering the field and existing educators in attaining AA and BA degrees in early childhood.
- Increase the number of educators entering the field by expanding opportunities for early care and education preparation in high school that can be leveraged in higher education.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

- Create educator compensation requirements that align with kindergarten educator compensation across publicly funded ECE programs (i.e. Oregon Prekindergarten, Preschool Promise, contracted slots) and increase public investment to implement those requirements.
- Create financial incentives for ERDC and TANF child care providers to support compensation that is aligned with kindergarten educators and increase public investment to support implementation.
- In collaboration with Early Learning Hubs and other partners, create understanding of the role and impact of early childhood educators among policymakers and the public.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

- Incorporate professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits) into program standards.
- Collect and use data to improve professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits).

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Physical and emotional health provide the foundation for school readiness. More remains to be done to leverage Oregon's significant commitment to children's health care coverage. While Oregon is a leader in providing health insurance for children, access alone cannot eliminate health disparities that inhibit the ability of young children to learn and flourish. For example, there are significant racial disparities in Oregon's infant mortality rate – Native American and African American children are nearly twice as likely to die before their first birthday as their white counterparts.[xx] Health equity must be addressed.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

- Improve access to patient-centered primary care homes for all young children.
- Strengthen the early childhood focus of Coordinated Care Organizations (CCOs) by adding Early Learning Hub representation on CCOs' governing boards or using other tools to improve relationships and coordination.
- Increase the integration of physical, behavioral, and oral health for young children.
- Incentivize high-quality, evidence-based pediatric care, including rural communities.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

- Increase access to culturally responsive mental health services by ensuring there are diverse providers with expertise in children birth through age 5.
- Train home visitors, mental health professionals, and early care and education providers in relationship-based infant mental health and equity approaches.
- Focus on children whose families are affected by substance abuse and family separation, including by ensuring access to community health workers.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

- Increase access to and address disparities in prevention and treatment dental services for young children.
- Advance provider trainings such as First Tooth and Maternity Teeth for Two.
- Continue integration of oral health services in early care and education settings.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

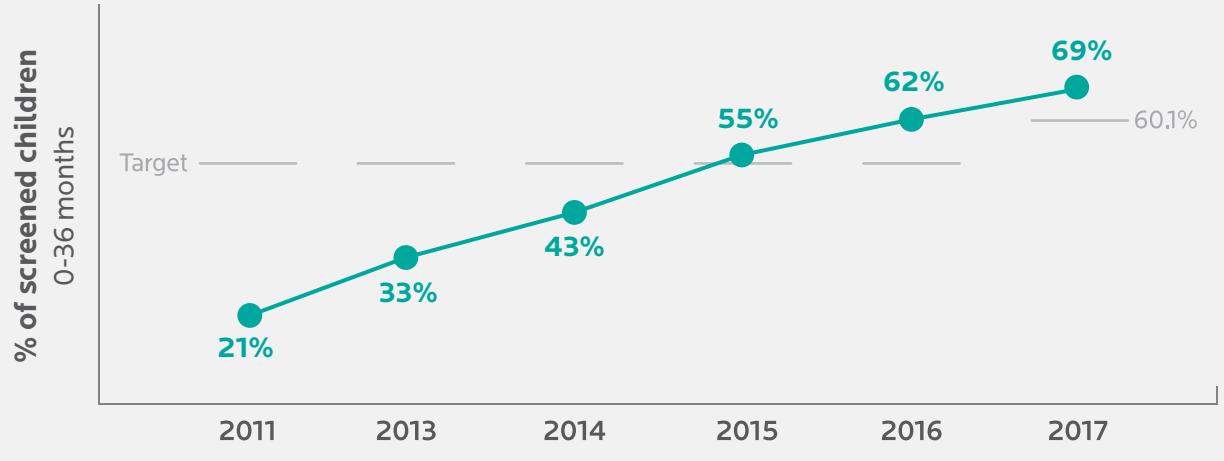
- Provide health consultation across ECE settings.
- Collaborate to support families and ECE providers in implementing safe sleep practices.
- Identify areas of shared accountability across housing, health, and ECE, and expand joint activities that promote environmental health, injury prevention and safety, physical activity, and healthy foods.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Oregon has made significant progress in ensuring that children with social-emotional, developmental, and health care needs are identified early. The rate of developmental screening for children enrolled in the Oregon Health Plan in the first thirty-six months of life has increased from 21% in 2011 to 69% by 2017.

However, too many children in Oregon who are identified with developmental delays at screening never receive services. Building local community-based systems that ensure early learning detection and a family-friendly process of referral to the supports that best address the needs of the individual child and family is essential to achieving that end. Services for children who are identified and enrolled in Early Intervention and Early Childhood Special Education (EI/ECSE) remain too limited due to funding, with only 34% of infants and toddlers currently enrolled in Early Intervention receiving the recommended level of services.[xxii]

Figure 8. Oregon developmental screenings in the first thirty-six months of life[xxi]



Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/ Early Childhood Special Education services.

- Increase funding so that Early Intervention/ Early Childhood Special Education services are at an adequate level to support the positive development of children with special needs as defined by the 2010 report to the Oregon Legislature.
- Review the criteria used to determine whether a child is eligible for Early Intervention/Early Childhood Special Education services and make and implement recommendations regarding the appropriate eligibility thresholds to ensure that all children needing these services are able to access them.
- Provide resources for communities to expand the array of services available to infants, toddlers, and families that need additional supports.
- Enable integration of Early Intervention and Early Childhood Special Education with other funding streams so that children are served in inclusive early care and education settings.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

- Improve screening.
- Scale successful approaches to build community-based referral systems from screening to services that meet the diverse needs of young children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

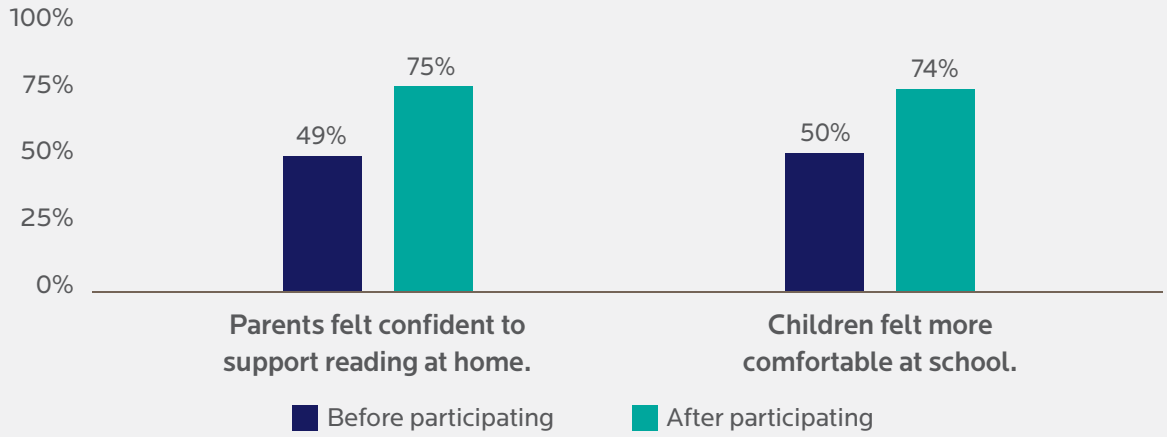
- Align policies across ECE programs and K-12 regarding suspension and expulsion.
- Improve data systems to track suspension and expulsion across the birth-to-five early learning system and early grades, disaggregated by race and other critical indicators.
- Provide culturally responsive mental health consultation to ECE providers.
- Increase access to anti-bias early childhood education training for ECE providers.

Children who arrive at kindergarten with strong social-emotional skills, as measured by Oregon's Kindergarten Assessment, are more likely to be on track in third grade reading and math.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Oregon has made meaningful strides in supporting kindergarten transitions over the last several years, particularly in relation to the implementation of summertime transition camps and parenting education programs. After participating in family engagement and kindergarten transition activities supported by the Kindergarten Readiness Partnership and Innovation Fund (KPI), parents felt more confident in supporting their children's learning in reading and math, and children and parents felt more comfortable and welcomed in school.

Figure 9. Benefits of Kindergarten Readiness Partnership and Innovation fund (KPI) programs[xxiii]



However, significant work remains to be done to scale culturally responsive, developmentally appropriate transition practices across the state, and to achieve greater alignment across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice between early care and education and K-3 that supports all domains, including social-emotional learning.

- Support Professional Learning Teams, consisting of both early learning and kindergarten to grade 3 (K-3) educators, with participation in shared statewide and regional professional development activities on the part of both early learning and K-3 educators, including elementary school principals and ECE directors.
- Support school districts in aligning attendance, curriculum, instructional, and assessment practices across the prenatal-to-third-grade continuum with a focus on high-quality (culturally responsive, inclusive, developmentally appropriate).
- Scale and expand the work of Early Learning Hubs and local communities through KPI and local funding sources, to support social-emotional learning across the P-3 continuum.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

- Enhance the Kindergarten Assessment (KA) process for children whose home language is not English and who are emerging bilingual children, focusing first on children whose home language is Spanish.
- Provide sufficient support to school districts to ensure that the assessment is administered properly and in ways that are developmentally appropriate.
- Improve the communications and data analysis/ interpretation tools for the KA so policymakers, Early Learning Hubs, providers of early learning services, school districts, and elementary schools have access to timely, accessible, and actionable data that supports regional and local decision-making.
- Develop a Kindergarten Entry Family Survey that enables families to provide information about their children's experiences and provides a more holistic picture of children's development.

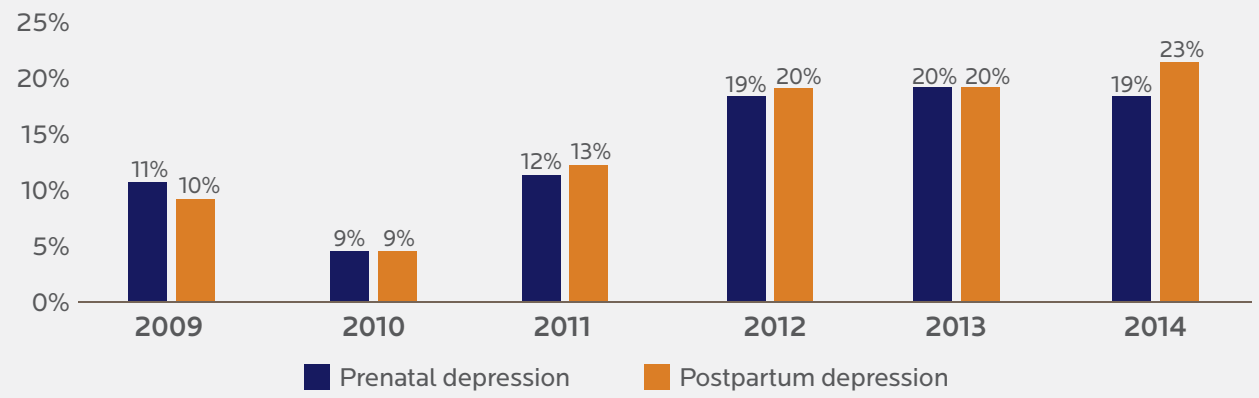
SYSTEM GOAL 2:
CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.

Children's healthy development depends to a large extent on the health and well-being of their parents and caregivers. But parent and caregiver health and well-being in Oregon is compromised by various factors including health care costs, disparities in prenatal care, the cross-generational transmission of trauma through their own adverse childhood experiences (ACEs), and the chronic disease of substance use disorder (SUD). These factors have a large impact on children, with SUD alone leading to nearly 75% of Oregon's foster care placements.[xxiv]

Maternal prenatal and postpartum depression is also on the rise in Oregon, with one in five women in the state suffering from it. Optimizing parental mental health is critical for disrupting the transgenerational impact of maternal depression, and improves children's social-emotional development, secure attachments, and kindergarten readiness.

Figure 10. Perinatal depression in Oregon[xxv]



Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

- Increase access to traditional health workers (e.g., doulas) and home visiting services.
- Address the needs of women impacted by substance use disorder (SUD), such as through integrated prenatal care and SUD treatment, as well as those of infants affected by neonatal abstinence syndrome.

Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- Reduce the financial burden of health care costs to families.
- Expand accessible and culturally responsive systems that support family unity while addressing parent co-occurring health, mental health, addiction, and/or parenting strategies.
- Improve access to health care for families who are pregnant or have young children.
- Ensure a continuum of services for children and their caregivers when families are affected by mental health conditions and substance use disorders (SUD).
- Handle the cross-generational transmission of trauma by identifying and addressing adverse childhood experiences.
- Increase partnerships between Coordinated Care Organizations (CCOs) and community health workers to enable access.

OBJECTIVE 8: All families with infants have opportunities for connection.

A nurturing, supportive relationship between a caregiver and child is an essential ingredient for positive child development, and the bond formed between parent and child during the first few months of a child's life sets the foundation for healthy development. But economic necessity often forces parents to return to work shortly after the birth or adoption of a child when critical bonds and attachments are forming. Families with newborn children also often lack a non-stigmatizing and accessible point of contact to help them address the challenges of parenting a newborn and connect with additional support and services when needed.

Strategy 8.1 Create a universal connection point for families with newborns. Health

- Build, in partnership with local communities, Early Learning Hubs, Coordinated Care Organizations, and public health agencies, a system to deliver home visits for all families with newborn children that provides parenting information and helps families with deeper needs connect to additional services.

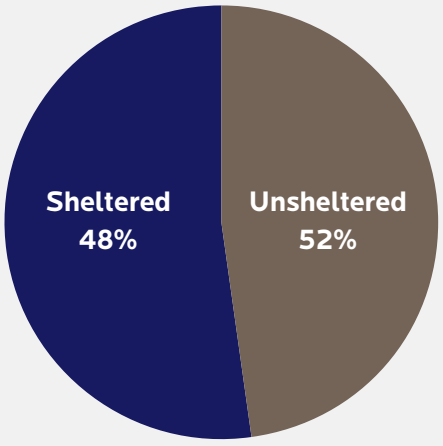
Strategy 8.2 Provide paid family leave. Health

- Provide paid family leave to all families with a newborn or newly adopted child to support the development of bonding and attachment during this critical window.

OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.

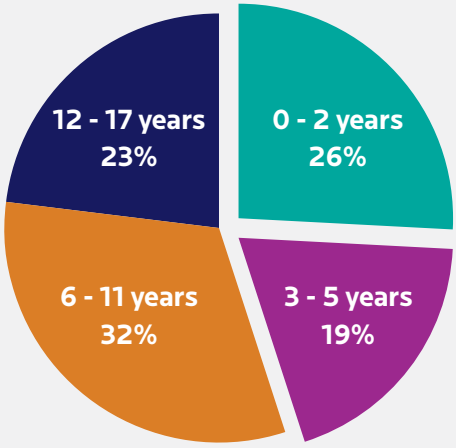
Homelessness, housing-cost burdens, food insecurity, employment instability, and the high cost of child care can create severe or chronic stress within families that, in turn, can affect children. Recent studies show strong correlations between housing stability and child outcomes, thereby pointing to the pressing need for addressing housing as part of an early childhood agenda.[xxvi] In 2017, Oregon had the second highest rate of homelessness among people in households with children in the United States. According to the 2017 Point-in-Time Count, 3,519 of the 13,953 Oregonians experiencing homelessness were families with children.[xxvii]

Figure 11. Homeless familes in Oregon with children[xxviii]



When families experience stressors, including not being able to meet their material needs, they are at an increased risk of involvement with the child welfare system. Oregon's high rate of families with young children involved in the child welfare system is cause for concern. In 2017, 11,077 children in Oregon experienced abuse and neglect. Almost half of these children were under the age of six and more than a quarter were under the age of three. Reducing the number of children who enter into the child welfare system must be a priority for all Oregonians. Doing so will require strong relationships across sectors and with communities and families.

Figure 12. Abused and neglected Oregon children, 2017[xxix]



Approximately 5,000 young children under age six every year are abused or neglected.

Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

- Expand and focus housing subsidy for families with young children, starting with families with children prenatal to 12 months of age who are experiencing unsheltered homelessness.
- Expand the supply of affordable housing and rental assistance for families with children by exploring new programs and working with providers to establish priorities for assisting families with young children.
- Strengthen relationships between Early Learning Hubs, Community Action Agencies, Department of Human Services (DHS) field offices, and local housing authorities to focus on families with infants and toddlers.

Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

- Increase access to evidence-based early learning programs (e.g., Relief Nurseries, parenting education, home visiting programs) proven to reduce abuse and neglect for families at imminent risk of entering into the child welfare system.
- Expand access to family coaches for local parenting support organizations, including community-based, culturally responsive organizations.
- Collaboratively develop community-based early childhood child abuse and maltreatment prevention plans.

Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

- Promote breastfeeding.
- Improve connections between the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and primary care medical homes and other community services.

Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

- Implement strategies such as waitlist prioritizations and incentives.
- Develop innovative child care networks, connected to affordable housing complexes, to deliver high-quality early care and education.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

OBJECTIVE 10: State-community connections and regional systems are strengthened.

In order for Oregon's children to arrive ready for kindergarten and live in healthy, stable, and attached families, comprehensive solutions and greater coordination with every sector – early care and education, health, human services, K-12, housing, and the business community – will be required. State-community connections must be deepened and regional systems strengthened, with Early Learning Hubs playing a unique role as they build coherent local systems through which families with young families can easily connect with needed supports and services. Families must be engaged, with their voices guiding the development of policies and programs.

Strategy 10.1 Ensure family voice in system design and implementation.

- Increase authentic input of family voice in the design and implementation of state policy and programming that welcomes all families.
- Establish a mechanism, in collaboration with Early Learning Hubs, for authentic leadership in parent voice to inform Early Learning Council systems-building work.
- Work with Early Learning Hubs and their partners in developing local capacity to facilitate culturally responsive family engagement activities across their communities, prioritizing communities that have not yet been engaged.

Strategy 10.2 Ensure family-friendly referrals.

- Develop centralized systems locally to coordinate eligibility and enrollment of services across sectors, starting with early care and education (ECE).
- Develop shared principles for building a community-level, family-friendly, respectful, and easy-to-navigate referral system so that families can easily access services and supports.

Strategy 10.3 Further develop the local Early Learning Hub system.

- Incentivize active participation across sectors on the Early Learning Hub Governance Boards to ensure investment in shared goals, policy, and programming as well as coordinated implementation across a region.
- Strengthen the Early Learning Hub role in informing community needs assessments that meet the requirements of each sector, supporting coordinated and aligned community planning and shared problem solving.
- Create ongoing feedback loops between the state sectors and communities to improve communication, policy implementation, and collaboration, and address barriers in order to make progress toward the three systems goals.

OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.

All of the work in this plan must be guided by a deep commitment to equitable outcomes for children and families in historically underserved communities. This means taking action to address the avoidable conditions that impact those who have experienced socioeconomic disadvantage or historical injustices, and using data to evaluate the impact of policies and services that eliminate race as a predictor of a child's success. All sectors must come together on a regular basis to analyze disparities in access and outcomes to achieve the goals of this plan.

Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

- Collect, analyze, and consolidate data, across agencies and committees, on disparities in access and outcomes related to the goals of this plan.
- Share the results and recommendations for further improvement, including cross-sector funding opportunities.

Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- Develop a coordinated state approach to increasing the capacity of culturally specific organizations to seed and scale promising culturally responsive practices and programs in early childhood.
- Expand funding of culturally specific organizations to implement early childhood programming and build partnerships with other programs.

Objective 12: The alignment and capacity of the cross-sector early learning workforce is supported.

Despite working in different settings, the early learning workforce – consisting of health, human services, K-12, and the early care and education sector – serves young children and their families largely toward the same end: ensuring that children's health and development is on track. This requires some common knowledge and skills, as well as collaboration with one another. In order to support families and children in a consistent way, key areas of shared knowledge and competency must be identified and supported across the entire system.

Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

- Analyze existing core knowledge and competency frameworks or standards across disciplines for the family- and child-serving workforce to identify commonalities and gaps across sectors.
- Create and implement opportunities for shared professional learning across sectors in established areas of need (e.g., trauma-informed practices and family-centered referral pathways).
- Collaborate with the Higher Education Coordinating Commission and professional learning partners to incorporate identified areas of shared knowledge into curriculum.

Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- Through the Children's Cabinet, require state agencies to report on the diversity of race/ethnicity, language, compensation, and working conditions of front-line staff within each sector.
- Analyze data across the early learning workforce to determine common strengths and shared challenges regarding diversity, compensation, turnover, qualifications, and professional learning pathways in each sector.
- Use data analysis to create and implement a plan based on common strengths and shared challenges.

OBJECTIVE 13: The business and philanthropic communities champion the early learning system.

A strong early learning system is inextricably linked with Oregon's economy and workforce. Just as no one sector alone can achieve the state's early learning system goals, Oregon needs the support and partnership of the private sector to finance an early learning system for the state. This will require that Oregon build on its existing partnership with philanthropy and cultivate champions from the business community, deepening their understanding of financing strategies and the return on investment of high-quality early learning programs.

Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

- Engage business leaders in addressing the lack of ECE programs necessary to support Oregon's workforce, including the availability of high-quality, affordable child care.
- Demonstrate the value of early educators to leading businesses and business associations.
- Share information on the return on investment of ECE in contributing to Oregon's economy.

Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

- Share information on early childhood brain development and the impact of adverse childhood experiences.
- Include business leaders as members of the Early Learning Council.

OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.

The success of all these strategies will depend on the effective use of data to drive decision-making and ensure that disaggregated data is used to assess impacts of policies and investments on children in historically underserved communities. In order to realize this goal, Oregon needs to increase its capacity to collect, integrate, analyze, and disseminate data to inform decisions at the state and local levels of the early learning system.

Strategy 14.1 Strengthen data-driven community planning.

- Increase access to state and local data, and resources, to improve Hub capacity to use data in its planning to ensure the highest needs are met and that the greatest impact for children and families is achieved.
- Address data sharing and data governance barriers, while protecting family privacy, that limit community access to data needed for decision-making.
- Incorporate specific data on children of color and children from historically underserved communities.
- Bring state and community leaders together to better understand data in order to track the well-being of children and families in communities, guide a process of continuous quality improvement, and facilitate collaboration across sectors and partners.

Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

- Build state and program capacity to collect, monitor, and analyze data from early care and education programs in order to support quality improvements in the delivery of early care and education services and programs for children prenatal to kindergarten entry and their families.
- Use integrated data from the Statewide Longitudinal Data System to determine impacts of early childhood investment and identify the most effective strategies for supporting positive outcomes for children and their families.
- Incorporate specific data on children of color and children from families in historically underserved communities.

Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

- State agencies collaborate to finance, develop, and implement a population survey of Oregon families with young children that provides holistic information on their well-being.
- Ensure that the survey is developed and implemented so as to provide accurate and holistic information on the well-being of families from historically underserved populations.

Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

- Create and regularly monitor an early learning system dashboard that fosters collective impact and shared cross-sector, cross-agency accountability for population-level outcomes for children prenatal to five and their families.
- Incorporate specific data on children of color and children from historically underserved communities.

NEXT STEPS

Moving from this plan to action requires many partners working together as we strive to do more and better for young children and their families. Within state government, key systems partners will create implementation plans with measurable outcomes and timelines. The Early Learning Council will maintain an active role in overseeing, disseminating, and championing the plan, and supporting the state's early learning system in moving it forward.

APPENDIX A:
MEMBERS OF THE EARLY LEARNING COUNCIL

Sue Miller ..... Chair, Early Learning Council

Patrick Allen ..... Director, Oregon Health Authority

Martha Brooks ..... Western States Regional Director, Fight Crime: Invest in Kids and ReadyNation

Miriam Calderon ..... Early Learning System Director, Early Learning Division

Donalda Dodson ..... Executive Director, Oregon Child Development Coalition

Colt Gill ..... Deputy Superintendent of Public Instruction, Oregon Department of Education

Holly Mar ..... Vice President of Community Impact, United Way of Lane County

Fariborz Pakseresht ..... Director, Department of Human Services

Eva Rippeteau ..... Political Coordinator, Oregon AFSCME

Shawna Rodrigues ..... Oregon Head Start Collaboration Director, Early Learning Division

Donna Schnitker ..... Director of Early Childhood Programs, Harney ESD

Teri Thalhofer ..... Director, North Central Public Health District

Kali Thorne Ladd ..... Executive Director and Co-Founder, KairosPDX

Bobbie Weber ..... Research Associate, Family Policy, College of Public Health and Human Sciences, Oregon State University

Agency Advisors

Kim Fredlund ..... Director, Self-Sufficiency Programs, Department of Human Services

Candace Pelt ..... Assistant Superintendent, Office of Student Services, Oregon Department of Education

Cate Wilcox ..... Maternal and Child Health Manager, Title V Director, Public Health Division, Oregon Health Authority

APPENDIX B: GLOSSARY

The following glossary was originally published by the Oregon Child Care Research Partnership, Corvallis, Oregon, August 2016 and updated by the Early Learning Division. This glossary presents a list of terminology and definitions used to discuss state support, regulation, and involvement in early care and education services in Oregon. Oregon-specific terms are interspersed with terms used both within Oregon and nationally, as reflected in Research Connections' Child Care and Early Education Glossary.

Affordability
The degree to which the price of child care is a reasonable or feasible family expense. States maintain different definitions of "affordable" child care, taking various factors into consideration, such as family income, child care market rates, and **subsidy** acceptance, among others.

At Risk
A term used to describe children who are considered to have a higher probability of non-optimal **child development** and learning.

Attachment
The emotional and psychological bond between a child and adult, typically a parent or caregiver, that contributes to the child's sense of security and safety. It is believed that secure attachment leads to psychological well-being and Resilience throughout the child's lifetime and is considered a key predictor of positive **child development** and learning.

Child Care Access
Refers to the ability of families to find quality child care arrangements that satisfy their preferences, with reasonable effort and at an affordable price. **See related: Child Care Availability.**

Child Care Assistance
Any public or private financial assistance intended to lower the cost of child care for families. **See related: Child Care Subsidy.**

Child Care Availability
Refers to whether quality child care is accessible and available to families at a reasonable cost and using reasonable effort. **See related: Child Care Access.**

Child Care Desert
A community with more than three children for every regulated **child care slot**.

Child Care Provider
An organization or individual that provides early care and education services.

Child Care Resource & Referral (CCR&R)
Child Care Resource and Referral services promote the health, safety and development of young children in child care settings as part of Oregon's Early Learning System. They are responsible for providing a wide variety of program services which include recruiting, training, and promoting retention of a **high-quality**, diverse early learning workforce through professional development and collaboration with community partners to align and coordinate local early learning systems.

Child Care Slots
The number of openings that a child care setting has available as dictated by its **licensed capacity**. The desired capacity of a facility is often lower than its licensed capacity. Child care slots may be filled or unfilled.

Child Care Subsidy
A type of **child care assistance** primarily funded by the federal Child Care and Development Fund program. **See related: Employment-Related Day Care (ERDC).**

Child Development
The process by which children acquire skills in the areas of social, emotional, intellectual, speech and language, and physical development, including fine and gross motor skills. Developmental stages describe the expected, sequential order of gaining skills and competencies that children typically acquire.

Child Welfare System
A system that includes preventive, protective and foster care, as well as adoption services for children who have experienced or at risk of experiencing maltreatment. Oregon's Child Welfare system is part of the Department of Human Services.

Children of Incarcerated Parents
Refers to children who have a parent or parental figure(s) involved in the criminal justice system from arrest through parole.

Children's Cabinet
The Governor's Children's Cabinet involves the major sector partners involved with ensuring young children enter kindergarten ready to succeed. It includes the agency leadership from the Department of Human Services, Oregon Department of Education, Early Learning Division, Oregon Health Authority and Oregon Housing and Community Services.

Coaching
A relationship-based process led by an expert with specialized knowledge and adult learning competencies that is designed to build capacity for or enhance specific professional dispositions, skills, and behaviors. Coaching is typically offered to teaching and administrative staff, either by in-house or outside coaches, and focuses on goal-setting and achievement. See related: Technical Assistance.

Collective Impact
A commitment to a common agenda for solving a complex social problem by a group of actors from different sectors. A collective impact model provides a foundation for the work of Oregon's Early Learning Hubs.

Communities of Color
Four communities are traditionally recognized as being of color – Native American, African American, Asian, and Latino. Additional groups that have been impacted by racism in a given community can be added.

Community-Based Child Care/Community-Based Organization (CBO)
A nonprofit organization that provides educational or related services to children and families within their local community. CBOs that provide child care may be associated with faith-based organizations or other nonprofit organizations. CBOs are subject to section 501(c)(3) of the Internal Revenue Code.

Competencies (refers to Workforce Knowledge or Core Competencies)
Refers to the range of knowledge and observable skills that early childhood practitioners need to provide effective services to children and families. Competencies, sometimes referred to as "core competencies," are typically linked with states' early learning guidelines and provide a framework for professional development at various career stages.

Comprehensive Services
An array of coordinated services that meet the holistic needs of children and families enrolled in a given program, from health and developmental screenings to family literacy trainings and parent education.

Continuity of Care
Refers to the provision of care to children by consistent caregivers in consistent environments over a period of time to ensure stable and nurturing environments. Research shows that maintaining continuity and limiting transitions in a child's first few years of life promotes the type of deep human connections that young children need for optimal early brain development, emotional regulation, and learning.

Contracted Slots
Contracted slots are an agreement made between a state and a child care provider prior to service delivery that the provider will make available a certain number of child care slots, which will be paid for by the state as long as contracted state program or attendance conditions are met.

Coordinated Care Organization (CCO)
A network of all types of health care providers (physical health care, addictions, mental health care, and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions, such as diabetes. This helps reduce unnecessary emergency room visits and supports people in being healthy.

Core Body of Knowledge

The Core Body of Knowledge for Oregon's Childhood Care and Education Profession is the basis for training and education essential for on-going professional development in the childhood care and education profession, a foundation for both the Oregon Registry and the Oregon Registry Trainer Program. It embodies what professionals should know and be able to do to effectively care for and educate Oregon's young children, ages 0-8, with special consideration for children 9-12 years old. Ten core knowledge categories make up the Core Body of Knowledge. Three sets of knowledge constitute a progression of increased depth and breadth of knowledge within each core knowledge category.

Cost of Care

The monetary cost of providing early care and education services. Major contributors to the cost of care include staff wages and salaries, benefits, rent, supplies, professional development, and training. The cost of care can be different from the actual price of care charged by the provider.

Cultural Responsiveness

A term that describes what happens when special knowledge about individuals and groups of people is incorporated into standards, policies, and practices. Cultural responsiveness fosters an appreciation of families and their unique backgrounds and has been shown to increase the quality and effectiveness of services to children.

Curriculum

A written plan that includes goals for children's development and learning, the experiences through which they will achieve the goals, what staff and parents should do to help children achieve the goals, and the materials needed to support the implementation of the curriculum.

Department of Human Services (DHS)

DHS is Oregon's principal agency for helping Oregonians achieve well-being and independence through opportunities that protect and respect choice and preserve dignity, especially for those who are least able to help themselves. DHS manages Employment-Related Day Care (ERDC), Oregon's major child care subsidy program.

Developmental Screening and Assessment

The practice of systematically measuring a child's development across multiple domains and looking for signs of developmental delays. Screening and assessment tools are typically administered by professionals in health care, community, or school settings with children and families and can consist of formal questionnaires or checklists that ask targeted questions about a child's development.

Developmentally Appropriate

Practices, behaviors, activities, and settings that are adapted to match the age, characteristics, and developmental progress of a specific group of children.

Developmentally Appropriate Practice (DAP)

DAP in early learning settings reflects knowledge of child development and an understanding of the unique personality, learning style, and family background of each child.

Early Childhood Mental Health Consultation

A strategic intervention geared towards building the capacity of early childhood staff, programs, families, and systems to prevent, identify, treat, and reduce the impact of mental health problems in children from birth to age six. In a child-focused consultation, the consultant may facilitate the development of an individualized plan for the child. In a classroom-focused consultation, the consultant may work with the teacher/caregiver to increase the level of social-emotional support for all the children in the class through observations, modeling, and sharing of resources and information. In a program-focused consultation, the consultant may help administrators address policies and procedures that benefit all children and adults in the program.

Early Childhood Special Education (ECSE)

Specialized instruction that is provided by trained early childhood special education professionals to preschool children with disabilities in various early childhood settings such as preschool, child care, Oregon Prekindergarten and Head Start, among others and requires the development of an Individualized Education Plan. ECSE is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part B.

Early Head Start
A federally funded program that serves low-income pregnant women and families with infants and toddlers to support optimal child development while helping parents/families move toward economic independence. EHS programs generally offer the following core services: (1) high-quality early education in and out of the home; (2) family support services, home visits, and parent education; (3) comprehensive health and mental health services, including services for pregnant and postpartum women; (4) nutrition; (5) child care; (6) ongoing support for parents through case management and peer support. Programs have a broad range of flexibility in how they provide these services.

Early Intervention (EI)
Services that are designed to address the developmental needs of infants and toddlers with disabilities, ages birth to three years, and their families. Early Intervention services are generally administered by qualified personnel and require the development of an Individualized Family Service Plan (IFSP). Early Intervention is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part C.

Early Learning Council (ELC)
In 2011 the Oregon Legislature created the ELC to provide policy direction and oversee and coordinate Oregon's comprehensive early learning system. The Council also serves as the policy rulemaking body for all programs administered by the Early Learning Division. Council members are appointed by the governor for a term of four years.

Early Learning Division (ELD)
In 2013, the Oregon Legislature created the Early Learning Division to oversee the early learning system, including policies and programs within the early care and education sector. The Division is overseen by the governor-appointed Early Learning System Director.

Early Learning Hubs
The 2013 Legislature authorized creation of 16 regional and community–based Early Learning Hubs to make support more available, accessible, and effective for children and families, particularly those from historically underserved communities. Hubs bring together the following sectors in order to improve outcomes for young children and their families: early education, K-12, health, human services, and business.

Early Literacy
Refers to what children know about and are able to do as it relates to communication, language, reading, and writing before they can actually read and write. Children's experiences with conversation, books, print, and stories (oral and written) all contribute to their early literacy skills.

Education Cabinet
The Education Cabinet is convened to include all major sector partners in supporting the P-20 education continuum. The Cabinet includes agency leadership from the Chief Education Office, Early Learning Division, Oregon Department of Education and Higher Education Coordinating Commission.

Emerging Bilingual Learners
Refers to children under the age of five who are in the process of learning more than one language, and is used to recognize and communicate the value of knowing and being able to communicate in multiple languages.

Employment-Related Day Care (ERDC)
Oregon's major form of financial assistance for child care for low-income families is funded by a combination of federal Child Care and Development Fund and Oregon General Fund dollars. The program is managed by DHS.

Equity
Equity is the notion that each and every person will receive the necessary resources he/she needs individually to thrive, regardless of national origin, race, gender, sexual orientation, first language, or differently abled or other distinguishing characteristics.

Equity Lens
Oregon's Chief Education Office (formerly, the Oregon Education and Investment Board) works to ensure that the Equity Lens it adopted guides education policy. The Lens articulates a set of beliefs. It is intended to "clearly articulate the shared goals we have for our state and the intentional investments we will make to reach our goals of an equitable educational system, and create clear accountability structures to ensure that we are actively making progress and correcting where there is no progress. This lens was created to propel the educational system into action to shift policies, procedures, and practices in order to move from our commitment to an equitable system into actively pursuing an equitable system."

Evidence-Based Practice

A practice, regimen, or service that is grounded in evidence and can demonstrate that it improves outcomes. Elements of evidence-based practice are standardized, replicable, and effective within a given setting and for a particular group of participants.

Family Coach

Assists families transitioning into a state of independence through collaboration and partnership within the community.

Family Friend and Neighbor Care (FFN)

Child care provided by relatives, friends, and neighbors in the child's own home or in another home, often in unregulated settings.

Family Engagement

Refers to an interactive process of relationship-building between early childhood professionals and families that is mutual, respectful, and responsive to the family's language and culture. Engagement in the early years prepares families to support their children's learning throughout their school years and support parent/family-child relationships that are key to healthy child development, school readiness, and well-being.

Head Start

A federal program that provides comprehensive early childhood education, health, nutrition, and parent involvement services to low-income families. The program is designed to foster stable family relationships, enhance children's physical and emotional well-being, and support children's cognitive skills so they are ready to succeed in school. Federal grants are awarded to local public or private agencies, referred to as "grantees," that provide Head Start services. Head Start is administered by the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS). See related: Oregon Head Start PreKindergarten and Early Head Start.

Healthy Families Oregon

Healthy Families Oregon is an accredited multi-site state system with Healthy Families America (HFA) that provides family support and parenting education through home visiting, and is Oregon's largest child abuse prevention program.

High-Quality

Refers to the characteristics of early learning and development programs and settings that research has demonstrated are associated with positive child outcomes. These programs identify and support the needs of children from diverse cultures, children who speak a language other than English, and children with emerging and diagnosed special needs. These programs and settings seek out and use their resources in an equitable manner to ensure developmentally appropriate, culturally, and linguistically responsive communication, activities, and family engagement. They create a dynamic relationship between the family and the educator that works to define what the physical, social, emotional, and cognitive needs are for that child to ensure an optimal learning environment for that individual.

Historically Underserved Communities

Refers to communities that the Early Learning Council Equity Implementation Committee identified as African American, Asian and Pacific Islander, English Language Learners, Geographically Isolated, Immigrants and Refugees, Latino, Tribal Communities, and Children with Disabilities, Economic Disparities, or of Incarcerated Parents/Parental Figures.

Home Visiting Programs

Programs that aim to improve child outcomes by helping high-risk parents who are pregnant or have young children to enhance their parenting skills. Most home visiting programs match trained professionals and/or paraprofessionals with families to provide a variety of services in families' home settings. Examples of home visiting services can include health check-ups, developmental screenings, referrals, parenting advice, and guidance with navigating community services.

Housing/Oregon Housing and Community Services (OHCS)

Oregon Housing and Community Services is Oregon's housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for Oregonians of lower and moderate income.

Inclusion
The principle of enabling all children, regardless of their diverse backgrounds or abilities, to participate actively in natural settings within their learning environments and larger communities.

Individualized Education Program (IEP)
The Individualized Education Program (IEP) is a written document that is developed for each child who is eligible for special education services. The IEP is created through a team effort and reviewed at least once a year and is required by the federal Individual with Disabilities Education Act (IDEA). See related: Early Childhood Special Education; IEP Team.

Individualized Education Program (IEP) Team
The members of the multidisciplinary team who write a child's IEP.

Individualized Family Services Plan (IFSP)
A written plan that outlines the special services children ages birth through two years and their families will receive if found eligible for Early Intervention services. The plan is mandated by the federal Individuals with Disabilities Education Act (IDEA), Part C. See related: Early Intervention.

Infant/Toddler Mental Health (ITMH)
Defined as the healthy social and emotional development of young children, birth to three years of age. ITMH builds on responsive relationships with primary caregivers (parents, family, child care) that build healthy attachment and foundations for life.

Kindergarten Assessment (KA)
Assessment developed by Oregon and aligned with the state's early learning and development standards to assess what children know and are able to do as they enter kindergarten.

Kindergarten Transition
Refers to a process or milestone in which a child moves from a preschool setting to kindergarten.

Licensed Child Care
The care and supervision of a child, on a regular basis, unaccompanied by his/her parent or guardian, in a place other than the child's own home, with or without compensation.

License Exempt Child Care
Child care that is not required to be licensed based on a series of exemptions in the state of Oregon. See related: Regulated Subsidy Child Care Provider

Mentoring
A form of professional development characterized by an ongoing relationship between a novice and an experienced teacher or provider to deliver personalized instruction and feedback. Mentoring is intended to increase an individual's personal or professional capacity, resulting in greater professional effectiveness. See related: Coaching.

Monitoring
The process used to enforce child care providers' compliance with licensing rules and regulations. States may use "differential monitoring" as a regulatory method for determining the frequency or depth of monitoring based on an assessment of the child care facility's compliance history and other quality indicators.

Office of Child Care
A public office located within the Early Learning Division responsible for child care licensing, compliance, background checks, and monitoring.

Oregon Department of Education (ODE)
ODE is responsible for implementing the state's public education policies. The department is overseen by the governor, acting as state superintendent of public instruction, with an appointed deputy superintendent acting as chief administrator.

Oregon Health Authority (OHA)
OHA is the state agency at the forefront of work to improve the lifelong health of Oregonians through partnerships, prevention, and access to quality, affordable health care. It includes most of the state's health and prevention programs such as Public Health, Oregon Health Plan, and Healthy Kids, as well as public-private partnerships.

Oregon Parenting Education Collaborative (OPEC)
Oregon Parenting Education Collaborative (OPEC) was founded to help parents along on their parenting journey. The OPEC initiative provides access to regional Parenting Education Hubs that provide high-quality (research-based) resources and parenting education classes in Oregon.

Oregon Head Start PreKindergarten and Early Head Start

Oregon Head Start PreKindergarten (OHSPK) and Early Head Start (EHS) are comprehensive high-quality early childhood development programs offering integrated services. OHSPK and EHS programs receive funding from the federal Office of Head Start, the Early Learning Division, or both. All OHSPK programs follow the same guidelines for providing services.

Parent Choice

Refers to families' ability to access child care that they choose. The term is often used to refer to the federal Child Care and Development Fund that parents receiving child care subsidy should be able to use all legal forms of care.

Parenting Education

Instruction or information directed toward parents and families to increase effective parenting skills.

Preschool

Programs that provide early education and care to children in the two or three years before they enter kindergarten, typically from ages 2.5-5 years. Preschools may be publicly or privately operated and may receive public funds.

Preschool Promise

A high-quality state preschool program serving 3- and 4-year old children living in families at or below 200% of the federal poverty guidelines. It was created by the 2015 Oregon Legislature with a commitment to supporting all of Oregon's young children and families with a focus on equity and expanding opportunities to underserved populations. The program is administered by Early Learning Hubs throughout the state, bringing together early learning programs operated by Head Start, K-12, licensed child care, and community-based child care in a mixed-delivery model.

Professional Development (PD)

Refers to a continuum of learning and support activities designed to prepare individuals for work with, and on behalf of, young children and their families, as well as ongoing experiences to enhance this work. Professional development encompasses education, training, and technical assistance (TA), which leads to improvements in the knowledge, skills, practices, and dispositions of early education professionals.

Regulated Subsidy

Regulated subsidy refers to federal child care funds offered through the state to qualifying families to support care that is provided to their children. See related: Subsidized Child Care.

Regulated Subsidy Child Care Provider

A Regulated Subsidy Provider is a non-relative who cares for children whose families are eligible for child care assistance through the Department of Human Services (DHS), but who is not required to be licensed. A Regulated Subsidy Provider (sometimes referred to as a License-Exempt Child Care provider) is required to be listed with DHS and to follow new federal regulations for training and allow a visit by the Office of Child Care.

Relief Nurseries

A public-private partnership program that offers families at high risk for abuse and neglect the intensive trauma-informed support they need.

Retention (of Staff)

Refers to the ability of programs to retain their employees over time. Staff retention is a well-documented problem in early childhood programs that affects program quality.

Risk Factors

Refers to circumstances that increase a child's susceptibility to a wide range of negative outcomes and experiences. Risk factors for low school readiness may include parental/family characteristics such as low socioeconomic status and education, children's characteristics, such as whether the child has special needs, or community conditions and experiences, such as whether the child has access to high-quality early care and education.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs serves Oregonians of all ages through a variety of programs and partnerships with the goal to reduce poverty in Oregon, help families create a safe, secure environment through careers and housing, and stop the cycle of poverty for the next generation.

Social-Emotional Development
Refers to the developmental process whereby children learn to identify and understand their own feelings, accurately read and comprehend emotional states in others, manage and express strong emotions in constructive manners, regulate their behavior, develop empathy for others, and establish and maintain relationships.

Spark
Spark, formerly known as Oregon's Quality Rating and Improvement System (QRIS), is a statewide program that raises the quality of child care across the state. Spark recognizes, rewards, and builds on what early childhood care and education professionals are already doing well.

Special Needs
A term used to describe a child with an identified learning disability or physical or mental health condition requiring special education services, or other specialized services and supports. **See related: Early Intervention (EI); Individualized Education Plan (IEP); Individualized Family Services Plan (IFSP).**

Statewide Longitudinal Data System (SLDS)
The Oregon State Legislature charged the Chief Education Office with providing an integrated, statewide, student-based longitudinal data system that monitors outcomes to determine the return on statewide educational investments. This data system will provide secure, non-identifiable educational data to enhance the ability of policy makers, educators, and interested parties to improve educational outcomes for students.

Subsidized Child Care
Child care that is at least partially funded by public or charitable resources in order to decrease the cost to families. **See related: Regulated Subsidy.**

Subsidy
Private or public assistance that reduces the cost of child care for families.

Supply Building
Efforts to increase the quantity of child care programs in a particular local area.

Technical Assistance (TA)
The provision of targeted and customized supports by a professional(s) with subject matter expertise and adult learning knowledge and competencies. In an early education setting, TA is typically provided to teaching and administrative staff to improve the quality of services and supports they provide to children and families. **See related: Coaching; Mentoring; Professional Development.**

Trauma Informed Care
Refers to an approach used in working with children exposed to traumatic events or conditions. Children exposed to trauma may display heightened aggression, poor social skills, and impulsivity; they also may struggle academically or engage in risk-taking or other challenging behaviors. Service providers and family members that are trained in TIC learn effective ways to interact with these children, such as helping them cope with traumatic "triggers," supporting their emotion regulation skills, maintaining predictable routines, and using effective behavior management strategies.

Workforce
The broad range of individuals engaged in the care and education of young children. Members of the early childhood workforce may include teaching, caregiving, and administrative staff, as well as consultants, learning specialists, and others that provide **professional development**, training and **technical assistance** to programs.

Wrap-Around Services
A team of providers collaborate to improve the lives of the children and families they serve by creating, enhancing, and accessing a coordinated and comprehensive system of supports. Supports might include formal services and interventions, such as enrichment and academic supports outside of regular child care programming; community and health services, such as doctor visits; and interpersonal assistance, such as family counseling.

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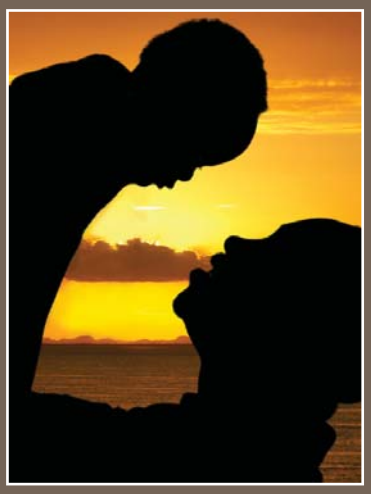


RAISE UP OREGON:
A STATEWIDE EARLY LEARNING SYSTEM PLAN
2019 -2023

The report is issued by the Oregon Early Learning Council

early.learning@state.or.us
oregonearlylearning.com/raise-up-oregon

Safe Sleep for Oregon's Infants

All the moments in an infant's day matter

A self-study training opportunity for family serving professionals

Oregon Department of Human Services
CHILD WELFARE DIVISION

Oregon Health Authority

Acknowledgment: Thank you to Oregon's Early Learning Division (ELD) and specifically Roni Pham and Sydney Traen for your work on the ELD version of the self-study training. Thank you to Anna Stiefvater with Oregon Health Authority (OHA), Public Health, Maternal and Child Health, Chelsea Whitney with Lane County Health and Human Services and Sara Stankey with ODHS Child Welfare in Lane County, for rolling out a safe sleep training in Lane County and sharing your resources. Also, a thank you to the Office of Child Welfare Programs, ODHS Child Welfare professionals, the ODHS Office of Equity and Multicultural Services, Oregon's Nine Confederated Tribes and the ODHS Tribal Affairs unit with special thanks to Ashley Harding, Joan Bacchus, Native American Rehabilitation Association of the Northwest, the Oregon Foster Parent Association, the Oregon Coalition Against Domestic and Sexual Violence, Oregon domestic violence programs, Oregon substance use disorder treatment programs and those served by these programs, OHA Public Health, ODHS Self Sufficiency professionals, Oregon Parenting Education Collaborative (OPEC) Coordinators, OPEC Parenting Educators and Shauna Tominey Ph.D. with Oregon State University and OPEC.

Primary Audience: Professionals engaging families in the community or the home environment.

Length: Approximately one hour to one and a half hours.

You can get this document in other languages, large print, braille or a format you prefer. Contact Child Welfare's Child Fatality Prevention and Review Program at CW.Prevention@dhsoha.state.or.us.

DHS 2416d (9/21)

Contents

Dear Oregon professionals,

Thank you for your commitment to the safety of Oregon's children. It is important for us all to continue to learn and refresh our knowledge to provide quality services and support to Oregon's families.

Safe sleep practices are critical in preventing child fatalities. This training is an opportunity for professionals working with parents and caregivers to learn about safe sleep practices, how to reduce risk and your role in supporting families to reduce risk to infants in their care.

These organizations and individuals are excited to support infant safe sleep and this effort to achieve consistent messaging across all of Oregon's family serving professionals:

Oregon Association of Hospitals and Health Systems

Oregon Coalition Against Domestic Violence and Sexual Assault

Oregon Department of Education, Early Learning Division

Oregon Department of Human Services, Child Welfare

Oregon Department of Human Services, Self Sufficiency Programs

Oregon Health Authority, Public Health Division

Oregon Medical Board

Oregon Parenting Collaborative

Oregon State Board of Nursing

Ben Hoffman MD, Medical Director, Tom Sargent Children's Safety Center, OHSU Doernbecher Children's Hospital

Joan Bacchus, Native American Rehabilitation Association of the Northwest

Karen L Ayers, Program and Partnership Manager, Safe Kids Oregon/Oregon Child Development Coalition

Safe Sleep for Oregon's Infants

A Self-Study Training Opportunity

How to complete the "Safe Sleep for Oregon's Infants" self-study:

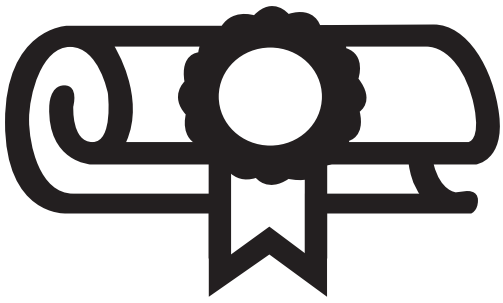
1. Watch the lived experience video at https://youtu.be/Xx0Yfv42rOg

   This video is on YouTube. The title is "Sudden Infant Death Syndrome (SIDS)" and it is provided by St. Elizabeth Healthcare. The five-minute video is an opportunity to hear from parents who have experienced the sleep-related death of an infant. These individuals present the importance of safe sleep practices. While this video is powerful and moving and can be used as a tool with parents and caregivers, please prioritize your self-care when deciding whether to watch.

2. Read the self-study information and complete all the activities. (Your responses are private.) This document contains the self-study information and related activities.
3. Complete the knowledge check. The knowledge check includes 10 questions and the answer key is in this document.
4. Complete the survey. Once you complete the self-study, there is a link within this document to an online survey and opportunity to provide feedback related to the self-study materials.

Consider printing or saving these materials for future reference. Also consider discussing what you learned with your peers and practicing having conversations about safe sleep.

If you have questions or need assistance with the self-study, please email: CW.Prevention@dhsoha.state.or.us



What to expect:

Each professional who takes this training has a vital role in child safety. Whether a parenting educator, treatment provider, health care professional or other professional engaging families with infants, it is critical for you to know how to keep infants safe and be able to share that knowledge with parents and caregivers.

"Infant" refers to a child between birth and age one. This training will give you valuable information about safe sleep practices for infants in a way that honors families' unique values and needs.

Many of us come to this topic with our own beliefs and experiences. Be aware the content of the training may evoke different emotions and may be difficult depending on individual's personal or professional experience. Reflect on your own feelings and those families may have when discussing this topic. Please complete the training at your own pace and engage in needed self-care.

Objectives:

1. Explore how your own experiences and preferences with sleep connect with the recommendations for infant safe sleep practices.
2. Understand your responsibilities around safe sleep as a professional who serves families.
3. Understand sleep-related risks.
4. Understand what actions increase and decrease sleep-related risks.
5. Understand how to talk about safe sleep practices with parents and caregivers.

The sections of this self-study training cover:

Part 1: Understanding sleep-related sudden unexpected infant death (SUID) and how to reduce risk
Part 2: Safe sleep practices and substance use
Part 3: Communicating with parents and caregivers
Part 4: Wrap up: Professional action plan, knowledge check and survey

By the end of this training, you will be able to:

- Articulate your responsibilities regarding safe sleep
- Define sleep-related SUID

- Identify actions that increase and decrease risk factors for SIDS and sleep-related infant deaths
- Recognize safe and high risk sleep environments, and
- Communicate safe sleep practices to parents and caregivers with a strength-based, trauma aware approach that honors their values and needs.

Part 1: Understanding sleep-related SUID, risk factors and what risks a parent or caregiver can change

Examine your current knowledge and/or practices

Imagine that you are sitting in a rocking chair holding a baby. The baby hungrily sucks from a breast or bottle while you both enjoy exploring each other's face and eyes. After several burps over your shoulder, you hold them in the crook of your arms again. The baby starts to fall asleep but wakes slightly to make sure you're still there keeping them safe. Finally, the baby falls asleep and you hear their breathing as their chest rises and falls. You get up to lay the baby down to sleep. You are confident that you have made the sleeping area safe and free from all risks.

What do you already know about safe sleep for infants?

Use the space below to write what you did in the story above to make the sleeping space safe and free from all risks.

What does sleeping comfortably look like for you as an adult?

Imagine that it is the end of a long day. All you want is to get comfortable and have a good sleep. Use the space below to write what you have done to make this happen for you. What comforts have you prepared to help you get the sleep you so need and want? What makes it so comfortable? For example, think about your sleep position, bedding, pillows and clothes. What gets you ready for sleep?

In this training you will learn that adult sleeping behaviors and comfort needs are different from infant sleeping needs. Some adult sleep comforts can be risky to an infant's safety. This doesn't mean infants will be uncomfortable; it means they will sleep safely

How did you develop your current knowledge or practices around laying an infant down to sleep?

As a professional who serves families, it is important to know research-supported best practices to safely lay an infant down to sleep, whether for a nap or for the night. People often rely on experiences, knowledge, culture, friends and family to know how to care for an infant. Use the space below to write how you developed your current knowledge or practices around laying an infant down to sleep.

Your role in safe sleep

Professionals who serve families may interact with the families they serve in their home environments, virtually, on the phone or in the community. Their responsibilities often include sharing information about parenting practices that support children's safety, health and well-being. You are in a unique position to talk to parents and caregivers about safe sleep

As part of an intake, evaluation or during ongoing work with a family, consider:

1. Observing the infant sleep environment when possible or asking for a description
2. Asking about sleep practices the family uses anytime the infant is laid down to sleep
3. Providing education on safe sleep recommendations (consider providing both written information and a verbal explanation), and
4. Helping the family problem solve to reduce risk.

Many people have strongly held beliefs about sleep practices, but you are still encouraged to make sure parents and caregivers are aware of safe sleep practices. For many families, discussions about how to reduce risk for their infants will be more effective in changing their practices than simply giving them written material.

Professionals who serve families must be equipped to share the most up-to-date, research-supported practices with families caring for an infant. This training uses current information and research from multiples sources. Please carefully read the information and complete the activities to test your knowledge along the way.

Why safe sleep practices are important

You touch the lives of children and their families in many important ways. Safe sleep practices are critical to reducing the risk of sleep-related infant death. Not following these practices could have a devastating outcome. Helping parents and caregivers understand the importance of safe sleep practices and supporting these practices as part of a family's routine may save lives.

The connection between SUID and safe sleep

Once a child reaches one month of age, the most common cause of death is Sudden Unexplained Infant Death (SUID).

The three commonly reported types of SUID are:

- Sudden Infant Death Syndrome (SIDS)
- Accidental suffocation and strangulation in bed (ASSB), and
- Other ill-defined or unspecified causes

Here are the definitions of SUID and SIDS:

Sudden Unexplained Infant Death (SUID)	Sudden Infant Death Syndrome (SIDS) (a type of SUID)
SUID is the sudden and unexpected death of a seemingly healthy infant under 12 months of age in which cause of death is not immediately obvious.	SIDS is a SUID death that is still unexplained after a death scene investigation, autopsy and review of the infant's medical history.[1]

The goal of safe sleep practices is to reduce sleep-related SIDS deaths and ASSB deaths. Infant deaths in a sleep environment that are not considered SIDS may be caused by suffocation or strangulation and fall under the category ASSB, so it is important to understand both.

Mechanisms that lead to accidental suffocation include the following:

- **Suffocation by soft bedding**
  For example, when a pillow or waterbed mattress covers an infant's nose and mouth.
- **Overlay**
  For example, when another person rolls on top of or against the infant while sleeping.

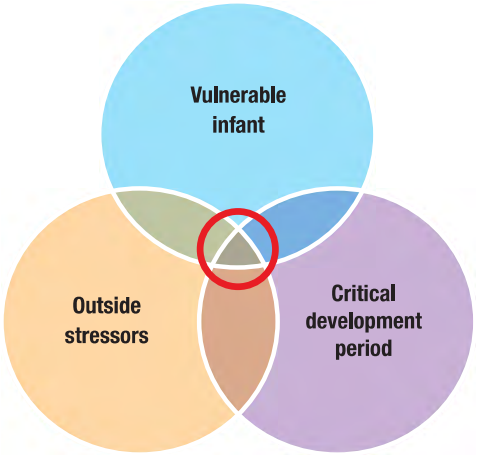
- **Wedging or entrapment**
  For example, when an infant is wedged between two objects, such as a mattress and wall, bed frame or furniture.
- **Strangulation**
  For example, when an infant's head and neck become caught between crib railings.

Now for the good news…

The good news is, a parent or caregiver can take actions to lower the risk of SIDS and in most cases prevent ASSB. Most of these actions relate to the infant's sleep environment. Understanding how safe sleep reduces risks for Sudden Infant Death Syndrome (SIDS) and other sleep-related deaths is key to engaging parents and caregivers in conversations and planning that may save a child's life.

Before going over ways to reduce risk, first let's learn more about SIDS and the risk factors a parent or caregiver can and can't change..

Multiple risk factors for SIDS[2]



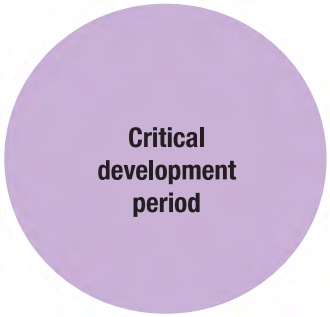
There is no one definitive cause of SIDS. This diagram shows how three common risk factors interact. When an infant is experiencing risk factors from all the three circles, as shown in the center area of the diagram, they are at a much higher risk for SIDS. Although these factors contribute to higher risk, all infants are at risk.

Let's look at each of the risk categories in the diagram individually.

Vulnerable infant

All infants are vulnerable to SIDS. Some factors can make an infant more vulnerable. These can be unknown to parents, caregivers and heath care providers. Risk factors include:

- Genetic conditions passed down from biological parents
- Unknown physical developmental issues, and
- Issues with brain development.



Critical development period

Infants' brains grow and develop a lot in the first six months of life. They are at highest risk for SIDS during this time because the part of the brain that allows them to wake up when their oxygen level is too low or their carbon dioxide level is too high is still developing. The muscles in the neck and core are also not fully developed at this time. This means the infant can't roll over or pick up their head if their airway is blocked.

Outside stressors

The only risk factors that a parent or caregiver has an ability to change are in the "**outside stressors**" category. These are called "outside stressors" because they occur outside the infant's body. Some examples of outside stressors include:

- Bumper pads
- Too much clothing
- Loose bedding
- Being placed on their stomach, and
- Exposure to cigarette smoke.

Professionals who serve families have a role in helping parents and caregivers reduce these risks. Reducing **outside stressors** is best for an infant's health and safety.

Reducing outside stressors

Knowing the outside stressors and how to reduce the number of outside stressors is critical to having informed, constructive conversations with reporters about safe sleep practices.

The outside stressors focused on in this training are the 5 safe sleep categories Child Welfare professionals must evaluate and discuss.

1. Sleep position
2. Sleep surface and area
3. Sleep location
4. Smoke free environment
5. Sleep temperature

1: Sleep position:

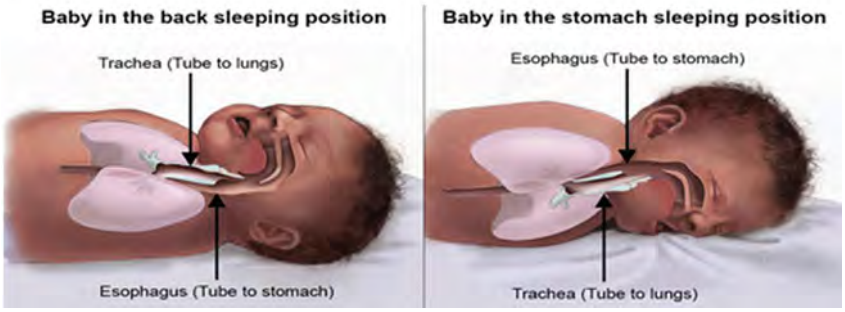
Decreased risk	Increased risk
The infant is placed on their back to sleep.	The infant is placed on their stomach or side to sleep.

More information about sleep position:

- Placing an infant on their back is the most effective way parents and caregivers can reduce the risk of SIDS.

  If an infant is a stomach or side sleeper at home, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on their stomach because the infant can accidentally roll to their stomach. If an infant is put to sleep on their back and rolls on their own to their stomach, in this instance, it is not necessary to change their position. If a swaddled infant is able to roll, it is important to stop swaddling altogether.
- Infants love consistency. In fact, infants who usually sleep on their backs but are then placed to sleep on their stomachs, like for a nap, are at very high risk for SIDS.[3]
- **Tummy time** (placing your awake infant on their stomach) is important. Infants need tummy time to develop different muscles and to get a good view of their world. However, tummy time should only take place when the infant is awake and supervised.[4] If an infant falls asleep during tummy time, they should be placed on a safe sleep surface on their back.
- Swaddled infants may roll more easily from back to stomach and can't use their arms for support. Swaddled infants have an increased risk of death if they are placed or roll onto their stomach. If swaddling is used, infants should always be placed on their back. When an infant exhibits signs of attempting to roll, swaddling should no longer be used. To be safe, stopping swaddling by two months of age is recommended.[5]
- Infants are less likely to choke on their backs.

  It used to be a common belief that back sleeping increases the chance of choking if an infant vomits while they are sleeping. This is not true. Infants can clear fluids better when they are on their backs. When an infant is sleeping on their back, the trachea (airway that goes to the lungs) lies on top of the esophagus (tube that goes to the stomach). When an infant spits up, gravity will keep the spit-up in the esophagus and it will either come out of the mouth or the infant will swallow it. Either way, the trachea is protected when the infant is on their back. When an infant is sleeping on their stomach, any spit-up will pool at the opening of the trachea. This makes it easier for the infant to choke from breathing fluid into their lungs.



Because of misinformation about back sleeping, you may encounter new parents who have heard from grandparents and others that their infant slept on their stomach. Many infants who sleep on their stomach never experience SIDS. However, the risk of SIDS is far greater for those infants. This is part of the conversation you will have with parents and caregivers about how, over time, research has informed new best practices. Seat belts are a good example to use; they were uncommon in cars until 1958 and then their use was inconsistent. Many children were not harmed by riding in cars with no seat belt, but some experienced devastating consequences. So, while many of us survived never wearing a seat belt, we wear them now. We now know that if we were in a car crash, our chances of surviving are much greater if we are wearing a seat belt.

Since the Back to Sleep campaign started in 1992, there has been a 50 % reduction in infant deaths.

2: Sleep surface and area

Decreased risk	Increased risk
The infant sleeps on a firm, flat surface (for example, a safety-approved bassinet, crib or Pack N' Play). The firm surface, even a Pack 'N Play, has a fitted sheet and no other soft bedding or loose materials.	The infant sleeps on soft surface or surface that is not flat (for example, a couch, armchair, adult mattress such as memory foam, mattress topper, waterbed or car seat). There is soft bedding or loose materials in the sleep area (for example pillows, toys, stuffed animals, blankets or bumper pads).

Sleep surfaces can vary depending on cultural tradition, space and mobility. The most important thing is to put an infant to sleep on a firm, flat surface. The most common firm, flat surfaces are bassinets, cribs or Pack N' Plays.

Below are examples of firm, flat sleep surfaces other than bassinets, cribs or Pack N' Plays that may be used:

Basket

Box or carton

Drawer

Washtub

Below are examples of traditional tribal sleep surfaces:

Umatilla Tribe style cradleboard[7]

Navajo Tribe style cradleboard[8]

First Nations and Woodlands Tribes moss bag[9]

Many traditional sleep surfaces have been around for a long time. Some of the safest traditional sleep surfaces come from American Indian/Alaska Native (AI/AN) or First Nations (FN) traditions. If you are caring for an AI/AN or FN child, some traditional sleep surfaces may be available. These include:

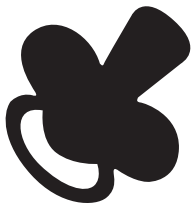
- Cradleboards or baskets, which are common across many AI/AN tribes, and
- Moss bags, which are common among Canadian First Nations and Woodlands AI/AN Tribes.

American Indian and Alaska Native communities may have originated the concept of "Back to Sleep" with the use of traditional infant sleep devices. Although the specific design of the sleep devices differ between Tribes, the infant is placed on their back and swaddled into place in a safe and secure environment. Rates of infant death and SIDS are high in many American Indian or Alaska Native communities, and using these traditional methods is a good way to keep infants safe. If you are unaware of specific Tribal safe sleep practices, contact the infant's Tribe to learn more. Understanding how to use traditional Tribal sleep devices is critical to keeping the infant safe.

No matter what container or device is used, the surface should be firm and flat. If the sleep surface can't accommodate a snug fitting mattress, it is safer to place the infant on the firm, uncovered surface than it is to use a pillow or other soft or loose surface.

Infants who sleep on soft surfaces or are placed with soft, squishy objects are at risk for SIDS or suffocation. Examples of soft surfaces or objects include:

- Soft mattresses
- Pillows
- Blankets, comforters and quilts
- Other loose bedding (such as non-fitted sheets)
- Sheepskins
- Bumper pads
- Stuffed toys, and
- Infant positioners (products designed to keep an infant in a certain position, such as wedges, padded tubes or mats with side bolsters).



More information about sleep surface and area:

- Sitting or reclining devices, such as car seats, strollers, swings, infant carriers and infant slings, are not recommended for routine or unsupervised infant sleep. Infants in these sitting devices may be able to move into a slouched forward position that can cut off their airway. Even using the straps included in the device does not prevent this.
- Soft objects and loose bedding can obstruct an infant's nose and mouth.
- It is **not** recommended to put an infant to sleep with a bottle propped in their mouth.
    - It is a choking hazard and can lead to bottle rot as teeth come in.[10]
    - The items typically used to prop a bottle (such as blankets or stuffed animals) pose a suffocation risk.[11]
- Infant sleep clothing, such as a wearable blanket or sleep sack, is an alternative to blankets.
- Swaddling can be an effective technique to help calm infants, but if the infant breaks free of the swaddle, the blanket can then be available to cover their face and block their airway. However, it is also important to make sure the blanket is not too tight. The infant's hips and legs should be able to move freely, and two or three fingers should fit between the infant's chest and the swaddling blanket. Also, swaddling may decrease an infant's arousal, so that it's harder for them to wake up. According to HealthyChildren.org, "We know that decreased arousal can be a problem and may be one of the main reasons that babies (infants) die of SIDS."5
- Bumper pads are not necessary to prevent head entrapment because of new safety standards for crib slats.
- Remove teething necklaces or jewelry when laying an infant down to sleep.
- Although the reason is unclear, studies have reported pacifiers may reduce the risk of SIDS. Offering a pacifier to infants is recommended. Pacifiers help infants wake from sleep more easily, which is important if their breathing becomes blocked. A pacifier falling out of the infant's mouth and on to the sleep surface is ok.
- If a pacifier is used when placing the infant for sleep, it does not need to be reinserted once the infant falls asleep. If the infant refuses the pacifier, they should not be forced to take it.
- It is recommended that the crib, bassinet or portable crib follow the safety standards of the Consumer Product Safety Commission (CPSC). See the "Resources" section in Part 4 of this training and click on the CPSC link for more information on safety standards.

3: Sleep location

Decreased risk	Increased risk
Room sharing The crib or bassinet is close to parent or caregiver	The infant shares a sleep surface with caregiver, non-primary caregiver, siblings, other person or pets The crib or sleep surface is located in a separate room

Room sharing versus bed sharing

Before discussing room sharing and bed sharing, here are the definitions of each of these terms:

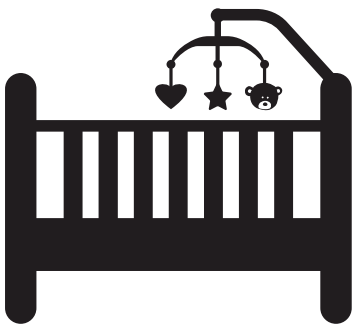
Room sharing refers to an infant sleeping in the same room as a caregiver or other household members but not sharing the same surface such as a bed, couch, chair or futon.

Bed sharing refers to an infant and one or more adults or children sleeping together on any surface, not necessarily a bed; they could be sharing another surface, such as a couch, chair or futon.

It is recommended that infants sleep in the parents' or caregivers' room, close to the parents' or caregivers' bed but on a separate surface designed for infants. The American Academy of Pediatrics (AAP) guidelines are designed to promote breast feeding, bonding and safety. Keeping the infant close to the parent or caregiver supports these goals.

The AAP recommendations acknowledge that parents frequently fall asleep while feeding an infant. Evidence suggests it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair. However, adult beds are associated with a lot of risk factors, such as soft, pillow-top mattresses, blankets and pillows. Infants are not coordinated enough to move a blanket or pillow off their face.

Bed sharing is not recommended. Bed sharing increases the risk of suffocation, entrapment and other sleep-related causes of infant death. An adult bed is not designed for infants, and there are no safety standards for adult beds.



Although bed sharing is **not** recommended by the AAP, there are many rational reasons why a parent chooses to bed share:

- It encourages breastfeeding by making nighttime breastfeeding more convenient.
- It makes it easier for a nursing mother to get her sleep cycle in sync with her infant's.
- It helps infants fall asleep more easily, especially during their first few months and when they wake up in the middle of the night.
- It helps infants get more nighttime sleep (because they awaken more with a shorter feeding time, which can add up to a greater amount of sleep throughout the night).
- It helps parents regain closeness with their infant after being separated from their infant during the workday.
- It is a common practice within the family's culture.
- The parent or caregiver had a positive experience with bed sharing with other children.
- If a parent or caregiver has experienced domestic violence, bed sharing may occur:
    - Because the abusive partner requires the infant to be in the bed
    - To protect an infant from an abusive partner
    - To be prepared to leave quickly, or
    - As a coping mechanism after fleeing an unsafe situation.

Oregon Health Authority and AAP recommend precautions to consider if, contrary to recommendations, a parent or caregiver chooses to have their infant sleep in their adult bed:

- ❑ Wait until the infant is older than four months old.
- ❑ Remove pillows, quilts or comforters.
- ❑ Do not have pets or other children in the bed at the same time as the infant.
- ❑ Avoid sleeping on soft surfaces such as a waterbed, mattress topper, sofa, couch or armchair.
- ❑ Avoid bed sharing if the adult is actively smoking.
- ❑ Avoid bed sharing if the adult has consumed alcohol, used substances that may impair them, taken sleep aids or if they are overly exhausted and there is a chance that they will not awake in an emergency. This will be addressed with more detail in the next section

More information about sleep location:

- Exhaustion is an inevitable part of parenting an infant. Support the parent or caregiver by developing a plan to lay the infant down to sleep safely when managing exhaustion. A plan may involve other adults in the home. When planning, always listen to what the

caregiver says is doable. Especially when there are no other adults in the home, consider a plan involving a babysitter, respite provider or other alternative caregiver providing scheduled or as-needed respite to allow the parent or caregiver to get uninterrupted sleep.

- Room sharing is safer than bed sharing or solitary sleeping in a separate room.
- Placing the crib or bassinet next to the caregiver's bed can make nighttime feedings easier.

4: Smoke-free environment

Decreased risk	Increased risk
The infant is in a smoke-free environment.	The infant is exposed to secondhand or thirdhand smoke.

Secondhand smoke effect

Secondhand smoke is smoke inhaled from tobacco being smoked by others. This happens when you are in an enclosed space or sitting near someone who is smoking. Exposure to secondhand smoke significantly increases an infant's chances of dying from SIDS.[13] Children exposed to secondhand smoke are also at higher risk of other diseases, such as asthma, the common cold and other viruses.

Thirdhand smoke effect

Thirdhand smoke is tobacco smoke toxins that remain after the cigarette is put out. Thirdhand smoke toxins can build up on the smoker's hair, clothing and other surfaces. The toxins in smoke can cause harm to an infant's developing brain.

To reduce infants' risk of exposure to thirdhand smoke, parents and caregivers can cover their clothing with a jacket or sweater, pull back long hair or wear a hat to cover their hair while smoking. After smoking, it is important to wash their hands and face and change any clothing that will come into direct contact with the infant. This will protect the infant's vulnerable developing body systems.

5: Sleeping temperature

Decreased risk	Increased risk
The room temperature is comfortable for a lightly clothed adult. The infant is in a maximum of one layer more than would typically be comfortable for an adult to wear.	The room temperature is too warm or uncomfortable for an adult. The infant is overdressed or underdressed for the temperature of the room.

Overheating increases sleep-related SUID risk. Overheated infants are more likely to go into a deep sleep that might be more difficult for them to wake up from. Signs that an infant is too hot include sweating, damp hair, flushed cheeks, heat rash and rapid breathing.

Many parents and caregivers are concerned that an infant will get cold without a blanket. Blankets can increase the risk of SIDS and accidental suffocation. Instead of a blanket, use the general guideline of dressing an infant in clothes, sleepers or a nonrestrictive sleep sack that provide one layer more than would typically be comfortable for an adult. Healthy infants do a good job regulating their own body temperature. Extreme temperatures, such as sleeping outdoors in winter, may require additional layers. If adding layers, pay special attention to the signs the infant is too hot.

Overheating may also occur if an infant is swaddled. If caregivers swaddle, including swaddling for a cradleboard or other traditional Tribal safe sleep practice, it is important to consider what else the infant is wearing and the temperature where the infant is sleeping.

Share the message

The parents and caregivers of infants look to you for parenting guidance and support. There are many opportunities when working with families to share information about safe sleep practices. It is important to make sure the information is shared with all the individuals in a family who have a role in laying the infant down to sleep. Encourage parents and caregivers to share this information with family members, friends and others who also provide care for their infant, including babysitters and childcare providers.

For American Indian/Alaska Native families, provide information in a way that does not confront or question the family's knowledge about Tribal traditions. Consider engaging elders from Tribal communities and do so in a manner that does not question their authority as important community members with knowledge and expertise that could benefit families. Learn about traditions that are important to families. Ask for guidance about how to support families within Tribal communities to make decisions that both honor their values and traditions and follow research-supported practices.

What did you learn about increasing and decreasing the risk of sleep-related deaths?

Activity 1: Identify which actions in the list increase risk of SIDS:

1. Placing the infant on their side to sleep
2. Placing only one stuffed animal in the crib
3. Wearing a hat to cover your hair when smoking
4. Swaddling when the infant can roll
5. Placing no blankets at all in the crib

Answers: 1, 2 and 4 increase risk

Activity 2: If you were with a family and saw the sleep practices in the photos below, would you recognize the outside stressors and know what to recommend the family do to reduce risk?

View the photos below and write your answers and observations in the space provided for each photo.

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Part 2: Bed sharing and substance use

Substance use prior to bed sharing

As you learned in Part 1, bed sharing increases the risk of sleep-related infant death. While the AAP recommends avoiding bed sharing, some parents and caregivers will choose to continue to share a sleep surface with their infant for a variety of reasons. In this case, engage in conversations as much as possible and partner with the parent or caregiver to develop a plan to reduce risks. A parent may continue to bed share, but they may agree to remove the comforter from the bed and have the other adults or children sleep elsewhere. Harm reduction is an important approach when talking to families about infant safe sleep.

"Substance use" includes many legal or illegal drugs with potential for misuse, including controlled substances, prescription medications, over-the counter medications and alcohol. However, right now let's look at marijuana specifically.

What are your attitudes and beliefs about marijuana use?

Marijuana use is common and legal in Oregon. As a professional who serves families, it is important to examine your own beliefs about marijuana use and parenting to make sure personal bias does not interfere with how you provide parental support and education. In the space below, write your understanding of how marijuana use while parenting may put an infant at risk.

Bed sharing, substance use and infant death

Marijuana, alcohol and prescribed substances are legal in Oregon. The form, method or legality of a substance does not make its effects on parental impairment and child safety less dangerous. Whether a substance is legal or illegal, prescribed or not prescribed, is not the issue. The focus is on the affect the substance has on the parent or caregiver.

When a parent uses sedating substances such as marijuana, it increases the probability that they the will go to sleep faster and sleep harder and deeper than usual. Being sedated or impaired can make a parent or caregiver unresponsive to an infant. The parent may not be aware they have rolled onto the infant and may not feel the infant or hear the infant's distress sounds. According to BASIS (Baby Sleep Info Source):

> The most recent studies have shown that most bed sharing deaths happen when an adult sleeping with a baby (infant) has been smoking, drinking alcohol, or taking drugs (illegal or over the counter meds) that make them sleep deeply.[14]

For this reason, it is even more crucial to have conversations, provide information and make plans for infant safe sleep practices with families where parents or caregivers use substances. There is a clear standard here. It is unsafe for a parent or caregiver to bring an infant into their bed if they have used any substance that could interfere with their normal sleep patterns. If the parent or caregiver is impaired and plans to share a sleep surface with their infant, support the family in making an alternative plan. This support may include reaching out to other individuals in the family or community. If all attempts are unsuccessful, consider whether it is a mandatory report of child abuse.