A Blueprint

For Improving The Lives Of

New Britain's Young Children

Birth Through 3rd Grade

All children in New Britain
from birth to nine will be:
safe, healthy and successful learners.

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Executive Summary

Project History

In January 2008, New Britain initiated a community-based planning effort to address the needs of its children from **birth to age eight**. This effort examined factors related to the health and development of both New Britain children and families and was jointly funded by the CT Early Childhood Cabinet the William Caspar Graustein Memorial Fund and the Children's Health and Development Institute. Additionally the Discovery Collaborative received support from the Community Foundation of Greater New Britain, the United Way and American Savings Foundation.

The plan that follows is the culmination of two years of work involving New Britain parents and professionals who have a strong and demonstrated interest and passion for a healthy, productive future for New Britain's children.

The formal process of developing the plan began with a Community Kick Off session on March 25, 2008. Eighty-five community members attended: including the Mayor, Superintendent of Schools, other elected officials, local clergy, healthcare and social service providers and many local parents. Following the presentation at that meeting, a Leadership Work Group and **four interest area committees were formed: Family Literacy, Early Care and Education, Health and Family Support.**

Community Indicators

Based upon community input and research, The Leadership Work Group established five city-wide indicators to improve the quality of life for young children in New Britain:

A. Reducing the number of Low Birthweight Babies
B. Increasing the number of Mothers with a High School Diploma
C. Reducing the rate of Obesity in 3 and 4 year old Children
D. Increasing the number of Children Ready for Kindergarten
E. Increasing the number of Children Reading at Grade Level

The committees were charged with: identifying relevant issues; gathering data and the stories behind the data; researching city, state, and national trends; identifying existing resources; developing strategies, identifying partners to help address the issues; and projecting implementation costs. Input was widely sought through focus groups, surveys, and conversations with New Britain families and professionals. Translators assisted to ensure a wide body of community voices were heard.

Overview of Indicators

A. Reducing The Number Of Low Birthweight Babies

Research shows that low birthweight babies raised in poor families are less likely to graduate from high school by age nineteen than siblings born at a healthy birthweight. Data indicates that New Britain has a consistently higher rate of low birthweight babies than the state average. The plan highlights three primary strategies to address these factors in New Britain:

1. Reducing teen smoking
2. Improve access to prenatal care for women without private health insurance
3. Improve the delivery of prenatal care.

Action steps related to each strategy address each of the underlying conditions that negatively affect pregnant women and their unborn children.

B. Increasing The Number Of Mothers With A High School Diploma

Research shows that the education level of a child's mother is one of the strongest overall predictors of a child's academic performance. In New Britain, recent data indicates that the rate of births to mothers without high school diplomas is twice the state average. Although New Britain's birthrate to teens still in school is above the state average, births to women who have previously dropped out of high school, and births to immigrant women who never completed their education make up a significantly higher percentage of New Britain mothers without a high school diploma. Strategies to address both groups are included in the plan:

1. Reduce the high school dropout rate.
2. Support mothers who haven't finished high school to complete their diploma before having another child.
3. Prevent teen pregnancy so more women finish high school before having a child.
4. Expand efforts to help immigrant women learn English and finish their education.

Action steps related to the strategies include convening a working group of providers and community members to address the needs of both populations and successfully reach our goal.

C. Reducing The Rate Of Obesity In 3 And 4 Year Old Children

Childhood obesity is often accompanied by asthma, and leads to chronic health problems like high blood pressure, high cholesterol, juvenile diabetes, and painful joint conditions. All of these conditions can result in lost time from school. The costs of untreated childhood obesity in terms of additional medical expense and lowered quality of life are enormous. On a national level childhood obesity rates have tripled since 1975. Recent community research indicates New Britain's young children are also becoming increasingly obese. Although, the primary causes of childhood obesity are high caloric intake and a sedentary lifestyle, community conditions suggest other local factors contribute to this problem. Strategies related to this problem include:

1. Expand efforts to prevent childhood obesity.
2. Identify childhood obesity early and begin interventions right away.

Action steps related to the strategies address community conditions that inhibit young children from maintaining a healthy weight.

D. Increasing The Number Of Children Ready For Kindergarten

Children who start school behind are more likely to remain behind. The infamous "achievement gap" is fundamentally a preparation gap. Children who enter kindergarten with poor literacy, behavioral, and social skills are less likely to achieve grade level expectations than other children regardless of socioeconomic status. This is true throughout all the years of primary and secondary school education and is even tied to decreased high school graduation rates. The rate of access to high quality preschool programs is a critical factor in how prepared our children are for kindergarten. Despite great recent strides in preschool access, New Britain's children still start kindergarten far less prepared than their suburban peers. Plan strategies to address this issue are comprehensive and include:

1. Improve preschool teaching skills in the domains of language development, early literacy, and social emotional development.
2. Collect and analyze the data on student progress and adjust teaching strategies accordingly.
3. Increase the supply of qualified early childhood teachers.
4. Support parenting skills in promoting children's development.
5. Identifying children with developmental delays and starting interventions earlier
6. Increase the supply of early care and education in New Britain.

Action steps related to these strategies build upon the existing systems and partnerships that support the development of young children in New Britain.

E. Increasing The Number Of Children Reading At Grade Level

Reading well by the end of third grade is strongly predictive of high school graduation. If a child cannot read well by the end of third grade, they will not be able to "learn from their reading" as required in higher grades. In New Britain, most children arrive at kindergarten unprepared in the areas of language and pre-literacy skills. According to the kindergarten teachers, only fifteen percent of New Britain's kindergarteners were considered able to consistently demonstrate these skills. Basic skills needed for success in kindergarten like holding and exploring books independently, recognizing basic letters, identifying sounds, connecting letters to sounds, and writing their name are beyond the skills of many New Britain children. Failure to address this issue when children are young, will further negatively impact school success and graduation rates as children grow older. Strategies to address reading this indicator include:

1. Support family literacy.
2. Increase the number of English Language Learners starting preschool at age three.
3. Maintain All-Day Kindergarten and restore paraprofessionals in kindergarten classrooms.
4. Improve reading instruction in the public schools.

Action steps related to these strategies incorporate a combination of promising practices that exist in New Britain with proposed new projects that have demonstrated success in other similar communities.

Conclusion

Detail in The Blueprint includes information on plan structure, cost estimates, and implementation partners. Next steps include the development of specific implementation plans, timeline, and roles and responsibilities for implementation.

The Blueprint has been developed not as a static document, but as a fluid plan that will evolve to meet the changing conditions of the New Britain community. Monitoring progress towards successful efforts in reaching the community's goals is inherent in this plan. The issues addressed are too large and complex to be addressed by a single entity. Therefore, it is important that this plan be supported by the wider community at large. Action steps towards the plan's success must be a collaborative effort between parents, community leaders, providers, and others who have a stake in the well-being of the New Britain community.

A Steering Committee will oversee the plan's implementation and will publish an annual report card detailing community progress towards the plan's goals however, on-going participation by a wide representation of community members will be necessary to ensure success.

INTRODUCTION

ABOUT THIS PLAN

What Is The Opportunity For New Britain?

In January 2008 New Britain, along with 23 other Connecticut communities, embarked on a community based planning project to address the needs of children ages birth to 8 and their families. This effort was funded jointly by a private public partnership between CT State Department of Education, the Early Childhood Cabinet and the William Caspar Graustein Memorial Fund. The framework of this effort is guided by the CT Early Childhood Cabinet report, "Ready by 5, Fine by 9" and subsequent work from which the following result statements come:

Connecticut Early Childhood Result Statements:

- All children are healthy and ready for school success at entry to kindergarten.
- All children are healthy and achieving school success by age 9
- All infants and toddlers achieve optimal health and development in safe, nurturing families and environments.

The opportunity for New Britain lies within the cooperative nature of this effort. No one organization can solve these problems alone. Working together as a community of organizations, institutions, and families and taking a larger systemic view of the needs and services, we can get more done. Engaging families as partners in this effort yields more relvant strategies and increased ownership on the part of the families.

Engaging families and service providers in a dialogue about their needs and personal perspectives allows the data to come alive. As a result, service providers get a broader view of what causes the issues. With that broader view in mind, and with service providers working together to address issues as a system, rather than as individuals, this plan will better use resources to meet the needs of the families of young children.

While new funding is currently not available for many of the larger cost initiatives, through this planning process we have analyzed and estimated the costs of those larger projects so that, when resources become available, we are ready to move forward.

What Are The Basic Requirements Of The Plan?

When we committed to developing this plan we also committed to:

- Involvement of community members, especially parents
- Use of concrete data as a starting point for decision making
- Use of Results Based Accountability (RBA), a model for planning focused on concrete results and measurements
- Strategies that include no- or low-cost options
- Use of all formal training provided by Graustein from CSSP – Center for the Study of Social Policy (those who have developed and implemented similar plans across the country); and Charter Oak Group (for RBA).

How Was The Community Involved?

The plan that follows is the culmination of 18 months of work that has involved parents and professionals who live and work in New Britain and who have a strong demonstrated interest and passion for a healthy, productive future for New Britain's children.

Building on the Discovery Collaborative, New Britain established a Leadership Work Group (LWG) to guide the process and make decisions about the contents of the community plan. Represented on the LWG are parents, Mayor's Office, New Britain Board of Education, Hospital of Central Connecticut, American Savings Foundation, Literacy Volunteers, New Britain Public Library, Human Resources Agency Inc, YWCA, Community Health Center, Family Resource Center, Discovery Collaborative, Early Childhood Council, Head Start, School Readiness Council.

The formal process began with The Community Kick Off session held March 25, 2008 at Vance School. Eighty-five members of the community attended including the Mayor, Superintendent of Schools, Common Council members, State Representatives and Senators, local clergy, health care providers, and many parents and children. After a brief presentation about this planning effort and its ultimate goal, participants formed groups and listed the needs of New Britain's families with young children. At a follow up session they formed interest area committees: Family Literacy, Early Care and Education, Health, and Family Support.

The committees were charged with the following responsibilities:

- Identify the relevant issues
- Gather data on relevant conditions in New Britain
- Research New Britain trends compared to state and national trends
- Get the stories behind the data
- Identify existing community resources
- Develop strategies to address the issues
- Identify partners to implement the strategies
- Estimate implementation costs, looking for opportunities to capitalize on existing funding by reallocating resources; and low cost/no cost options

New Britain is rich in diversity. The committee members sought input to this planning process through focus groups, surveys, and conversations with families and professionals who live and work in New Britain. Translators have helped gather input from families for whom English is not their primary language.

During the following 14 months, the members of various committees conducted focus groups to hear from parents and providers. Included in those focus groups were:

- Parents of young children enrolled in accredited child care programs
- Parents involved with the DCF system
- Teen mothers
- Spanish speaking parents
- Parents who work at local provider agencies
- Pediatricians
- Mothers who attend Family Resource Center programs
- Mothers of children with special needs

- School nurses

Why Are We Using Results Based Accountability?

Several years ago, the CT Legislature's Appropriations Committee became interested in using Results Based Accountability (RBA) to evaluate programs and make funding decisions. To pilot its use, they chose early childhood programs as the area of state government to use as the test case. RBA's value lies in starting with the desired result and ensuring that all strategies and action steps will lead, directly and indirectly, to achieving the result. It requires data driven decisions and measurements.

How Was Data Collected To Inform This Plan?

In order to ensure this plan responds to the most critical needs of New Britain's young children and their families we conducted a comprehensive community wide data collection process reviewing local, state, and national trends and research relevant to the success of young children. Focus areas of data were a community profile, health and wellness, early care and education, and academic success.

Specific sources of quantitative data for New Britain include, but are not limited to:

2000 Federal Census
State Department of Education
State Department of Public Health
State Department of Social Services
New Britain School District
Hospital of Central Connecticut
WIC
New Britain Head Start
School Readiness Council

In These Economic Times Is This Plan Doable?

Yes. The arrival of financial hard times while we were in the midst of planning made us highly attuned to the economic choices we need to make and to the realities of what is possible.

Even though many in the community recognize the needs of young children and their families, there are insufficient programs and services to meet the increasingly challenging needs. Throughout this planning process, service providers have worked together to identify the community needs, the existing services, and to discuss and develop ideas to address those problems in different ways and by combining existing resources.

To successfully implement this plan requires systemic approaches and thoughtful and candid decisions about how best to allocate resources in a way that heads us toward the result we want for New Britain's young children and their families.

Indicators of Child Well Being

- **The Trends**
- **The Stories Behind the Numbers, and**
- **Strategies to Turn The Curve**

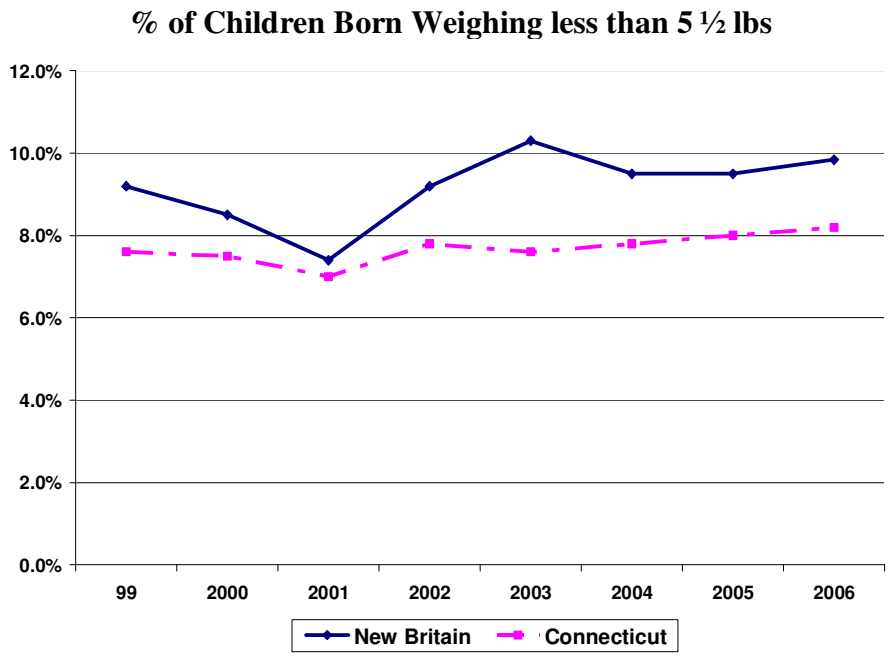
Desired Result: **All of New Britain's babies will be born at a healthy weight**

In Brief

During 2006:

- 9.8% or 107 babies were born weighing less than 5 ½ lbs.
- 22.9% of mothers got late or no prenatal care
- 37% of pregnant women did not receive adequate prenatal care
- 17.7% of babies were born to mothers under 20 years old
- 11.25% of babies on WIC were born weighing less than 5 ½ lbs

The Trend



Why it's important

Low birth weight is a condition from which most children fully recover. For middle class children with good health coverage, low birth weight has virtually no impact on the child's future academic performance. However, research shows that low birth weight babies raised in poor families are 79% less likely to graduate from high school by age 19 than their siblings born at healthy birth weight.[i] The combination of the health problems related to low birth weight and all of the issues that go along with poverty such as reduced access to healthcare specialists, poorer nutrition, higher stress, etc. result in a set of conditions that keep these children from reaching their full potential. The researcher's comparison of graduation rates of low birth weight children vs. their healthy weight brothers and sisters rules out many other possible explanations and means that low birth weight combined with poverty is a causal factor to poor academic performance.

What we know about the situation in New Britain

With the exception of 2001 New Britain has consistently had a higher rate of low weight births than the state average. The primary causes of low birth weight are multiple births (twins, triplets etc), premature births and inhibited fetal development. The primary risk factors for prematurity and constricted fetal development are smoking during pregnancy, poor nutrition, inadequate prenatal care, teen pregnancy and risky behaviors including the use of alcohol, and drugs.

Globally, low birth weight is most often caused by poor nutrition of the mother. In Connecticut, one of the richest states in an advanced industrial country, one would not expect this to be a serious problem. However, New Britain is the second most food insecure community in Connecticut with thousands relying on food pantries each year. The New Britain office of Bristol Hospital's Women Infants and Children Nutrition Program (WIC) served 83% (907 of the 1088) babies born in New Britain.[ii] The WIC food package has just been changed to improve the nutritional value of the foods mothers and babies are able to get with their checks.

For those not suffering from malnutrition, cigarette smoking during pregnancy is the single most important known cause of low birthweight. It nearly doubles the likelihood of delivering a low birthweight baby.[iii] Nationally the percentage of mothers who smoke during pregnancy has declined over the past decade. In 2006 5.9% of mothers in CT reported smoking during pregnancy down from 6.3% the year before. In New Britain, 10.9% of mothers reported smoking during pregnancy in 2006 up from 9.8% the year before. Reducing the number of women who start smoking as teenagers is critical as are efforts to help women quit before they get pregnant. Nicotine is highly addictive and even with intensive behavioral interventions only one in five women successfully controls the habit during pregnancy.[iv] Nicotine replacement therapies (gum & the patch) can help people to quit, but are not approved for pregnant women. The oral smoking cessation medication that is approved for pregnant women is not currently covered by HUSKY (Connecticut's public healthcare program for low income children and their parents).

Beyond tobacco, there are of course other "harder" drugs that have negative impacts on the baby in utero. The Hospital's prenatal clinic staff has reported that IV drug using patients have discovered that unlike the hospital clinic, the private OBGYN practices don't routinely conduct drug tests on the patients. Since a positive drug test can result in DCF removing the baby, these IV drug users now intentionally avoid the hospital clinic so that they are not tested.

The lack of appropriate prenatal care increases the likelihood of negative birth outcomes including prematurity and low birth weight. Late and inadequate prenatal care is a major issue in New Britain. In 2006, the last year for which data has been published, 37% of the mothers who gave birth had care considered inadequate.[v] The vast majority of prenatal care in New Britain is delivered through private medical practices. OBGYN's as medical specialists are frequently reluctant to take on new patients covered by public plans like HUSKY due to lower payment rates than private insurance companies. Indeed one of the city's larger practices stopped accepting new HUSKY patients for several months staring in the spring of 2009 and has only just started accepting HUSKY patients covered by one of the several Medicaid managed care plans. New Britain now has the second highest rate of babies born to low-income families in the state; 63.9% of births to New Britain families are paid for by public sources (HUSKY or Medicaid). This rate is only exceeded by Hartford.

The fact that almost 23% of the women who gave birth in 2006 received late or no prenatal care indicates that women are having trouble accessing care or are unaware of its importance. Nationally 18 to 35 year olds are one of the largest groups of uninsured people. In Connecticut when an uninsured woman becomes pregnant she also becomes eligible for HUSKY, which will cover her prenatal care (assuming she is a citizen). However, many women don't know this and the process of getting approved for HUSKY is not immediate. The combination of these factors frequently delays the start of prenatal care, often beyond the first trimester.

Of particular concern is New Britain's large immigrant population, much of which is not eligible for prenatal care under HUSKY. While the babies born here are by birth US citizens, and their deliveries are covered by HUSKY or Medicare, their prenatal care is not covered if their mother is undocumented or even if she has the proper documents but has been in the country for less than 5 years.[vi] This means that HUSKY will pay for an extremely expensive stay in the neonatal intensive care unit, but won't pay for the relatively inexpensive prenatal care that could prevent the need for intensive care.

Another area where state policy governing HUSKY coverage is problematic is in the area of oral health. Periodontal disease is a known cause of infant mortality as the infections in the mother's mouth can be transmitted through her blood to the baby. In its less extreme form, a mother's poor oral health can contribute to premature birth which is generally associated with low birth weight. Under HUSKY, parents have dental coverage in theory, but not generally in practice. HUSKY reimbursement rates for oral health have long been a problem. Only last year a long running lawsuit brought by dentists finally resulted in a settlement that raised reimbursement rates for children's dental care. However, adult dental care reimbursement rates remain so low that dentists lose money on every adult HUSKY patient they see.

Women who give birth as teenagers have a higher incidence of low birth weight babies. Generally the younger the mother, the higher the likelihood of a low birth weight delivery. New Britain has a very high rate of teen pregnancy. With 17.7 % of births being to teen mothers, New Britain's rate of teen pregnancy is two and a half times that of the rest of the state. High teen birth rates are generally associated with poverty and are more prevalent in African American and Latina populations, but other communities in Connecticut with similar demographics have lower teen pregnancy rates. Of particular note is that showed New Britain has the highest rate of teen births to Hispanics in the state. In 2006 more than one quarter of births to Latina mothers were to women under 20[vii].

Strategies to Turn the Curve on Low Birth Weight

Strategy 1 – Reduce the incidence of teen smoking

Action Steps

- **Develop anti smoking campaigns in the high school and middle schools** explore creative ways to engage teens in leading the anti smoking campaign using social media.
  Possible partners: school district, CCSU students, middle school after school programs, high school students.

- **Step up enforcement of law against sale of tobacco to minors**
  Possible partners: police department, police explorers

- **Help teens quit smoking if they have started** Replicate the current evidence based tobacco cessation program at NBHS's clinic in other school based clinics and private doctor's offices.

Strategy 2 - Improve access to prenatal care for women without private health insurance

Action Steps

- **Increase the capacity of New Britain's health care system to provide timely, effective prenatal care** with a model of comprehensive services appropriate to the at-risk, target population of women not currently receiving adequate prenatal care. These services should including medical /prenatal, dental, and behavioral health services.

  Possible partners: The Hospital of Central Connecticut's prenatal clinic, private OBGYN practices and the Community Health Center.

- **Expand outreach to women as they learn that they are pregnant and develop a system of intensive case management for high risk patients.**
  Poor young women who do not yet have a child and are therefore not yet covered by HUSKY are one of the largest groups of uninsured people in CT. Lacking insurance, most of these women do not regularly see a doctor. Once pregnant, this group of patients is at particular risk for starting their prenatal care late because they must both get into HUSKY and find an OBGYN practice that will take them. Finding these women and connecting them to health coverage, medical care and other supports like WIC was once the work of the Healthy Start program. Through their good work New Britain brought its incidence of low birth weight down to the state average in 2001. The following year, as a budget reduction measure, the Healthy Start program was cut and the New Britain and Hartford service areas combined under a grant awarded to the Hartford City Health Department. The impact of this decision has been that Healthy Start has essentially ceased to function in New Britain. Healthy Start also provided case management to make sure women got to their appointments and followed their doctors' recommendations. These same approaches need to be reinstated, whether through restoration of Healthy Start in New Britain, expansion of the VNA's care caller program or the new approach of provider coordinated care (PCCM)

  Potential outreach partners: Pharmacies, medical labs, Laundromats, hairdressers, nail salons, churches, DSS, the Community Health Center.

  Potential case management Partners: The Health Department, VNA, The Hospital of Central CT, CHC, HUSKY Managed Care Organizations (MCO's)

Strategy 3 - Improve the delivery of prenatal care

Action Steps

- **Ensure that non English speaking women receive their prenatal care in the language of their preference whether by interpreter, translator or telephonic translation service.** Almost 60% of the children in New Britain's schools live in homes where English is not the primary language. This means that a majority of women having babies in New Britain are not native English speakers and come from different cultures. Medical providers who can overcome the language barriers and understand cultural differences are able to provide care in a way that will result in better compliance with physician recommendations and result in better birth outcomes.

  Possible Partners: OBGYN practices, Hospital of Central Connecticut, the Spanish Speaking Center, Family Resource Centers, Connecticut Health Foundation

- **Institute a system for identifying high risk pregnancies** and a protocol to provide appropriate care including case management to improve outcomes. There are a number of risk factors that impact pregnancy that include, but are not limited to: substance abuse, maternal depression, a history of miscarriages and premature births. New Britain could benefit from a common standard of care offered in all of the OBGYN practices designed to address the applicable risk factors.

  Potential partners: the Hospital of Central Connecticut, OBGYN practices, Mental health and substance abuse counseling/treatment programs, VNA and WIC.

- **Expand the use of best practices such as small group prenatal care** that have been shown to reduce the incidence of low birth weight. The Community Health Center in Meriden has been its prenatal patients the option of a group-care model known as Centering Pregnancy for over two years. In this model, groups of about eight mothers with the same estimated delivery date meet with an obstetrician or a midwife for 10 sessions of approximately two hours each, which take place from 16 to 40 weeks gestation. The group process stresses education, self-care, and peer support. Self-empowerment activities include keeping one's own health records, active participation in collecting data (e.g., blood pressure, fetal heart rate), and in-depth discussions within the group about participant concerns. Each group provides continuity of care from a single provider and a "one-stop shop" for all services required by its members.[viii] National research on this approach has shown a reduction in preterm births and the incidence of low birth weight.[ix] CHC in Meriden has also noted better outcomes for breast feeding.

  Potential partners: The Hospital of Central Connecticut Clinic and other OBGYN practices.

- **Expand efforts to encourage women to stop smoking during pregnancy.** Prenatal care is an opportunity for doctors to connect with their patients at a time when they may be more motivated to quit smoking. While there are medications to assist in smoking cessation that can be used during pregnancy, HUSKY does not currently cover them. The Community Health Center currently uses an evidence based smoking cessation program with its regular patients that should be replicated in prenatal care settings. Key to the success of the effort will be development of funds to make the medications available at no cost.

Possible Partners: Community Health Center, Hospital of Central Connecticut, WIC, OBGYN practices, Quitline –funded by DPH

- **Improve oral health of pregnant women**
  The VNA has purchased a mobile dental chair with funding from the New Britain Health Department and will provide dental cleanings at their free well child visits. This creates a resource that could also be used to provide care for pregnant women. Through the New Britain Oral Health Collaborative the Tunxis Community College hygienist training program learned of this resource and created educational materials and a simple screening tool for use in OBGYN offices so that pregnant women without a dentist can be referred to get their teeth cleaned for free at the VNA clinic. In cases where hygiene visit indicates more serious problems, the Oral Health Collaborative can advocate for additional care.

  Possible Partners: Health Department, VNA, Hospital prenatal clinic, OBGYN practices, CHC, Tunxis Community College Dental Hygienist program.

How will we measure our progress towards this result?
Initially we can count changes in the amount of services provided, but to determine if the additional services are making a difference we will need birth weight data. The Department of Public Health releases detailed statistical information about births each year. However, this data is always 2 to 3 years old. Fortunately WIC, which serves 83% of the pregnant woman and virtually all the poor women, is much timelier than DPH. The state WIC office has already provided data two years more current than the information published by DPH.

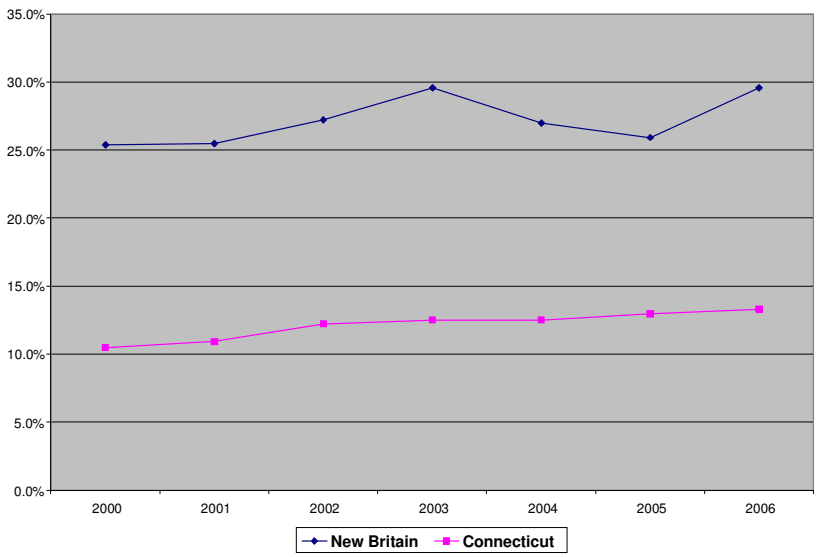
Desired Result: **All of New Britain's Mothers will Attain a High School Diploma**

In Brief

- New Britain's rate of births to women without a high school degree is twice the state average
- New Britain's teen pregnancy rate is two and a half times the state average
- 24% of Adult Education students have children under age 6
- 26% of Adults in New Britain function at the lowest levels of literacy

The Trend

% of Mothers Without a High School Diploma



Why this is Important

Research shows that the education level of the mother is one of the strongest predictors of a child's academic performance. The higher the mother's education level the more likely the child will succeed in school. Conversely, children of low literate parents are twice as likely to become low literate adults.[i]

What we know about the situation in New Britain

In 2006, 322 babies out of 1088 were born to New Britain mothers who had not finished high school. That rate of 29.6% is twice the state average. Of the total births in New Britain, 68 are to high school aged girls. Approximately 50 of them were attending classes at New Britain High School while they were pregnant. The rest were either enrolled elsewhere or had already dropped out prior to their pregnancy. As part of the data gathering process for this report, a focus group with teen mothers was conducted. Most wanted to finish high school but could not find child care during school hours. For any mother of an infant, finding affordable child care so that she can complete her schooling is an enormous problem. New Britain has just 7 licensed childcare slots per 100 infants and toddlers. Even if care was available the average cost of $185 to $220 per week is far too expensive for teen mothers. This problem has been complicated by the closure of the Care4Kids state childcare subsidy to new participants.

The phrase "Births to mothers without a high school diploma" might be associated only with high school students who become pregnant. In New Britain, it is certainly a problem as the

incidence of births to teen moms is 17.7% of total births or 2.5 times the state average. However, births to younger teens who are (or should be) in school is actually a relatively small part of a larger problem, 75% of the births to mothers without a high school diploma, are to women over age 19.

In New Britain, two major factors contribute to this problem: an elevated school drop-out rate and a large adult immigrant population without a high school education. Many new immigrants fled war or grinding poverty in places with relatively few schools and some immigrate from cultures that don't value education for girls. Data on births to foreign born mothers is hard to come by, but the school district reports that 58.9% of its students live in homes where English is not the primary language. Efforts by these families to learn English are hampered by a 200-person waiting list for tutors at Literacy Volunteers.

Students drop out of high school for many reasons. In "The Silent Epidemic, Perspectives of High School Dropouts" the Gates Foundation reports that their survey and focus group data suggest that about a third of high school students who drop out do so because they are failing. The other two thirds thought they could have graduated had they tried. Nearly half (47%) said that a major reason for dropping out was that classes were not interesting. About a third of high school drop outs said they had to get a job to earn money and a quarter said they had to care for a family member. The top two things that drop outs thought could have helped them complete their education were better teaching to make classes interesting and opportunities for real world learning (internships, service learning, etc.) to make class room learning more relevant[x]

New Britain reports an official drop out rate of 25.8%, four times the state average. [ii] While New Britain's drop outs have not been surveyed as to the reason they left school, it is reasonable to guess that the percentage who drop out due to school failure could be higher than the percentage who reported doing so in the Gates Foundation report. In New Britain, more than 40% of eighth graders read at the below basic level, meaning they are significantly below grade expectations. For those who drop out because they are failing, the problem did not begin in high school. Children who start school unprepared, and who never learn to read well, will continue to fall further behind. Many of these students conclude that they can't be successful in high school and give up. Drop out prevention programs and alternative schools can help, but it is harder to help students after 10 years of falling behind than it is to address or even prevent problems when the student is younger. This plan does just that with a strong focus on the importance of quality early childhood education both at home and in preschool settings.

What's Working

A collaboration between the Jefferson Family Resource Center and Literacy Volunteers of Central CT enabled 26 Arabic speaking mothers to take a "Survival English Class" in the spring of 2009. Several of these mothers had not been able to go beyond 3rd grade as children in Yemen. Most of these women are continuing with Literacy Volunteers to improve their English

The Pathways Sendaros program lives by the motto "Diplomas before Diapers." Pathways is an intensive program that enrolls students the summer before 6th grade and provides summer and after school activities designed to support their academics and keep them from getting pregnant through high school. Pathways serves 50 at risk youth from the Arch Street neighborhood. Among its many success stories are a growing number of first in the family high school and college graduates.

Strategies to Turn the Curve on Births to Women Without a High School Diploma

Strategy 1 – Reduce the high school dropout rate.

Action Steps

- **Identify students at risk of dropping out** in elementary and middle school and provide extra support to keep them in school

- **Use alternative methods** like individualized computer instruction to enable students to make up missed work or retake classes they failed

- **Provide professional development to help high school teachers** move away from an over reliance on lecture style teaching to more engaging methods

- **Develop paid internships and service learning** so that students can connect real world experiences with their class room instruction

- **Engage Parents** in supporting their children's education**.**

Possible Partners: The Consolidated School District, the New Britain Youth Network, local businesses and CCSU's education department

Strategy 2 - Support mothers who haven't finished high school to complete their diploma before having another child.

Action Steps

- **Convene a working group to explore the following approaches to providing support for mothers who have not finished their high school diploma including:**

    - **On site child care at the high school** to encourage teen mothers to return to school and graduate.
    - **A cohort support group approach to working with a group of teen moms as they attempt to finish their schooling**. Cohort based support groups have shown success with other groups of nontraditional students.
    - **Bringing Even Start to New Britain.** Even Start is a federally funded family literacy program that integrates early childhood education, adult literacy (adult basic and secondary-level education and instruction for English language learners), parenting education, and interactive parent and child literacy activities for low-income families particularly teen parents..
    - **On site child care for Adult Education students**.
    - **Bringing Early Head Start to New Britain**. This will require securing additional funds to supplement the Early Head Start grant, which does not cover the full costs of operating the program. High quality infant toddler care with the associated parenting and family support services required by the Early Head Start program are estimated to cost $16,000 to 18,000 per child in Connecticut. The Early Head Start grant would provide approximately $10,000 per child.

Possible partners: the school district, Adult Education, HRA, The Children's Trust Fund, Nurturing Families, the FRC's, the Even Start network.

Strategy 3 - Prevent teen pregnancy so more women finish high school before having a child

Action Steps

- **Convene a working group to:**
    - **Target prevention activities at the younger sisters of teens who become pregnant.** National research indicates that younger sisters are at extremely high risk to follow their sisters into teen pregnancy. Programs that can expose teens to a broader range of life possibilities and help them see that more options are available to them both personally and professionally can help them to make better life decisions.
    - **Identify or develop culturally appropriate strategies to address the high rate of teen pregnancy among Latinas** (nationally half of all Latinas become pregnant before age 20).[iii] In New Britain more than half of the babies born each year are Hispanic and in 2006 a quarter of births to Hispanics were to teenagers.

- **Allow school based health centers to provide family planning services.** The Board of Education has a long standing policy baring conversations about family planning. This means that clinic staff is not allowed to speak frankly about the various options to prevent teen pregnancy for students who are or may become sexually active.

Possible Partners**:** the school district social work staff, the youth network, the Community Health Center, the Health Department Sexually Transmitted Disease clinic

Strategy 4 - Expand efforts to help immigrant women learn English and finish their education.

Action Steps

- **Recruit additional literacy volunteers** to work with parents learning English as a second language.
- **Support efforts to expand family literacy efforts** that enable parents to learn with their children.

Potential Partners: Literacy Volunteers, Family Resource Centers, Adult Education, the school district.

How Will We Measure Progress

Birth data which includes figures on births to mothers without a high school diploma comes from the Department of Public Health's registry report which is compiled from birth certificates. Typically there is a two to three year delay in the release of data. Therefore various other measures will have to be used in the mean time. These include the number of mothers who graduate from New Britain high school. Number of parents with children under 6 enrolled in the Adult Education program. The Adult Education retention rate for parents with children under six and the graduation rate for those parents.

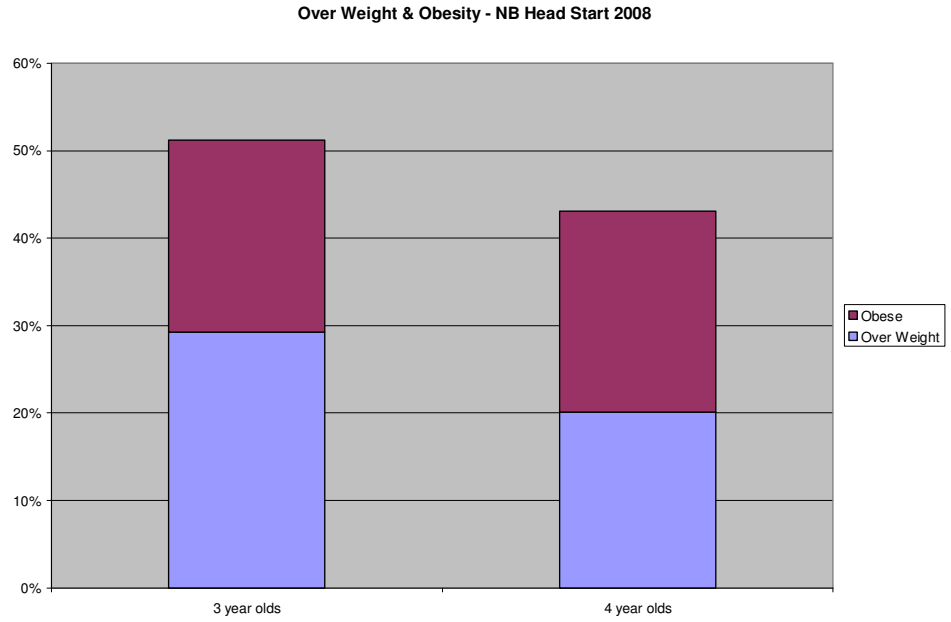
Desired Result: **All of New Britain's preschoolers will be in the healthy weight range**

In Brief

- 19% of the four year olds receiving WIC are obese.
- 23% of the four year olds in Head Start are obese
- 28% of next year's four year old class at Head Start are obese
- 42% of the Community Health Centers patients ages 3-11 are overweight
- 51% of the 3 year olds enrolled in Head Start are overweight or obese.

The Trend

% of Obese & Overweight Head Start 3 and 4 year olds 2008-9



Why it's important

Childhood obesity is often accompanied by asthma, and leads to chronic health problems like high blood pressure, high cholesterol and painful joint conditions; as well as a soaring incidence of juvenile diabetes, all of which can result in lost time from school. Untreated, childhood obesity generally leads to obesity in adulthood and an array of weight related medical issues including hypertension, and heart failure. The costs of untreated childhood obesity in terms of additional medical expense and lowered quality of life are enormous.

What we know about the situation in New Britain

The graph above shows the overweight and obesity statistics for the preschoolers enrolled in the spring of 2008 at the Head Start program, which serves the city's poorest children. This data is presented as a proxy until the proposed annual collection of height and weight data in all the preschools enables us to get a fuller picture of the problem.

On a national level childhood obesity rates have tripled since 1975. The problem is most pronounced among poor children. The primary causes of childhood obesity are higher caloric intake and a more sedentary life style.

The New Britain Asthma Initiative has noted that many of its patients are also obese. Physical Education teachers in the schools report that many of their students sit out physical activities due to a medical condition, usually asthma.

New Britain is ranked as the second most food insecure community in Connecticut and 74% of children receive free or reduced lunch at school. Low-income parents often feed their children foods that are inexpensive and easy to prepare such as macaroni and cheese, fast food, juices high in sugar. Because these foods are high in simple carbohydrates (white bread, potatoes, white rice, pasta) they produce the sensation of feeling "full," but are not nutritionally healthy. Healthy foods, such as fresh fruit and vegetables, are more expensive and less available for these families.

The USDA food nutrition requirements that underlie the school lunch program and the childcare food program were premised on the notion of getting children enough calories. Relatively low funding for these nutrition programs leave schools and childcare programs also unable to afford fresh fruit and vegetables resulting in menus heavier in starches and other cheap calories. So again children are receiving high calorie, lower nutritional value foods from programs that should be helping them eat healthier.

When children develop obesity at a very young age, the issue is a family problem rather than an individual child issue. Young children don't buy their own food. They eat what is given to them by the adults who care for them. Quite frequently the parents of obese children are obese themselves. Mothers in focus groups reported that they wish they knew how to cook more healthy foods for their children.

Many of New Britain's poor families are immigrants from places where hunger is a real problem. This leads to the belief that a chubby child is a healthy one. Given New Britain's large immigrant population, understanding the cultural aspects of this problem is essential to developing culturally appropriate approaches to address it.

More than half of Connecticut's adults are now overweight or obese.[xi] This number probably under represents the problem in New Britain since the poor tend to be heavier. As this number grows, obesity becomes more socially acceptable, and people's sense of what is normal changes.

Many of the city's poor children live in multifamily rental housing lacking an outdoor play area. Parents frequently report concerns about their children's safety as a reason they don't let them play outside. American children now spend more time watching television than any other activity besides sleeping.

Strategies to Turn the Curve on Obesity Among Very Young Children

Strategy 1 - Expand Efforts to Prevent Childhood Obesity

Action Steps

- **Include education about the risks of childhood obesity in prenatal care particularly among higher risk mothers.** Develop materials and curriculum on the problem of

childhood obesity and ways to prevent it for use in prenatal education at WIC, the High School teen mothers program, VNA's Care Callers and OBGYN practices.

- **Promote breast feeding.** Babies who are breast fed are less likely to become obese. This needs to become a stronger piece of prenatal education so that more mothers try to breast feed. Overweight mothers are at higher risk of having children who become obese therefore special efforts need to be made to encourage them to breast feed. Breast feeding rates are lowest among teenagers and African American women, which indicates the need to focus on these populations in New Britain.

Possible Partners: OGYN practices, the Hospital, WIC, La Leche League

- **Incorporate nutrition and healthy meal preparation into parenting workshops.** Parents told us they wanted to learn how to prepare healthier meals.

Possible partners: Family Resource Centers, CHC family Wellness Center, HRA Head Start, School Readiness Preschools, CSDNB, nutritionists and the New Britain Food Security Collaborative

- **Promote the establishment of community gardens and additional farmer's markets to increase access to fresh fruits and vegetables.** Unlike many communities, New Britain has no community gardens. Community gardens are inexpensive ways for families who live in rental housing to get access to land on which to grow food. Farmers markets

Partners: City community development office, land owners, churches & schools, UConn Extension Service and master gardeners from Urban Oaks Organic farm.

- **Promote the development of Safe Routes to school to encourage more children to walk.** Most of New Britain's children ride a bus to school and therefore lose an opportunity to get some exercise. School bussing is also an enormous expense to the school district. In a cost cutting move, the district adjusted the schedule of summer school to four long days rather than 5 normal length days. By eliminating just 4 days of school busing the district saved $56,000 (almost the cost of a teacher) Some communities use the idea of the "walking school bus" with a parent at each end as they pick up additional children on the walk to school.

Possible Partners: Parents, the Police Department, City Public Works Department, area cycling enthusiasts.

Strategy 2 - Identify childhood obesity early and begin interventions right away.
It is clear in the face of a growing epidemic of childhood obesity, that the status quo is not addressing the problem. The two year old well child visit is the first time that pediatricians can calculate Body Mass Index (BMI). The current, "I'm concerned about your child's weight" approach in doctor's offices clearly is not enough. The vast majority of children who are obese at two or three years of age don't grow out of it, they get bigger.

Action Steps

- **Increase the amount of exercise children get in preschool** Work with area preschool providers to expand opportunities for children to run around and get more exercise.

Partners: School Readiness Council and area preschool providers

- **Continue work with the Childhood Obesity committee of the Head Start Health Advisory Group to:**

    - **Develop an obesity protocol for use by area pediatricians and the WIC staff to refer families with obese children to nutritional counseling and exercise programs.** This should start as soon as a BMI calculation indicates reason for concern. One possible referral is to the VNA for home based counseling.

    - **Develop culturally appropriate educational materials for parents including a report home from the preschools regarding the BMI calculations done at the annual height and weight measurements**. Conversations with clinicians indicate that many parents misinterpret high BMI percentile scores as something good. The systematic calculation of BMI for the 80% of the city's 4 year olds enrolled in preschool creates a teaching moment for parents. Part of this strategy is to create a set of one page sheet of recommendations for parents based on the child's BMI score with suggestions and resources to be sent home with children after the annual height and weight measurements.

- **Create programs to treat obesity as a family problem.**
  65% of adults in the United States are now over weight or obese and 21% of adults in Connecticut are obese.[xii] In most cases, when children are obese by age three or four, they have parents or care givers who are also obese. This family history of obesity requires a family approach to improving nutrition and increasing physical activity. Parents are unlikely to take their children's obesity seriously until they are willing to confront their own problem. To date efforts in New Britain to engage parents to participate in health and nutrition programs have had unimpressive results.

  The first step in developing more effective strategies would be to examine promising models from around the country. The next step would be to conduct focus groups with Head Start parents who have been referred to childhood obesity interventions but have not participated. Then, with the information from those focus groups as well as the research on models from around the country, attempt to design better interventions. The final step would be to test and evaluate several promising approaches.

Possible Partners: Head Start, Physicians and Nutritionists, Hospital, CHC, area preschools, FRC's, and UCONN EFNEP program (for an after school youth programs with a cooking component)

- **Advocate for change in state policy so that HUSKY will pay for weight loss programs.** Given the high costs of obesity related illnesses, effective early treatment to prevent these future expenditures should be a priority.

- **Advocate for changes to the USDA guidelines** and more funding for federal nutrition programs so that school lunches can include more fresh fruits and vegetables**.**

Possible Partners: The Connecticut chapter of the American Academy of Pediatrics, individual doctors, parents, VNA, CT Association for Human Services & the CT Early Childhood Alliance

Data Development Agenda

Systematically track the rate of childhood obesity through the calculation of BMI in the preschools during an annual height and weight measurement. The selection of obesity as an indicator of child health is based on both the disturbing national trends as well as an alarming growth in the percentage of overweight and obese children in New Britain's Head Start Program. However, the full picture of the problem is not clear due to limited data collection. In order to bring the picture into greater focus, the school readiness preschools as well as Head Start, will weigh, measure and calculate Body Mass Index (BMI) for every 3 and 4 year old enrolled in their programs each October beginning in 2009.

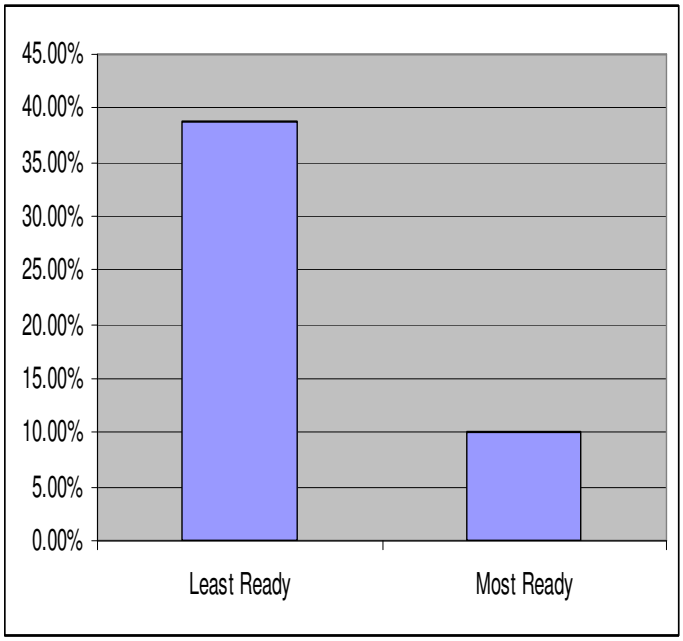
Partners: New Britain School Readiness Council, area preschool programs.

Desired Result: **All of New Britain's Children Will be Ready For Kindergarten**

In Brief

- Only 10% of children starting kindergarten in 2008 were rated fully ready by their teachers.
- 39% of children starting kindergarten in 2008 were perceived by their teachers as substantially not ready when they arrived at Kindergarten:
- 34% had insufficient language skills
- 40% had insufficient literacy skills
- 28% had insufficient social/emotional skills
- 21% of children arrive at kindergarten with no preschool experience and there is space for only half of the 3 year olds to attend.
- 102 preschool children were referred for evaluation of developmental delays in 2007-2008.
- 300 children are on the waiting list for infant/toddler care.

The Trend



Why it's Important:

Children who start behind are far more likely to remain behind. The achievement gap is largely a preparation gap. Children entering kindergarten with poor literacy, behavioral, and social skills are less likely to achieve grade level expectations than other children regardless of socio-economic status. If a child has good literacy skills in a language other than English, it has been demonstrated that many of these skills are transferable. He or she will learn English more successfully and achieve grade level expectations sooner than a child without solid literacy skills in his or her native language.

National research indicates that children who arrive at kindergarten without the basic skills needed for kindergarten success are far less likely to graduate high school.[xiii] Furthermore, children participating in high quality early childhood programs are more likely to arrive at kindergarten ready to learn.[xiv]

High quality pre-school programs are particularly important to the healthy growth of poor children. Poor children arrive at kindergarten with a significantly smaller vocabulary than their more affluent peers, which could be positively influenced by participation in high quality early education.[xv] Understanding this issue is critical to improving educational outcomes for children in New Britain. Children entering school who are not ready to learn require more extensive

remediation, are less likely to "catch up" to more prepared peers, and are more likely to drop out of school before high school graduation.[xvi]

Access to care and education that is of high quality benefits young children, particularly young children from low income families. "Children who attended higher quality child care centers performed better on measures of math, language, and social skills. High quality child care continues to positively predict children's performance well into their school careers."[xvii] But "access to poor or even mediocre care and early education has a detrimental effect on the healthy development of young children. Children who are traditionally 'at risk' of doing poorly in school are more sensitive to the effects of poor quality care."[xviii]

To improve educational outcomes for young children two aspects of program dynamics must be addressed. "The quality of child care **classroom practices** was related to children's cognitive development while the closeness of the child care **teacher-child relationship** influenced children's social development through the early years."[xix] Teacher education levels impact the quality of a child's care and education.[xx] Children educated in classrooms with better educated and trained teachers will have better educational outcomes than those in classrooms with less educated staff.

It is particularly important to identify and introduce children with special needs to quality early education when they are very young. "Research shows that providing supports to children with disabilities and other special needs in their early years reduces their need for special education and other supports later in life."[xxi] "A large proportion of children with disabilities and other special needs are in low-income families."[xxii] Although support for the early identification of children with special needs is available, many families do not access them. If the first opportunity for identification is the kindergarten setting, the child lost the benefit of early services and supports and may be relegated to years of special education services.

Parent involvement in a child's education and development is the greatest predictor of school success for disadvantaged children.[xxiii] Early Education does not begin in preschool, but at birth. Parents are children's first teachers and must be partners in the education of their young children. Parents who read to children at a very young age, have conversations with their children to build vocabulary, and who provide structure in the lives of children from the very beginning are setting the stage for children to learn.

There is no time to waste. The future of New Britain's children is critical to our community's success. Parents, professionals, New Britain leadership, and the public at large must rally to complete the steps necessary so young children in New Britain thrive.

What we know about the situation in New Britain

Last fall kindergarten teachers rated their students on a scale of one to three in six skill areas. New Britain's teachers noted that more than a third of their students were only just beginning to display the skills expected of kindergartners. At the other extreme, 10% of New Britain's kindergarteners were able to consistently use the skills without much direction from the teacher.[xxiv]

The profile of young children in New Britain indicates they are "at risk" from a very young age. A high percentage of New Britain's young children (26%) are growing up in poverty, more than

twice the state average.[xxv] More than 29% are born to mothers without a high school education.[xxvi] New Britain exceeds the state average for premature and low birth weight babies, which also has implications for a child's success in school.

According to the 2007-08 Strategic School Profile, 14% of New Britain children, pre-k to grade 12 (over 1400 students) are receiving special education services. However, children with special needs still arrive at preschool without previous identification and participation in Birth to 3, the state's initiative to support the development of young children with special needs. In 2007-08, The Consolidated School District reported that 102 children entering local pre-school programs were identified and referred to the school system for special education services without prior referral or experience in Birth to 3. The opportunity to serve these children during the earliest stages of development had been lost. The high percentage of children in New Britain with special needs dictates that finding and identifying children at the earliest stage possible is critical to their overall success.

Although the situation for preschool children has improved dramatically over the past ten years since the introduction of state funded school readiness programs and the expansion of Head Start, preschool is not available to every New Britain child whose family wants it. Seventy nine percent of children in the city have some preschool experience: only 50% have two years which is lower than the percentage of children from more affluent surrounding communities. Three hundred and fifty New Britain children, ages three and four, cannot attend because of the limited availability of preschool openings in the city.[xxvii]

The shortage of licensed programs is acutely reflected in the numbers of early education programs for infants and toddlers. Currently in New Britain, there is only enough care for 7 out of every 100 infants and toddlers.[xxviii] Competition for these openings is fierce; more than 300 children under age three are on waiting lists for slots at the city's accredited centers.[xxix] Many children will be forced to wait until preschool before entering early education programs.

New Britain kindergarten teachers working with students perceive the impact of the shortage of high quality education and support for young children.[xxx] The annual Kindergarten Inventory completed in the fall, indicates that teachers believe more New Britain children entering kindergarten are performing at the emergent skill level than the state average.[xxxi] Children performing at the emergent level require a greater degree of additional instructional support. Children perform the poorest in language and literacy skills. Many local children entering school and performing behind their peers are not able to advance. Subsequently New Britain's third grade Connecticut Mastery Test scores indicate only 16% of 3rd grade students are reading at the state's goal level which has significant implications for future school success.[xxxii] A greater emphasis is needed on language and literacy development for young children, both in preschools and at home.

Personal/Social skills scores coupled with anecdotal information from local teachers, indicate this is also an area of concern. One out of every four of New Britain's kindergarten children are functioning at the emergent level for Personal/Social skills. A child who requires extensive remedial support in this area may negatively impact the learning of all of the children in the classroom if his/her behavior is disruptive to classroom function. The social emotional development of young children must be addressed before they reach kindergarten so that all children can learn effectively in the kindergarten environment.

Given the percentage of children attending New Britain's Head Start and School Readiness Programs, targeting these programs for instructional improvement will positively impact a large percentage of New Britain's young children.

What's Working:

- Preschool capacity has increased by 50% since 1997 with the introduction of School Readiness grants and the expansion of Head Start.

- Currently 79% of children arrive at kindergarten with at least one year of preschool experience.

- The number of New Britain Early Childhood Programs that have achieved national accreditation has increased from 1 in 1997 to 10 programs currently, including Head Start, School Readiness, and Board of Education programs.

- Tuition support from the Community Foundation of Greater New Britain and American Savings Foundation is available for preschool teachers to advance their education in Early Childhood.

- Tunxis Community College makes available extra seats in classes at no cost to preschool teachers as part of the Community Foundation's Early Childhood Professional Educators' Consortium.

- Locally, Dr. Robert Dudley, Pediatrician associated with The Community Health Center, reported a 30% increase in referrals to Birth To Three when he introduced PEDS ("Parents' Evaluation of Developmental Status") to parents of his patients. PEDS is a tool that requires little training, and a small expenditure for materials.

- The Connecticut Birth to Three Initiative provides additional support for children under age 3, and their families.

- The Family Resource Centers in New Britain are instrumental in linking children's education with that of adults; provide parent skill training, and have been an important connection to immigrant populations in the city.

<u>Strategies to Turn the Curve on Kindergarten Readiness</u>

Strategy 1A - Improve preschool teaching skills in the domains of language development, early literacy, and social emotional development.

A critical mass of New Britain's preschool children (59%) are educated in state and federally subsidized programs.[xxxiii] Therefore targeting these programs, with the support and assistance of the New Britain's School Readiness Council will impact large numbers of local children.

Local School Readiness providers utilize the same curriculum, <u>Creative Curriculum</u> (Diane Trister Dodge and Laura J. Colker, Teaching Strategies, Washington DC, 1996) selected by New

Britain's School Readiness Council to achieve their educational goals. The Creative Curriculum, provides teacher supports that align with the strategies endorsed by this plan. These include: literacy training and coaching training to increase the effective use of Creative Curriculum in the preschool classroom.

This strategy requires New Britain's School Readiness Council to plan and coordinate training in both literacy and coaching for School Readiness and Head Start staff. Requirements for program participation and monitoring associated with this training must also be developed. Then assessment of the success of training and coaching will be completed by the School Readiness Liaison or a consultant hired by the council. Implementation of this strategy will be supported by funds from the Connecticut State Department of Education Quality Enhancement funds associated with School Readiness program funding. Additional support may be available from The Community Foundation of Greater New Britain whose focus is Early Childhood Education and which supports the regional Early Childhood Professional Educators' Consortium.

In addition to initially training preschool staff in the use of the curriculum, and providing coaching to help staff implement it in their classrooms, it is also essential that the management of the preschools have systems to assure fidelity to the curriculum. The Creative Curriculum Implementation Checklist is a tool that allows administrators to observe classrooms to determine whether The Creative Curriculum is being implemented as intended and develop strategies for classroom improvement if necessary.

Although The Creative Curriculum includes aspects of social emotional development, this plan calls for more intensive implementation of curriculum designed specifically to support a child's social and emotional development. The School Readiness Council has adopted Second Step (Committee for Children) to teach skills that promote the healthy social and emotional development of young children. The Council will roll out implementation of this project by supporting the purchase of the curriculum for all school readiness classrooms using Quality Enhancement funds and coordinating teacher training if needed.

Action Steps:

- **Train School Readiness Provider representatives in the Creative Curriculum coaching model.** The School Readiness Council will sponsor joint training for all the school readiness programs so that each may have several staff trained to coach others in the full implementation of the curriculum.
  - Hire Hartford Area Childcare Collaborative, Fall 2009.

- **Train preschool staff in teaching literacy using Creative Curriculum.** In addition to the standard Creative Curriculum, there is an additional literacy module. The School Readiness Council will sponsor joint training for staff from all of the preschool programs that still need training in this area.
  - Hire Hartford Area Childcare Collaborative, Fall 2009.

- Train Preschool managers in the use of the Creative Curriculum Implementation Checklist, training, Spring 2010. Roll out Spring 2010 forward.
- Hire Hartford Area Childcare Collaborative, Fall 2009.

- **Implement use of the "Second Step" curriculum** in each school readiness classroom. The School Readiness Council will purchase the curriculum for all of the preschool classrooms that still need it. Fall 2009.

Continued Action:

- School Readiness Council continues annual staff training in literacy.
- School Readiness Council continues to train staff in behavioral strategies.

Partners: The New Britain School Readiness Council, and the city's school readiness providers, which also includes Head Start: The Boys and Girls Club of New Britain, The Consolidated School District of New Britain, The Early Learning Center of Central Connecticut State University, The Hospital for Special Care, The Human Resources Agency of New Britain, and The YWCA New Britain, School Readiness Council, Hartford Area Child Care Collaborative, Tunxis Community College

Strategy 1B - Collect and analyze the data on student progress and adjust teaching strategies accordingly.

Currently, New Britain does not collect data on the performance of children in school readiness program. The analysis of data can support children's learning in addition to program effectiveness. Creative Curriculum, provides an on-line database (Creative Curriculum On Line) into which information about the developmental levels of children in preschool classrooms can be entered. Reports that summarize the developmental needs of the classroom can be generated and reviewed by teachers and administrators. In addition to monitoring student progress, teacher instruction can then be tailored to meet the needs of the children in each classroom.

Action Step:

- **Institute a system of uniform electronic reporting of child outcomes** in all of the school readiness preschool programs.
  - Evaluate the possible options
  - Pilot a promising system in at least one classroom in each preschool
  - Select and implement a system in all school readiness classrooms.

Strategy 1C - Increase the supply of qualified early childhood teachers.

Short term steps to improve classroom instruction must be coupled with longer term strategies to support the continuing education of preschool staff in school readiness programs. Moving staff along the credentialing continuum in Early Childhood Education is essential and supported as a strategy for classroom instructional improvement by this plan. [xxxiv]

CDA ⟶ Associates Degree ⟶ Undergraduate Degree

Not surprisingly, teacher qualifications and longevity improves teaching quality.[xxxv] Early childhood teachers are more likely to remain with programs longer term when they receive a higher salary and benefits, and are able to participate in professional development opportunities.[xxxvi]

Locally, providers indicate that parent tuition fees, reimbursement rates from the School Readiness Grant, and Head Start funding are simply not enough to increase salaries and compensation to teachers. In addition, the shortage of staff with credentials required for school readiness has delayed the opening of new classrooms. Central Connecticut State University, an important teacher preparation program for Connecticut and located in New Britain, closed its early childhood program because of the small number of students enrolled in it. Insufficient compensation for teachers continues to impact the field of early childhood. New Britain must join other districts to advocate for state and federal action to assist in addressing this situation before progress will be made.

Action Steps:

- School Readiness Council works with Community Foundation, American Savings Foundation to share information on scholarship programs, Spring 2010.
- School Readiness Council works with Tunxis Community College to support access to courses needed for CDA, 2 year degree, Fall 2009.
- School Readiness Council to set aside funding for tuition, Fall 2009.
- Join other communities to participate in statewide and national initiatives, like The Worthy Wages Campaign, to advocate for higher salaries and benefits for Early Childhood professionals.

Partners: The New Britain School Readiness Council, and the city's school readiness providers, which also includes Head Start, The Boys and Girls Club of New Britain, The Consolidated School District of New Britain, The Early Learning Center of Central Connecticut State University, The Hospital for Special Care, The Human Resources Agency of New Britain, and The YWCA New Britain, School Readiness Council, Hartford Area Child Care Collaborative, Tunxis Community College

Strategy 2 - Support parenting skills in promoting children's development

Beginning at birth, parents are a child's first teacher. Despite the enormous impact of parents on a child's academic success, in New Britain there is a shortage of services available to support parents in their parenting role. Currently, a patchwork system of programs delivers services independently, often without regard to service duplication or competition. Education programs are often poorly attended and waste precious resources. Many programs are not reflective of the cultural diversity of New Britain. Thirty two different home languages are spoken in New Britain schools.[xxxvii] Currently some segments of the community are receiving services, while others receive none at all.

To improve educational outcomes for children, parents must be part of the solution. A coordinated and comprehensive service model that reaches the entire community and includes culturally relevant parent participation at its core is needed to address this strategy and others that appear in this plan.

Action Steps

- **Implement a community wide system of parenting education.** This plan calls for the adoption of a holistic approach to parental support that includes parent education. A centralized, coordinating body that provides an array of services in multiple easy to access locations would be most effective. Components that support parent participation, transportation and childcare must be part of the equation.

  Providing education in a variety of formats: group or individual sessions, and home visits, using research based models that have been demonstrated to be effective, and including multiple community partners with expertise in parenting education are suggested.

- **Seek funding to expand home visitation programs using the Parents As Teachers (PAT) Curriculum**.

PAT helps to increase parents' knowledge of early childhood development and improve their parenting practices. Through age specific screening it helps to detect developmental delays and other health issues early, prevent child abuse and neglect, increase children's school readiness and school success. PAT is currently used by the hospital's Nurturing Families Program, the two Family Resource Centers and the YWCA. Combined the programs are able to visit 80 families in their homes and work with an additional 182 families who have children enrolled in the YWCA childcare. This means that PAT currently touches less than 1% of the roughly 3,000 families with children under 5. In order to focus limited resources on the families that most need support, this plan calls for the phased expansion of PAT. The first priority is to reach poor families with a low birth weight child, followed by teen parents and eventually all families with young children covered by HUSKY.

- **Improve access to and coordination of behavioral health services**

The city's preschools and kindergartens report an increase in severely disruptive and dangerous behaviors by even very young children. A research-based social emotional learning curriculum provides a foundation, but some children need more intensive behavioral interventions, outside of special education, in order to function appropriately in school and at home. While the availability of counseling services has recently increased in the community, issues of transportation, work schedules, and passive resistance impede access to the services. On-site behavioral health services in our preschools and elementary schools as well as in home services like those developed by Child First in Bridgeport for the most vulnerable families would reduce the obstacles to accessing needed counseling and interventions.

- **Improve Literacy at Home**

Reading to children is critical to their literacy development through the primary grades, and begins with families in infancy. The community must address issues of adult illiteracy, language differences, access to books, and parental understanding of the value of reading to their children. Provision of adult literacy programs, books in native languages, and parent workshops are needed. (see more on this in both the Reading Well by 3rd Grade and Mothers with a High School Diploma sections)

- **Improve at-home behavior and structure for children**

Children crave structure and consistent, loving discipline. Parents who provide this are assisting their children to develop in a healthy way and preparing them for success in school. Behaviors that disrupt their own and others' learning in school jeopardize the development and educational achievement of all children in the classroom. Trusted educators, from within the spectrum of New Britain's culturally diverse populations, who could share information on appropriate and effective disciplinary techniques and home structure, would support both parents and children.

- **Expand outreach to non English speaking parents**.

More than 59% of the children served by New Britain public schools have a home language other than English. In 2008-09, 32 different home languages were represented among the K-12 students who are English Language Learners. Spanish speakers are by far the largest group but there is also clearly a need for communication in Polish and Arabic, the two languages after Spanish spoken by most parents of our English Language Learner students.

Partners: The New Britain School Readiness Council, and the city's school readiness providers which also includes Head Start: The Boys and Girls Club of New Britain,
The Consolidated School District of New Britain (includes Family Resource Center and Adult Education), The Early Learning Center of Central Connecticut State University, The Hospital for Special Care, The Human Resources Agency of New Britain, and The YWCA of New Britain (includes Family Support Network), New Britain Public Library Literacy Volunteers of Central Connecticut, Legislative leadership on local, state and federal level, Community Foundation of Greater New Britain, American Savings Foundation, State of Connecticut Department of Education

Strategy 3 - Adoption of PEDS ("Parents' Evaluation of Developmental Status") screening for use with children, age 3 and under, in pediatrician's offices, WIC office, and childcare centers throughout New Britain.

Early identification of children with special needs is the most effective means of ensuring they receive the support needed to be successful in school. A more intensive, coordinated approach to identification and referral of children with possible special needs to Birth to 3 requires the cooperation of many partners. Pediatricians in the community see a large percentage of children in the city, coupled with the WIC office, which sees low income families and may see young children without a medical home. Professionals in these settings can assist parents in completing the PEDS survey and making referrals to Birth to 3 when warranted. It is anticipated that through this comprehensive approach, the referral rate will increase. Local school readiness programs can use PEDS with parents of 3 year olds who may have been missed by either the pediatrician or WIC. Referrals for 3 year olds with suspected special needs will be made to The Consolidated School District.

Action Steps:

- **Convene local medical providers** to advocate peers for the adoption/implementation of PEDS and set goals.

- **Make the initial purchase of PEDS surveys** through funds of the New Britain Discovery Collaborative.

- **Distribute PEDS surveys** to local pediatricians, WIC office, and School Readiness Providers.

- **Distribute information on Birth to Three and Special Education Services** for children, ages 3 and up, provided by the local School District through local pediatricians and WIC office.

Partners:
Local Pediatricians, Community Health Center, The Hospital of Central Connecticut, WIC (Women, Infants, Children), Birth to Three, School Readiness Providers, The Consolidated School District

Strategy 4 - Increase the supply of early care and education in New Britain.
The shortage of early childhood slots for young children of all ages makes this an important strategy. Given the large expense associated with this strategy, this plan recommends a two tiered approach: first, phasing in preschool slots into the community for 100 children with 250 more planned for later on.

The expansion of Infant/toddler slots is more complex and will require additional advocacy and partnerships. Currently, the high cost of providing care and the low rate of reimbursement for subsidized Early Head Start Programs makes it unlikely additional center-based care will be opened. A survey conducted by The Discovery Collaborative in 2003 indicates parents preferred infants and toddlers in home care settings. Therefore, improving and expanding Family Daycare Programs must be part of the solution for caring for New Britain's youngest children. Given the complexities of this issue and the expense required to achieve it, expansion must be addressed long-term.

Action Steps

- **Support the expansion of Head Start and School Readiness** at HRA's Clinton Street location, Fall 2010.

- **Support the expansion of the YWCA**, Glen Street location for School Readiness slots, Fall 2011.
- **Explore and identify classroom space within local school facilities** to accommodate school readiness classrooms, Fall 2011 and forward.

- **Advocate for public funding at state and federal level** to support additional Head Start and School Readiness slots, Spring 2010.

- **Identify and meet with local family daycare providers** serving children under age 3.

- **Work with family daycare providers** to develop a plan to increase quality of care.

- **Develop an infant/toddler sub-committee** to further analyze and propose action plan to increase supply of quality care in New Britain for children under age 3.

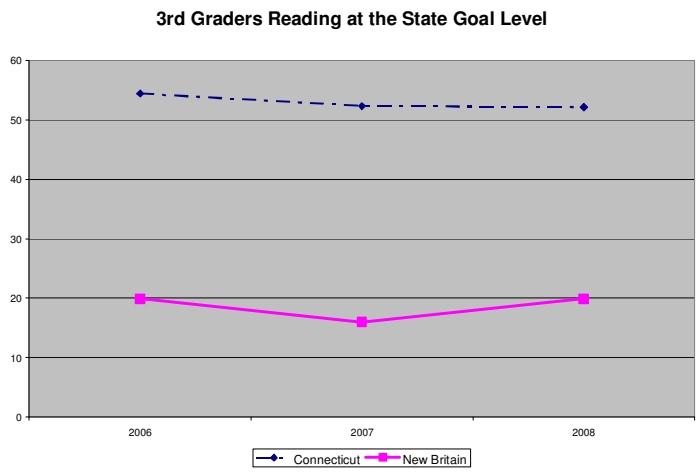
Partners:
The New Britain School Readiness Council, and the city's school readiness providers which also includes Head Start: The Boys and Girls Club of New Britain, The Consolidated School District of New Britain, The Early Learning Center of Central Connecticut State University, The Hospital for Special Care, The Human Resources Agency of New Britain, and The YWCA of New Britain, New Britain Family Daycare Association, Legislative leadership on local, state and federal level, Community Foundation of Greater New Britain, American Savings Foundation, State of Connecticut Department of Education, State of Connecticut Department of Public Health Licensing Division

Desired Result:	All of New Britain's children will read at grade level by the end of 3rd Grade

In Brief

- 64% of 3rd graders could not read proficiently on the 2008 CMT.
- 19.9% of 3rd graders read at the state goal level in 2008
- 47.5% of 3rd graders read at the lowest level (more than a grade level behind)
- Four out of five English language learners read at the lowest level.

The Trend



Why it's important

Reading well by the end of third grade is strongly predictive of high school graduation. The ability to read well is critical to future learning and success as an adult. School curriculums are based on the assumption that children learn how to read in the early grades and by fourth or fifth grade are able to start learning from materials they can read. This means that children who haven't mastered reading begin to fall further and further behind in their academics. In a community like New Britain where almost 2/3 of children are poor readers, teachers tend to focus on the majority of the class who need remedial help. Those children who are stronger readers may then find themselves bored and not advance as quickly as they are capable.

What we know about the situation in New Britain

The primary cause of low reading scores in New Britain is that most of our children arrive at kindergarten unprepared in the areas of language and pre-literacy skills. These children, who are starting kindergarten less prepared than their peers in the suburbs, simply aren't catching up. In the 2008 annual kindergarten entrance inventory, New Britain teachers rated only 20% of their students fully ready in their ability to converse in their native language. Students are expected to be able to listen attentively, retell a story that was read to them, speak in sentences with 5 or more words and follow two step directions. A third of kindergarteners were considered to have only emergent skills in the use of their native language and required a large degree of instructional support.

The area in which kindergarten teachers rated their children weakest was in the area of literacy skills. Children are expected to

- Hold a book and turn pages from the front to the back
- Understand that print conveys meaning

- Explore books independently
- Recognize printed letters, especially in their name and familiar printed words
- Match/connect letters and sounds
- Identify some initial sounds
- Demonstrate emergent writing (typically their name)

In this category, only 15% of New Britain's kindergarteners were considered able to consistently demonstrate the skills. At the same time 40% were considered to have only emerging literacy skills requiring a large degree of instructional support.

Many of New Britain's children arrive unready for kindergarten because they come from low literacy/low vocabulary families where most of the parent child interaction is the parent directing the child to do or stop doing something. Research on vocabulary development has shown that by age five, poor children hear 35 million fewer words spoken to them than their peers who are raised in white-collar professional families.[xxxviii] The researchers noted that by age three the children in the professional families used more, different words in conversation than the parents of the families in poverty.

One of the ways that families introduce their children to new words that might not come up in everyday conversation is by reading books to them. Nationally about 60% of young children are read to every day.[xxxix] The numbers vary by education level, income and race. In poor families regardless of race 50% of children are read to daily, in Hispanic families regardless of income or education level only 45% of children are read to daily, and in families where the mother didn't finish high school just 41% of children are read to daily. Given that 62% of New Britain's children are poor enough to qualify for free lunch at school and 29.6% of the mothers who gave birth in 2006 hadn't finished high school, its safe to say that there is not enough reading to children going on in New Britain.

The fact that 59.8% of the children enrolled in New Britain's schools live in homes where English is not the primary language is also a major factor. In most of these families, at least one parent speaks some English but many have difficulty with written English. Parents in these families have problems communicating with schools and teachers and may not be able to help their children with homework. Many of these families want to improve their English. Currently Literacy Volunteers has 200 people waiting for a tutor to work with them.

Of particular concern are children whose parents speak no English. These linguistically isolated families frequently are unaware of resources in the community like the free Head Start program and the subsidized School Readiness preschools. Their children particularly if they arrive in kindergarten speaking no English typically struggle in New Britain's schools. Currently, less than 10% of English Language learners are able to read English proficiently by 3rd grade. For these children there can be tremendous benefit from two years of learning spoken English from their teachers and classmates in preschool. At around 12 months of age the human brain has developed to the point where children begin to rapidly acquire language. Over the next few years they may learn over a thousand words. It is at this time when the brain is naturally developing its capacity for language that children find it easiest to learn a second language. Young children learn first to speak then to read. When children are exposed to a second language at an early age, they learn in this same natural pattern. National research points to a preschool through third grade approach as the most effective for teaching students a second language.[xl]

In New Britain there are an estimated 16,000 adults, or roughly 26% of the adult population who are functionally illiterate. It is unknown how many of them are parents of school age children or how many of them are native English speakers vs. people who may be trying to learn English as a second language. In either case, it means that New Britain is a low literacy city.

For children raised in low literacy families, high quality, language rich preschool programs can be a big help by introducing them to more conversation, singing, rhyming and stories. For years New Britain lagged behind the rest of the state in preschool enrollment. However, in just the past few years, the combination of smaller birth cohorts (fewer children born in a year) and a substantial increase in the state School Readiness Grant has brought the percentage of kindergartners who attended at least a year of preschool up to 79% (roughly the state average).

The fact that so many children remain so unprepared for kindergarten, speaks both to the language deficits in the home, and the fact that our preschools are not of high enough quality to enable children to overcome those deficits. (More on the strategies to improve the preschools in the Kindergarten Readiness section of this plan.)

While only 10% of the children entering kindergarten are considered fully ready by their teachers, other communities with similar demographics and levels of school readiness are having more success in teaching their children to read well by the end of third grade. This points to the need for more professional development for teachers around instructional strategies in reading. One area of particular weakness compared to other communities is teaching English language learners how to read proficiently by 3rd grade.

New Britain has seen substantial improvement in reading scores for some small groups of students. One of particular note is the Scholastic Academy. This group of low-income students piloted the use of the Break Though to Literacy program and accompanying individualized software that enables children to continuously work at their level of instruction in the components of reading.

Strategies to turn the curve

Strategy 1- Support Family Literacy

Three out of five students in the New Britain schools live in homes where English is not the primary language. These families, as well as low literacy native English speakers, all have problems helping their children learn to read and supporting the children's education.

Action Steps

- **Bring the *Let's Talk it Makes a Difference* program to New Britain**. This program reaches out to new parents in their native language with the message that what they do with their babies makes a difference. It teaches parents about the importance of intentionally talking to their babies as much as possible. Through small group workshops it models ways parents can turn situations into opportunities to talk with their children and introduces them to a style of interactive reading to promote conversation with their child.

The pilot program in Cambridge, MA has had great success using "Literacy Ambassadors" to reach into the various ethnic and linguistic communities and find the harder to reach families. These part time outreach workers are recruited from the graduates of the Adult English as a Second Language program. They work part time to find the families from their own ethnic group who are having a baby. Once the child is born, the Literacy Ambassador visits the family's home to talk with the parents about their role as their baby's first teacher and the importance of talking to their baby. Finally the Literacy Ambassador invites the family to participate in small group workshops with others who speak the same language. In addition to reaching families with the message about the importance of talking, they are also able to connect families with the other resources and programs in town like Literacy Volunteers and the English as a Second Language program.

Partners: Family Resource Centers, WIC, HRA, Nurturing Families, the Library, Hartford Area Childcare Collaborative & Agenda for Children (Cambridge MA).
Possible Additional Partners: the high school "Moms" program, Adult Education, the Spanish Speaking Center, and the hospital birthing center

- **Expand opportunities for parents to learn with their children.** In the past most programs have attempted to reach either children or parents but rarely both. The school district has proposed using some of the Federal ARRA stimulus funds to support ***Saturday Academies*** for children and their parents. These Saturday Academies would provide incentives for parents to attend classes that would build their educational and parenting skills, while their children participate in engaging educational activities.

Possible Partners*:* The school district, the Federal Government,

- **Expand programs to support families learning English** like ***Parenting for Academic Success*** run by Literacy Volunteers in collaboration with the Family Resource Centers and the school district. *Parenting for Academic Success* is a 12–unit curriculum designed for parents whose native language is not English. Its goals are two–fold:
  - To develop the English language skills of parents.
  - To increase the ability of parents to support the language and literacy development of their children in kindergarten through grade three.

Possible Additional Partners: Preschools, the Community Health Center, the Library, the Housing Authority

- **Expand Literacy Volunteer's programs to help low literacy parents learn what their children are doing in school and how they can support that learning at home**.

- **Support the two existing Family Resource Centers and work for the creation of a citywide family center** along the lines of the Middletown Family Wellness Center that offers a variety of programming for families with young children who will attend one of the 8 elementary schools that don't have an FRC . Family Resource Centers are one of few existing resources in the community that support parents of young children with information about parenting, literacy, child development and resources in the community.

Possible Partners: New Britain's Legislative Delegation, the school district, The Community Health Center.

Strategy 2 – Increase the number of English Language Learners starting preschool at age 3

Currently some of the children most likely to arrive at kindergarten without the benefit of preschool are children who live in households where none of the adults speak English. These are the very children who could benefit the most from preschool because it will introduce them to spoken English at the very time that their capacity for language is growing dramatically. This strategy will focus on educating and mobilizing the bilingual assets in the community to reach out to the linguistically isolated families with the message that getting their children into preschool early is the best way to help them learn English. The key to in this strategy will be to recruit community messengers through a number of different strategies depending on the target audience. For staff of social service and healthcare providers it will be a series of Lunch and Learns. At these "Free Lunches" there will be a brief program to educate the staff about how un ready for kindergarten many of their client's children are and to ask for their help in getting the word out about the various preschool programs. For hair dressers, nail salons and neighborhood bodegas it might be as simple as stopping by with posters, leaflets and some inexpensive giveaways. With church pastors it could be a clergy luncheon or individual meetings. Another key target group is students in the Adult ESL program. Many of these students are parents themselves, and they have their own networks within the various ethnic groups in town. The key is to create a buzz in the community that preschool is something parents should seek out to help their children learn.

Partners: The School Readiness Council, Preschool programs, Literacy Volunteers, The Community Health Center, WIC

Potential Additional Partners: Adult Literacy, Churches, The Spanish Speaking Center, The Food Collaborative, Spanish language media, Neighborhood bodegas.

Strategy 3 – Maintain All Day Kindergarten & restore paraprofessional to the kindergarten class rooms

Two years ago New Britain implemented full day kindergarten for all (with the exception of some late registrants). This was done because extending learning time is the simplest, proven way for a school system to improve student achievement. It was also based on the New Britain School District's own data that showed the 45% of students who received all day kindergarten prior to 2007 performed at a higher level than the students enrolled in the half day program. Since then, reading scores on the Developmental Reading Assessment v2 for the two grades that received universal all day kindergarten have improved compared to previous cohorts of children. As a result, fewer kindergarteners and first graders this year were referred for summer school than in previous years. State and local fiscal problems have left the school district facing deep and painful cuts. Funds for all day kindergarten teachers were saved last year at the cost of the paraprofessional that used to assist them. The loss of kindergarten paras has a substantial negative impact on teaching.

Strategy 4 - Improve reading instruction in the public schools.

With relatively similar student demographics, New Haven, Bridgeport and Waterbury all have better reading scores than New Britain. This points to a need to improve reading instruction in New Britain's classrooms. A recent study of efforts to improve achievement levels for poor children in New Jersey concluded that the districts showing the greatest improvements were not the ones that spent extravagantly on school restructuring consultants or new packaged curriculums, but rather the ones that focused on improving pedagogy (teaching).[xli]

- **More professional development around instructional strategies**. In 2008 the Board of Education adopted a policy of half days (Kaizan Thursdays) for professional development. During this first year, Kaizan Thursdays have focused on team work and data with each school creating data teams and getting everyone to understand what it told them about their students. Going forward the focus needs to shift to professional development around instructional strategies. Teachers need the training to know what to do when the data tells them that a group of their students are struggling with a particular concept.

- **Better use of data to drive instruction** and professional development. While Kaizan Thursdays have focused on data, the school district's computer system is antiquated and needs to be replaced. Administrators need to be able to readily look at data to see what's working and what's not.

- **Expanding use of Breakthrough to Literacy**, which provides lesson plans grounded in reading research, effective professional development, and individualized software. Results from the Scholastic Academy which began using the Breakthrough to Literacy program were impressive. This year the school district expanded use to the other kindergarten and 1st grade classes. Now it is a matter of expanding its use to the remaining 35 second and third grade classes.

- **Improve instruction for English Language Learners**. Less than 10% of 3rd grade ELL students read proficiently on the 2008 CMT. New Britain falls behind all other large cities in Connecticut all of which have similar English Language Learner demographics of poor children.

Partners: The Consolidated School District of New Britain

Measuring progress toward the goal.
If the 3rd grade Mastery reading test was our only measure of success and New Britain implemented the Let's Talk program next year, it would take another 8 years before we would see if it made a difference. Fortunately we have a number of other ways to determine if Let's Talk and the various other strategies are making a difference in the interim. The first method of measuring success will be enrollment and completion figures for each of the programs. These will help to determine how much is being done and what percent of the target population is being reached. The first indication of whether all that is being done is making a difference will be the scores on language and literacy sections of the kindergarten readiness inventory. After that are the Developmental Reading Assessments. These assessments are done at least once a year in kindergarten and three times per year in 1st grade through 3rd grade. Lexile measures may also be a useful tool for monitoring student progress.

MONITORING PROGRESS ON THIS PLAN

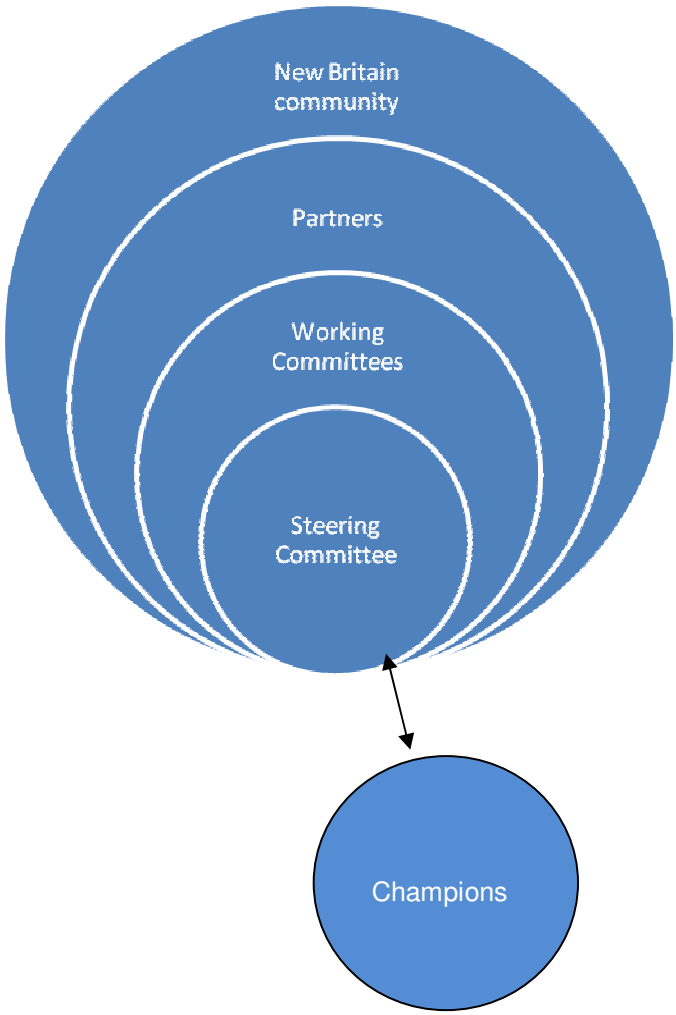
The plan presented here lays out the priority strategies, estimated costs, and implementation partners. The next step is to develop the specific implementation plans assigning target dates and specific responsibilities.

Essential to success is ongoing data collection and analysis to determine how we are doing in turning the curve in the areas where we are focusing. By accurately tracking progress we have the opportunity to alter the approach, as needed, and to acknowledge successes.

Annually we will publish a community report card specifying progress against the targeted goals in each "turn the curve" chart in this plan.

All of this requires ongoing participation and support from those who helped to develop this plan and others who will newly engage in this plan. It also requires an effective structure of working committees, participating agencies and organizations, and champions.

The structure for implementing and monitoring this plan is shown in the graphic below:



Roles:

Champions:

Personally commit, understand, and value the plan
Publicly support and champion the plan
Influence:

- Allocation of resources
- Public policy
- Convene
- Access to resources

Access to their networks
Facilitate collaborations to further the plan
Issue the annual Turning the Curve Report Card

Possible Champions

Mayor
Superintendent
School Board representative & chair
Council Majority Leader
City Council Member
State Reps
State Senator
Hospital of Central Connecticut, Chief of Pediatrics
CHC – Executive
HRA – Executive Director
Chamber of Commerce President
CCSU – President
New Britain Community Foundation
American Savings Foundation
United Way
NAACP
YWCA – Executive Director
Civic Clubs
Business Owners
Representatives from various sectors of the community to include the following sectors:
Hispanic
Polish

Steering Committee:
Oversees the plan's implementation
Negotiates memoranda of understanding (MOU) with partners

Discovery Collaborative
Board of Education
Hospital
Parents
Library
Literacy Volunteers
City Government
Head Start
YWCA
CHC
WIC
FRC
Health Department

Working Committees:
Develop the action steps, assign responsibilities and target dates to implement the plan

Partners:
'Partners' is the term used to represent all agencies, collaboratives, and organizations who, by working together, can successfully implement this plan. Members of partner organizations will participate in the Steering Committee and Working Committees.

New Britain Community:
Family members of young children have participated in this planning effort from the beginning by providing their perspectives and ideas. They, and other concerned citizens, will continue to be involved in the plan itself as well as being the recipients of the annual report card.

Appendix 1
WHAT WILL IT COST?

Cost Estimates

Presented below are cost estimates for each of the action steps listed in each strategy. Some of these action steps are more fully developed than others. Those that are not completely figured out are listed as To Be Determined (TBD). These items will be part of our ongoing efforts to refine the plan. Others items have been more fully explored and either the proposed strategy could be done for the cost of current services that the strategy step would replace, or existing under utilized resources have been identified to cover the cost. These items are listed Low/No Cost.

Indicator # 1 The percentage of children born at low birth weight

Strategy 1 Reduce Teen Smoking

Action Step	Capital	Operating
Engage teens in an anti smoking campaign	NA	TBD
Step up enforcement of "sale to minors" law	NA	TBD
Help teens quit smoking	NA	TBD

Strategy 2 Improve access to prenatal care

Action Step	Capital	Operating
Expand OBGYN capacity	TBD	TBD
Expand Outreach	NA	TBD

Strategy 3 Improve the delivery of prenatal care

Action Step	Capital	Operating
Provide OBGYN care in language of preference	NA	TBD
System for identifying high risk pregnancies and a protocol for appropriate care	NA	TBD
Use small group (centering pregnancy) prenatal care	NA	Low/No Cost
Reduce smoking during pregnancy	NA	TBD
Improve Oral Health for pregnant women	NA	Low/No Cost*

* As long as HUSKY maintains preventive (non emergency) coverage for adults

Indicator # 2 The percentage of children born to mothers without a high school diploma

Strategy 1 Reduce the High School Drop Out Rate

Action Step	Capital	Operating
Identify students at risk of dropping out	NA	Low/No Cost
Alternative methods like individualized computer instruction	NA	TBD
Professional development for teachers on more engaging teaching styles	NA	Low/No Cost
Internships and Service Learning	NA	TBD
Engage parents in supporting their child's education	NA	TBD

Strategy 2 Support mothers in completing their high school diploma before having another child

Action Step	Capital	Operating
Convene a working group to: • On site child care at the high school • A cohort based support group for teen mothers trying to finish their degree • Investigate bringing Even Start to New Britain • Bring Early Head Start to New Britain	TBD	TBD
Expand Home Visitation programs using Parents as Teachers Curriculum	NA	See Indictor 4 strategy 2

Strategy 3 Prevent Teen Pregnancy

Action Step	Capital	Operating
Convene a working to address: • Younger sisters of teen mothers • High teen birthrate among Latinas	NA	TBD
Allow family planning counseling at school based health centers	NA	Low/No Cost

Strategy 4 Expand efforts to help immigrant women learn English and finish their education

Action Step	Capital	Operating
Recruit additional literacy volunteers	NA	Low/No Cost
Expand family literacy efforts that enable parents to learn with their children.	NA	$10,000

Indicator #3 The % of children who are obese at age 4

Strategy 1-Expand Efforts to Prevent Childhood Obesity

Action Step	Capital	Operating
Include education about the risks of childhood obesity in prenatal care particularly among higher risk mothers.	NA	Low/No Cost
Promote breast feeding	NA	Low/No Cost
Develop community gardens and additional farmers markets to increase access to fresh fruits and vegetables.	20,000	25,000
Safe Routes to school to encourage more children to walk.	TBD	TBD

Strategy 2 Identify childhood obesity early and begin interventions right away.

Action Step	Capital	Operating
Increase the amount of exercise children get in preschool	NA	Low/No Cost
Work with Head Start Obesity Committee to: • Develop a childhood obesity treatment protocol • Create programs to treat obesity as a family problem. • Develop culturally appropriate educational materials	NA	TBD
Advocate for change in state policy so that HUSKY will pay for weight loss programs.	NA	TBD
Advocate for changes to USDA nutrition guidelines and increase federal funding for school lunch program	NA	TBD

Indicator #4 The percentage of children ready for kindergarten.

Strategy 1A - Improve preschool teaching skills in the domains of language development, early literacy, and social emotional development

Action Step	Capital	Operating
Train Creative Curriculum class room coaches	NA	$2,400
Train Preschool teachers in Creative Curriculum Literacy instruction	NA	$8,475
Train preschool managers in use of check list	NA	Low/No Cost
Provide "Second Step" kits for each preschool classroom	NA	$10,500
Train preschool providers to assess classrooms using Creative Curriculum Implementation Checklist	NA	Low/No Cost
School Readiness Council annually trains preschool staff in behavioral strategies.	NA	Low/No Cost

Note: All of these action steps will be paid for with redeployed Quality Enhancement grant funds.

Strategy 1B - Collect and analyze the data on student progress and adjust teaching strategies accordingly.

Action Step	Capital	Operating
Institute a system of uniform electronic reporting on child outcomes: • Evaluate possible options • Pilot a promising system in selected preschool classrooms • Implement system in all preschool classrooms	 NA NA NA	 Low/No Cost $1,276 TBD

Note: All of these action steps will be paid for with redeployed Quality Enhancement grant funds.

Strategy 1C - Increase the supply of qualified early childhood teachers.

Action Step	Capital	Operating
Work with local foundations to share scholarship info	NA	Low/No Cost
Work with Tunxis to support access to courses needed for CDA, and AA degree	NA	Low/No Cost
School Readiness Council fund scholarships	NA	$4,760
Join Worthy Wages Campaign, to advocate for higher salaries and benefits for Early Childhood professionals.	NA	Low/No Cost

Strategy 2- Support parenting skills in promoting children's development

Action Step	Capital	Operating
Implement a community wide system of parenting education.	NA	TBD
Expand Parents as Teachers home visitation programs • Option A - Low birth weight babies in poverty • Option B- Low birth weight babies & teen mothers • Option C - All births covered by HUSKY	NA	* $420,000 $900,000 $3,540,000
Improve access to behavioral health services	NA	TBD
Improve Literacy at Home	NA	See Indicator 5 Strategy 1
Improve at-home behavior and structure for children	NA	TBD
Identify languages schools need to focus on, beyond Spanish.	NA	TBD

*The costs estimates for home visitation are based on a per family annual cost of $2,000. The various options shown are based on the number of families falling into each risk category times three years of home visits until their child transitioned into preschool.

Strategy 3: Adoption of PEDS ("Parents' Evaluation of Developmental Status") screening for use with children, age 3 and under, in Pediatrician's offices, WIC office, and childcare centers throughout New Britain.

Action Step	Capital	Operating
Convene local medical providers to advocate peers for the adoption/implementation of PEDS and set goals.	NA	<$100
Purchase of PEDS survey kits	NA	<$900
Distribute PEDS surveys to local pediatricians, WIC office, and School Readiness Providers.	NA	Low/No Cost
Distribute information on Birth to Three and Special Education Services for children, ages 3 and up, provided by the local School District through local pediatricians and WIC office.	NA	Low/No Cost

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Strategy 4: Increase the supply of early care and education in New Britain.

Action Step	Capital	Operating
Add 350 preschool slots – 60% full day, 40% half day	$7.4 million	$2.6 million
Add 300 infant toddler care slots	$3.1 million	$5.5 million
Identify and work with home daycare providers	NA	TBD

Detail:

Capitol Costs to add preschool class rooms for 350 slots – 60% full day, 40% half day:
$1.6 million for new construction and equipment
Renovation costs are $5.8 million for YWCA building expansion to add
9 new classrooms
11 new classrooms
49 new staff

On-going preschool operating cost/child:
210 children, full day @ approximately $11,000 (includes school readiness allocation-$8346; $1500-parent share; $1154-Care 4 Kids. $2,310,000
140 children; part day @ approximately $8000/child (includes school readiness allocation-$6000; $1000-parent share; $920- Care 4 Kids). $1,120,000

Capitol Costs to add 300 Infant Toddler slots: $3.1 million for new construction and equipment
38 new classrooms
113 new qualified teachers
13,700 sq. ft. of classroom space
Operating cost: $350/child/week =$5,460,000 annually

Indicator #5 The percentage of children reading well by 3rd grade.

Strategy 1- Support Family Literacy

Action Step	Capital	Operating
Let's Talk it Makes a Difference program	NA	$150,000
Expand opportunities for parents to learn with their children (Saturday Academies)	NA	45,000*
Support families learning English like *Parenting for Academic Success*	NA	Low/No Cost
Expand Literacy Volunteer's programs to help low literacy parents learn what their children are doing in school and how they can support that learning at home.	NA	$15,000
Continue funding for two existing Family Resource Centers	NA	$194,400
Creation of a citywide family center	TBD	TBD

* Included in ARRA grant

Strategy 2 – Increase the number of English Language Learners starting preschool at age 3

Action Step	Capital	Operating
Mobilize the bilingual assets in the community to reach linguistically isolated families by: • Holding "Lunch and Learns" with bilingual healthcare & social service staff • Develop and print materials in appropriate languages • Purchase of "give aways" for distribution to hair dressers and nail salons • Clergy Luncheons	NA	<$1,000

Strategy 3 – Maintain All Day Kindergarten in the public schools

Action Step	Capital	Operating
Maintain the current all day kindergarten program and restore paraprofessionals for every kindergarten class	NA	* $900,000
Advocate for a new state source of funds for all day kindergarten to ease the pressure on the local budget	NA	TBD

*The additional cost of teachers to the school district for all day kindergarten vs. the half day program required by state law is $1,080,000 It is in the New Britain school district budget for the 2009-10 school year. However, tight budgets and the absence of a state requirement to provide all day kindergarten may put it in jeopardy in future years.

Strategy 4 - Improve reading instruction in the public schools.

Action Step	Capital	Operating
More professional development around instructional strategies	NA	$150,000
Purchase of new school district computer system to enable better use of data to drive instruction	$125,410*	$46,100*
Expanding use of Breakthrough to Literacy,	$542,500**	NA
Improve instruction for English Language Learners.	TBD	TBD

* Included in Title 1 ARRA grant.

**Breakthrough to Literacy licenses cost $15,500 per classroom. To expand to the remaining 35 grade 2 and 3 the total is $542,500. Included in ARRA grant.

Appendix 2

COMMUNITY PLAN DEVELOPMENT PARTICIPANTS

Ramona Anderson	New Britain Health Department, parent
Julie Arcila	New Britain School District, Social Worker
Maydie Bombart	New Britain School District
Liz Buczynski	United Way of Central Connecticut
Antonia Capriglione, MD	Chief of Pediatrics, Hospital of Central Connecticut
Ann Carrabillo	New Britain School District
Caroline Cooke	Bristol Hospital Women Infants and Children (WIC)
Sarah Cormier	City of New Britain, Youth Services Bureau
Liz Donnellen	Human Resource Agency (HRA)
Susan Doyan	Community Mental Health Association (CMHA)
Robert Dudley, MD	Community Health Center (CHC)
Melanie Gedraitis	VNA of Central Connecticut
Elrick George	Parent
Pamela Granucci, PhD	New Britain School District
Marlo Greponne	HRA, parent
Kathleen Griswold	Wellspring Church
Amy Griswold	HRA, Wellspring Church
David Lawrence Hawley	Klingberg Family Center
Barbara Heidenis	YWCA
Yvette Highsmith Francis	CHC, Director
Darlene Hurtado	Literacy Volunteers of Central Connecticut
Kim Jackson	Family Resource Centers at Jefferson and Smalley schools
Linda Johnson	YWCA, Childcare Director

Enrique Juncadella	Hospital of Central Connecticut, Director of Community Relations
Karen Kellerman	New Britain School District, Social Worker
Heidi Levitz	Wheeler Clinic
Amy Litke	New Britain Public Library Children's Librarian
Tracey Madden Hennessey	YWCA, Associate Director
Ghada Maroun	Parent
Kathleen McLean	Literacy Volunteers of Central Connecticut
Lisa Pavlov	Parent
Heide Perks	Wellspring Church
Anteia Perry	Parent
Hanna Petrisko	Former elementary school teacher, parent
Esther Santana	Nurturing Families
Robin Sharp	YWCA, Executive Director
Kathy Scalise	Hospital of Central Connecticut, Clinic Manager
Maria Sanchez	American Savings Foundation
Elena Trueworthy	HRA
Dawn Williams	Parent
Patti Zemsta	Parent

Appendix 3

RESULTS BASED ACCOUNTABILITY – Turning the Curve

New Britain's Community Planning Result Statement:

> **All children in New Britain age birth to eight will be safe, healthy and successful learners.**

Results Based Accountability (RBA) is a data driven framework that begins with gathering data to identify the population result desired for the community.

What is our desired result?

The first step of an RBA plan is to identify the desired quality of life condition for a target population in plain easy to understand language so that every tax payer and voter can see the issue and its importance.

Where do we want to Turn the Curve?

The primary goal of an RBA plan is to "turn the curve," or change the trend in those areas most relevant to achieving the desired result. The trends identified in the data suggest areas of focus such as reducing the number of low birth weight babies, reducing the incidence of obesity in children, increasing the level of education of mothers, improving access to early care and education, and improving early literacy.

What are the Stories behind the Data?

Knowing the data is only part of the picture. Hearing stories of the challenges families face in raising healthy, academically successful children in New Britain broadens the understanding of the data by answering questions about cultural norms, behavior patterns, and barriers that may lead to strategies not otherwise considered. For example, some immigrant families came from areas where starvation was prevalent. In that culture "thick" children are healthy children while "thin" children have a greater potential for dying. In other cultures, reading to children at home is not the norm; instead it is the job of the schools.

How will we Measure progress?

RBA measures progress at two levels by using population indicators and performance measures. Population indicators are a measure to quantify the achievement of a population result, such as the % of low birth weight babies. Performance measures track the success of a program, agency or service system by answering the questions: How much did we do? How well did we do it? Is anyone better off?

Ends and means are an important distinction in RBA. Results and indicators are about the ends we want for children and families. Strategies, programs, and performance measures are about the means to get there.

What Strategies will Turn the Curve?

Backed by community data, input from families and professionals, and national research the committees identified strategies – coherent collections of actions, which have a reasoned chance of improving results and represent the best thinking about what works. No single action by any one agency can create the improved results we want and need. For each strategy area the plan identifies partner organizations who have committed to working together to turn the curve.

How will we Finance this plan?

To implement the strategies and achieve this plan's result requires an investment on the part of all facets of the community.

While new funding is very limited, at best, the more costly initiatives are included in the longer-term strategies. With the expectation of future availability of funds New Britain, through this process, is ready with well thought out strategies and plans to allow for immediate application for funding when the opportunity becomes available.

Appendix 4

COMPOSITE STATISTICS FOR NEW BRITAIN:

Demographics

- 62.7% of children are eligible for free or reduced price meals at school

Family Literacy

- 26% of the population aged 16 and older are at the lowest level of literacy
- 58.9% of students speak a language other than English at home
- 29.1% of mothers who gave birth in 2006 did not have a high school diploma
- Regardless of the age or socio-economic status, parents want information about how best to raise their children
- Many parents are not aware of the existing programs and services for them and their children

Health and Wellness

- 9.8% of babies are born at less than 5.5 lbs., exceeding the state average of 8%
- 16% of babies are born to teen mothers, more than double the state average of 6.5%
- 37% of pregnant women do not receive adequate prenatal care
- Obesity rates among young children are rapidly increasing:
  - 19.4% of 4 year olds are obese (WIC)
  - 18.1% of 3 year olds are obese (WIC)
  - 29.5% of Head Start incoming 3 year olds are obese (up from 22% in 2008)
  - 28.5% of incoming 4 year olds (up from 21.5%)
- Parents report they are unable to leave work for medical appointments because of lack of flexibility in their schedules
- Transportation to medical, educational, and social services is difficult for many parents
- The 63% of children who rely on HUSKY face significant barriers in accessing any type of specialty care
- Despite improvement in preventive dental care, access to restorative dental care remains very limited
- New Britain's best in the state immunization rates are evidence that a focused coordinated effort does make a difference

School Readiness

- 36% of third graders read at grade level, the 2nd lowest level in the state [xlii]
- 15-20% of children have insufficient language, literacy and numeracy skills when they arrive at kindergarten
- Only 10% of children starting kindergarten in 2008 were rate fully ready by their teachers
- 39% of children starting kindergarten in 2008 were perceived by their teachers to not be ready
- 21% of children arrive at kindergarten with no preschool experience
- 102 children (10.7% of 946) who enrolled in community preschool in 2007-2008 were referred by their preschool providers for evaluation of developmental delays who had not previously received Birth to 3 services
- 300 children are on the waiting list for infant/toddler childcare

End Notes

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[ii] 2006 data

[iii] Child Trends, 2004: Chomitz, Cheung & Lieberman, 1995

[iv] Kids Count Indicator Brief Preventing Low Birthweight, 2009 Annie E Cassie Foundation. Rema Shore & Barbara Shore.

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[vi] Under the ARRA law (the federal stimulus package) states may use stimulus funds to drop this five year waiting period. It is unclear whether CT will take advantage of this.

[vii] CT Department of Public Health 2006 Registry Report.

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[ix] Group prenatal care and preterm birth weight: results from a matched cohort study at public clinics. http://www.ncbi.nlm.nih.gov/pubmed/14672486

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[xvii] "The Children of the Cost, Quality, and Outcomes Study Go to School," Ellen Peisner-Feinberg, Richard Clifford, Peg Burchinal, Noreen Yazejian, Patty Byler, Jean Rustici, www.fpg.unc.edu, 1999.

[xviii] Peisner-Feinberg, et al.

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[xxi] C.L. Salisbury and B.J. Smith (June 1993). "Effective Practices for Preparing Young Children with Disabilities for School," (ERIC Digest, #E519), Reston VA: ERIC Clearinghouse on Disabilities and Gifted Education.

[xxii] Children's Defense Fund, Position Paper, "Children with Disabilities and Other Special Needs: Opportunities to Participate in Quality Programs Must Be Expanded, http://www.childrensdefense.org.

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and Strategy for Family, School, and Community Partnerships," Harvard Family Research Project, http://www.hfrp.org/family-involvement/publications-resources/from-periphery-to-center-a-new-vision-and-strategy-for-family-school-and-community-partnerships; May 2009.

[xxiv] CT Early Childhood Cabinet analysis of kindergarten inventory data by quartile http://discovery.wcgmf.org/resources/sps_resource_1187.xls

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[xxix] As reported by center based Infant/Toddler caregivers in New Britain, 2009.

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