

# The State of Florida's Child

A Report for the Florida Children and Youth Cabinet

**PREPARED BY THE POLICY GROUP FOR FLORIDA'S FAMILIES AND CHILDREN ON  
BEHALF OF THE CHILDREN'S SUMMIT WORK GROUP**

2009

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March 17, 2009

**Lieutenant Governor Jeff Kottkamp**

State of Florida  
The Capitol  
400 South Monroe Street  
Tallahassee, FL 32399-0001



***The Children's Summit Workgroup***

**Members of the Florida Cabinet for Children and Youth**

Re: *The State of Florida's Child Report*

Dear Lieutenant Governor Kottkamp and Members of the Florida Cabinet for Children and Youth:

We are pleased to provide the Florida Cabinet for Children and Youth and the State of Florida with *The State of Florida's Child Report*. The report provides an objective knowledge base to support the Cabinet in its mission to improve outcomes for our state's children and families.

This report's organization intentionally aligns with the Cabinet's Guiding Principles. The Cabinet's strategic plan requires creative and aggressive action to:

- Empower families to provide a nurturing, healthy and safe environment for children
- Invest in children's health, safety, education and well-being
- Align public finances, information technology and human resources to support the healthy growth and development of children
- Ensure a long-term commitment to at-risk children and youth
- Improve family and child outcomes related to the Cabinet's vision for children
- Engage families, the community, stakeholders and businesses to improve child and family outcomes

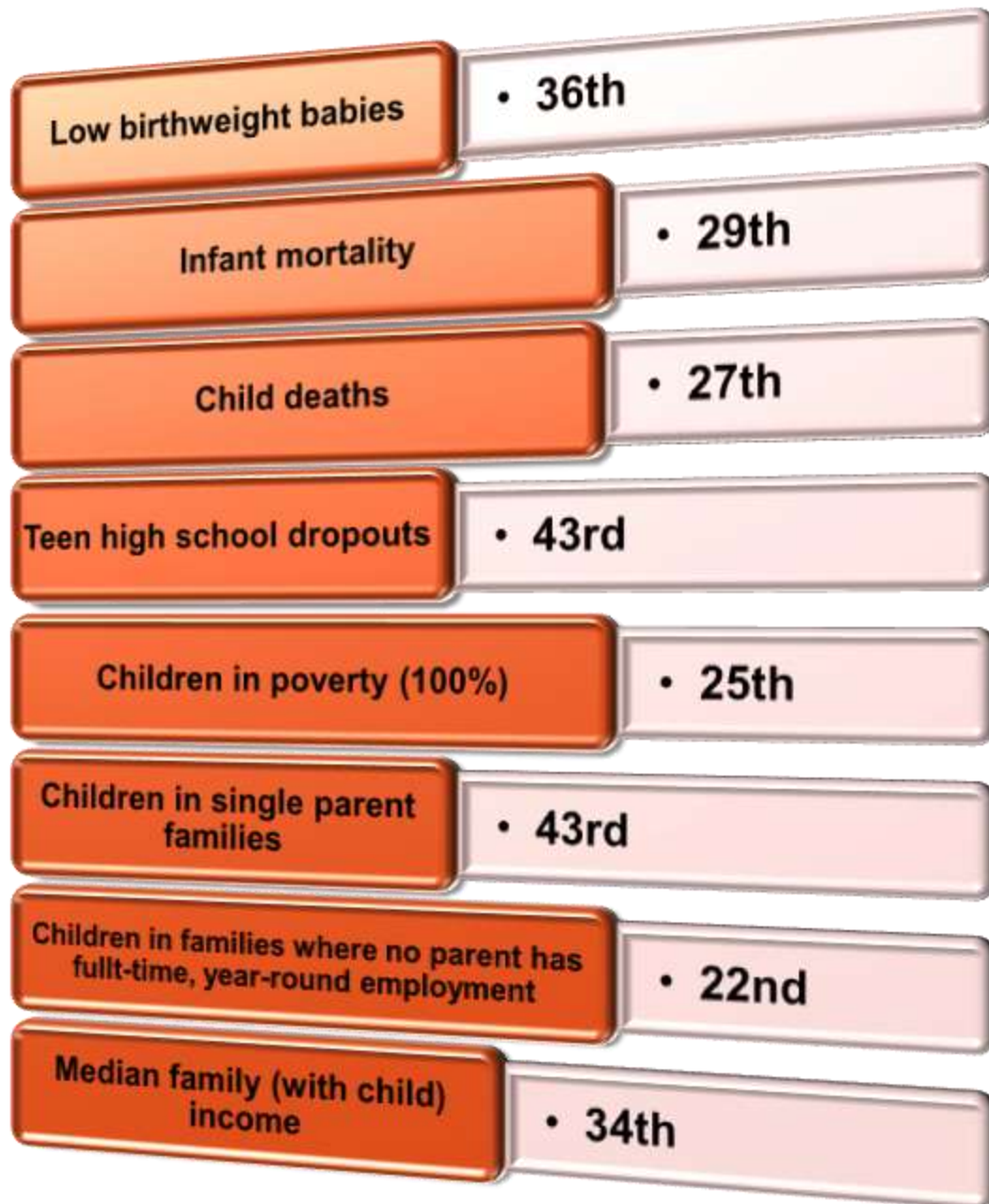
This report is provided as a tool for your use with all the experience, insight and skills you already possess. We believe this report will only realize its full value when accompanied by a strong and enduring commitment to Florida's children ... assuring they are healthy, learning, succeeding and nurtured by stable families living in safe and supportive communities. That is your challenge and your charge. We join you in this commitment because Florida's future depends on it.

Steve Freedman  
Chairman, The Policy Group for  
Florida's Families and Children

Ted Granger  
Chairman, The Children's Summit  
Workgroup

## How Florida Ranks with Other States on Selected Indicators

The Annie E. Casey Foundation ranks Florida 35<sup>th</sup> in the country overall based on several measures of child well-being – low birth weight babies; infant mortality rate; child death rate; teen death rate; teen birth rate; high school dropouts; teens not attending school and not working; children in families where no parent has full-time, year-round employment; children in poverty; and single parent families.<sup>1</sup> The ranking is based on changes in these indicators over the 5-year period 2000-2005.



<sup>1</sup> [http://www.kidscount.org/datacenter/profile\\_results.jsp?d=1&r=11](http://www.kidscount.org/datacenter/profile_results.jsp?d=1&r=11) Reported2007

## Report Recommendations for Improving Florida Child Well-Being

The State of Florida's Child Report recommendations are that the Florida Cabinet for Children and Youth:

1. Adopt the outcomes accountability process described in this report.
2. Identify and adopt a prioritized set of indicators that it will use as a roadmap for improving the lives of Florida's children by linking them to outcomes, budget and strategies to achieve the goals set forth in its strategic plan. The Cabinet may wish to shorten the list of indicators in each outcome area for priority focus moving forward.
3. Discuss and adopt strategies for financing an agenda to improve outcomes for children and families<sup>2</sup> as the Cabinet State Agency Budget Committee continues work on aligning state expenditures for children to *outcomes adopted by the Cabinet*. Specifically, the Cabinet examine and determine ways to redeploy resources already in the system, find new resources and restructure funding in a way that creates incentives to invest in prevention, use some funds flexibly and change the way programs and services work together for children and families.
4. Study, discuss and determine performance measures that allow state agencies to articulate and monitor their participation *programmatically* in reaching the goals discussed in this report and in improving results on the prioritized indicators.
5. Develop and implement *cross-agency* action plans focused on improving prioritized indicators. The Cabinet may wish to assign a state agency lead in convening partners and developing plans, but is encouraged to maintain a focus on integration of effort toward changing outcomes.
6. Determine where gaps and inconsistencies occur and develops ways to address them.
7. Establish a process for ongoing monitoring and updating of progress, including continued collaboration with the early childhood partners developing a framework, the Governor's Office on Child Adoption and Protection, the Child Abuse Child Abuse Prevention and Permanency Advisory Council and others interested in ensuring continuity and consistency across disciplines.

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<sup>2</sup> [http://www.raguide.org/RA/financing\\_self\\_assessment.htm](http://www.raguide.org/RA/financing_self_assessment.htm)

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# The State of Florida's Child

## A Florida Children and Youth Cabinet Report

### Introduction

The State of Florida's Child Report provides data and information from which the Florida Cabinet for Children and Youth can move toward its stated goal of promoting increased efficiency and improved service delivery by all governmental agencies that provide services for children and their families in Florida. This report, developed and written over the 10 months since the Cabinet approved the Workgroup recommendations May 19, 2008, collects baseline data that relate closely to indicators (or outcomes) shown by research to signify child well-being or improvement in child well-being. These indicators may be used to form a "results" framework leading to shared goals and a cohesive vision for child and youth outcomes. Ultimately, the results framework can and should be linked to resources and state budgets.

### Observations from The Children's Summit Workgroup

The State of Florida's Child Report is best viewed as a starting point. The data yield no surprises and point no fingers. Rather, the report provides a foundation for the Cabinet for Florida's Children and Youth to focus state work and create the "cohesive vision" stated in the strategic plan. There now is a wonderful opportunity to use this report to create meaningful ways to improve child well-being outcomes and evaluate results. This will require the investment of all stakeholders and a fierce determination even in tough economic times to accept nothing less than positive progress toward child well-being. Every Florida child deserves no less.

*If not us, who? If not now, when?*

QUOTE DERIVED FROM HISTORY<sup>3</sup>

### Origin of This Report

Early in 2008, the Florida Cabinet for Children and Youth asked the Children's Summit Workgroup to address the following specific sections of the Cabinet's strategic plan:

*Florida Children and Youth Cabinet Goal 1: Promote increased efficiency and improved service delivery by all governmental agencies that provide services for children, youth and their families*

<sup>3</sup> Around 70 B.C.E., Rabbi Hillel was born to a wealthy family in Babylonia, but came to Jerusalem without the financial support of his family and supported himself as a woodcutter. It is said that he lived in such great poverty that he was sometimes unable to pay the admission fee to study Torah, and because of him that fee was abolished. He was known for his kindness, his gentleness, and his concern for humanity. One of his most famous sayings, recorded in Pirkei Avot (Ethics of the Fathers, an essay of the Mishnah), is "If I am not for myself, then who will be for me? And if I am only for myself, then what am I? And if not now, when?" The Hillel organization, a network of Jewish college student organizations, is named for him. The quote as presented above is often attributed to the late Robert Kennedy.

*1a. Develop and implement a shared and cohesive vision for child and youth outcomes across state agencies, departments and programs*

*Florida Children and Youth Cabinet Goal 5:* Build, allocate and align sufficient resources and functions to meet the goals set forth by the Children and Youth Cabinet.

*5c: Identify gaps and resources required to meet the health, safety, educational and support needs of children and their families.*

Consensus among the Workgroup was that in order to identify gaps and resources to meet needs (5c) and implement a shared, cohesive vision (1a), it was first necessary to understand Florida's current status regarding our children. Once a "baseline" was established, it would then be possible for the Cabinet to more fully address the goals. The Workgroup prepared a concept paper on The State of Florida's Child, which formed the basis for this report and which included the following recommendations:

Long-term recommendation: Develop policies, practices and stable funding levels sufficient to meet quality standards that support communities in establishing integrated services for children and their families.<sup>4</sup>

Short-term recommendation: Develop a State of Florida's Child Report.

### How the Report Is Organized

*The State of Florida's Child* is presented in three main sections.

- The first section, **beginning on page 4**, provides a snapshot of Florida's children and Florida's status on some key indicators of child well-being. The section continues with a review of indicators (with Florida and United States comparisons) in four goal areas – healthy children, quality early learning experiences, stable and nurturing families, and safe and supportive communities - corresponding to the Cabinet's strategic vision goal areas.
- The second section, **beginning on page 36**, discusses an outcomes accountability process for changing baselines in positive directions, and includes an overview of strategies that work to improve outcomes for children.
- The third section, **beginning on page 47**, offers recommendations for moving forward.



<sup>4</sup> Foster, B., & Ghazvini, A. (2003)

## Comments on Data Availability

This report used a variety of data sources including respected Kids Count data and Child Trends data. All indicator data sources are provided, **beginning on page 51**. Most of the indicators present state data and national data for comparison. In all instances, the most current data available have been provided, even though the data may be from years prior to 2009. It should be noted that it is not unusual for some data to be reported annually, but collected in a previous year or years and simply updated annually. In some instances, states may change how they collect data and so comparisons cannot be made. In still other instances, data are collected during a given year, with extrapolated and/or further analyzed information released in subsequent years before data are again collected.

There are instances where only state data are provided, since the information is currently being collected and reported by the state because it is useful or unique to Florida's needs. Two well-being areas – health and readiness to learn - include risk indicators in addition to indicators of well-being. The risk indicators cover areas of general interest such as teen drinking, but are not considered well-being indicators in the truest sense. They are included here because they relate to age groups within the purview of Florida's Cabinet for Children and Youth. All Florida Performs<sup>5</sup> measures were reviewed for applicability to child well-being outcomes.

The capacity for monitoring child and youth well-being on the state, national and local level is limited but improving. Gaps in existing state-level child indicator systems include a shortage of data in important areas such as social-emotional development, positive behaviors and the influence of neighborhoods; scarcity of data for infants to about age 10; narrowly-focused surveys that collect data; and frequency of data collection to allow useful application of information to policy and practice.<sup>6</sup>

Finally, the indicators presented here were chosen based on research, input from a variety of state sources (see **Collaborations, page 48**), alignment with the Cabinet's strategic plan and ability to provide useful and helpful insight to the Cabinet. There is no intention to present these indicators as the only ones that definitively measure child well-being. (For a thorough overview of indicator use, see *A Guide to Resources for Creating, Locating, and Using Child and Youth Indicator Data*, Brown, Hashim & Marin, 2008 [Online]. Available at [http://www.childtrends.org/Files//Child\\_Trends-2009\\_01\\_05\\_FR\\_ChildIndicatorGuide.pdf](http://www.childtrends.org/Files//Child_Trends-2009_01_05_FR_ChildIndicatorGuide.pdf)).

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<sup>5</sup> [www.floridaperforms.org](http://www.floridaperforms.org)

<sup>6</sup> Brown & Moore, 2009

## Florida's Children

Of the 7-million households in Florida, about 3 in 10 include children under the age of 18. A little more than a million of these children are under the age of 5. Florida is very similar to the nation in terms of the distribution of youth by age group (Figure 1).

Twenty-two percent of Florida's total population is under 18 (N = 4.043-million), compared to 25% nationally. Fifty-one percent of the state's youth population is male. According to Kids County data compiled by The Annie E. Casey Foundation (2008), Florida ranks 14<sup>th</sup> in the country for grandparents taking care of grandchildren (5%), and 6<sup>th</sup> for children living in immigrant families (29%). Florida ranks 25<sup>th</sup> in the country for children living in poverty (17%).

The majority of Florida's children are in married couple households, but almost 36% are in single parent households (Figure 2). Florida's median household income level is \$46,602, yet 14.3% of families with children under 18 had incomes below poverty level in the past 12 months, according to 2005-2007 Census Data Bureau figures. This number likely has increased as a result of the economic stresses of the past months.

Seventy-eight percent of Florida's population was born in the United States. Between 2000 and 2010, Florida's population is projected to grow by 20%.<sup>7</sup> Census data in the prior 10-year census period show that Florida grew by 23.5% although this growth was

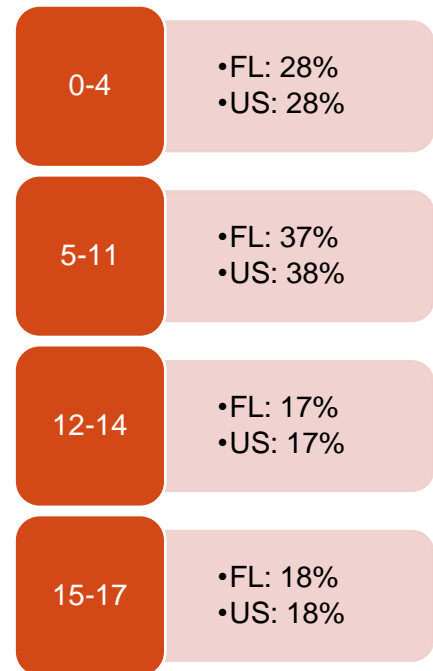


FIGURE 1 – FLORIDA CHILD POPULATION BY AGE GROUP (2005)

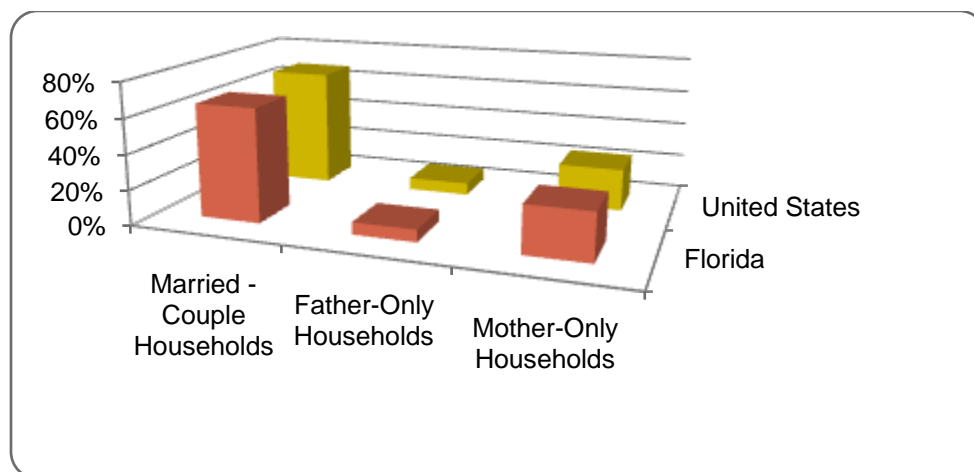


FIGURE 2 - PERCENTAGE OF FLORIDA CHILD POPULATION BY HOUSEHOLD TYPE, 2006

<sup>7</sup> Census Bureau, *Selected Social Characteristics in the United States: 2005-2007*, Data Set: 2005-2007 American Community Survey 3-Year Estimates, available online at [http://factfinder.census.gov/servlet/ADPTable?\\_bm=y&-geo\\_id=04000US12&-context=adp&-ds\\_name=ACS\\_2007\\_3YR\\_G00\\_&-tree\\_id=3307&-lang=en&-caller=geoselect&-format=](http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US12&-context=adp&-ds_name=ACS_2007_3YR_G00_&-tree_id=3307&-lang=en&-caller=geoselect&-format=)

not evenly distributed across the state. During that same period, the proportion of Hispanics, African-Americans and Asians also grew. Nearly half of Florida’s children live in non-Hispanic white households, and more than 20% live in Hispanic or Latino households (Figure 3).

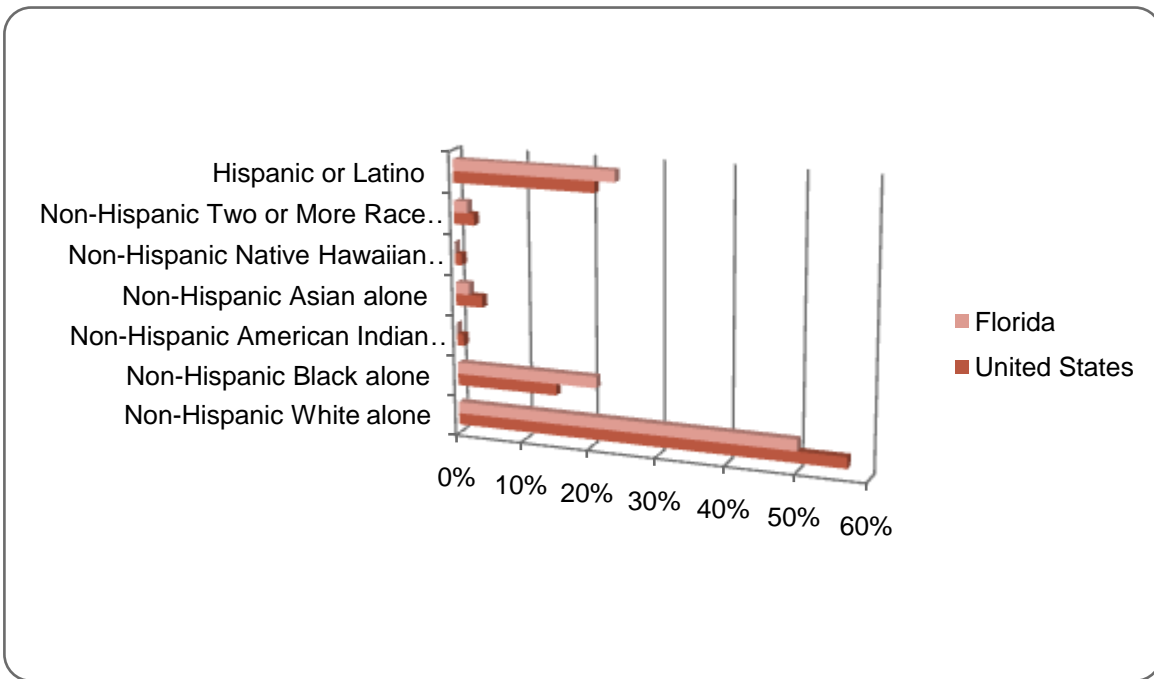


FIGURE 3 - PERCENTAGE OF CHILD POPULATION BY RACE (2007)

The future for Florida and its children holds many challenges. According to the Children’s Defense Fund’s *State of America’s Children 2008*,<sup>8</sup> of the 74-million children in the United States, more than half of them live in only nine states, one of which is Florida. More than half of all the poor children in the United States live in only eight states, among which Florida ranks 4<sup>th</sup>. More than half of all uninsured children live in six states, of which Florida ranks 3<sup>rd</sup>. Florida is one of only four states where fewer than 2/3 of ninth-graders graduate from high school within four years with a regular diploma.

<sup>8</sup> Retrieved 1/20/09 from [http://www.childrendefense.org/site/PageServer?pagename=policyareas\\_stateamericaschildren\\_2008](http://www.childrendefense.org/site/PageServer?pagename=policyareas_stateamericaschildren_2008)

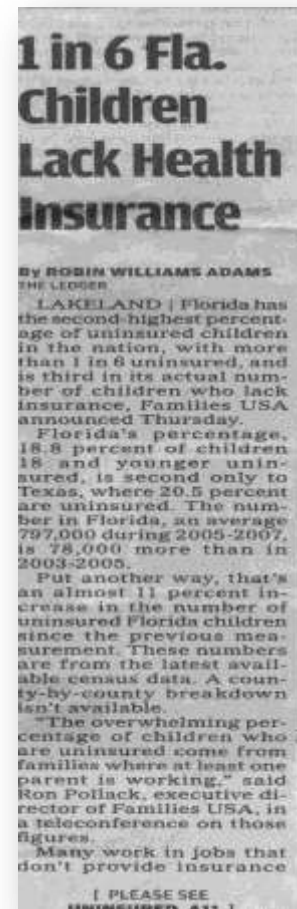
## Every Florida Child Deserves to be Healthy

All children need basic health care. Many health problems that might otherwise threaten a child's overall well-being can be prevented or treated. In the landmark national report, *From Neurons to Neighborhoods*,<sup>9</sup> early childhood is recognized as the great opportunity for optimizing health and developmental outcomes across the child's lifespan. There are certain conditions that children require in order to grow and develop to their fullest potential. In addition to dependable, nurturing relationships with healthy parents and caregivers and adequate family resources, health and developmental services are paramount.

Yet our current service delivery systems to support families have major deficiencies.<sup>10</sup> Developmental delays are frequently not identified by health care providers. Many families have difficulty accessing health care, and coordination among service providers is low. Mental health and oral health services for children are often unavailable, and 26.9% of children with special health care needs (CSHCN) ages birth-17 needing a referral have difficulty getting it.<sup>11</sup>

Research clearly demonstrates that children's health benefits from:

- **Improving health knowledge.** Strategies to improve health knowledge for parents and caregivers include a focus on wellness and health issues beginning in the early childhood setting and extending into school settings.
- **Accessible, affordable health care insurance.** All children, from conception to age 18, need access to preventive wellness care as well as treatment for acute and chronic conditions.
- **Expanding access to health care services and reducing disparities in access, treatment and quality of care.** Federal and state efforts to reduce racial and ethnic health disparities have resulted in designated funding for local community health efforts as well as advisory council identification of strategies to close the gaps in health outcomes.
- **Developing policies across agencies, funding sources and systems to integrate physical, dental and mental health services with educational, economic and social supports.** In order to create a wellness system, all aspects of health must be included, and support systems must be in place and integrated to help



<sup>9</sup> National Research Council & Institute of Medicine, 2000

<sup>10</sup> Halfon, Uyeda, Inkelas, & Rice, 2004

<sup>11</sup> U.S. Department of Health and Human Services, 2005,2006

families access, afford and utilize health services. Gaps in income and social opportunity must be addressed.

The goal statement in this section has been developed in tandem with the early childhood framework partners to align with the Cabinet's goals. The indicators and baselines in this section show Florida's status on measures of maternal and newborn health, health care for children, screening, identification and treatment of special needs, child morbidity and mortality, and risk indicators. Data sources for this section begin *on page 53*.

**GOAL: All Florida's children are physically, socially, emotionally and mentally healthy**

TABLE 1 - HEALTHY CHILDREN INDICATORS

Data sources for these indicators are on page 53

**MATERNAL AND NEWBORN HEALTH**

**Infants born to mothers receiving late or no prenatal care**

<p>Births that occurred to mothers who reported receiving prenatal care only in the third trimester of their pregnancy, or reported receiving no prenatal care</p>	<p><b>FL: 6.7%</b> <b>N=5,952</b> <b>US: NA*</b></p>
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**Subsequent pregnancies within two years of the previous birth**

<p>% of deliveries by women within an inter-pregnancy interval (IPI) of less than 18 months<sup>12</sup></p>	<p><b>FL: 37.9%</b> <b>N = 40,669</b> <b>US: 39.8%</b></p>
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**Children whose mothers are healthy**

<p>% of children birth to 17 whose mothers' health is excellent or very good  (Weighted estimate of the number of children based on number of valid responses to survey questions)</p>	<p><b>FL: 67.5%</b> <b>N=2,425,100</b> <b>US: 66.2%</b></p>
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**Low birth weights (under 2,500 grams or 5.5 pounds)**

<p>Low birth weight: live births weighing less than 5.5 pounds</p>	<p><b>FL: 8.7%</b> <b>N = 20,633</b> <b>US: 8.2%</b></p>
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<sup>12</sup> Florida data represent both Medicaid and non-Medicaid deliveries. The national data from the Centers for Disease Control Pregnancy Nutrition Surveillance System (PNSS) represent low-income women. The Florida percentage for Medicaid-only deliveries is 41.7% and for non-Medicaid deliveries, 34.5%.

## HEALTH CARE

### Young children who complete the basic series of immunizations

Percentage of children ages 19-35 months who have 4:3:1 Series Coverage	<b>FL: 80.3%</b> <b>N=265,931</b> <b>US: 77.4%</b>
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### Children with medical home or primary health care provider

% children ages 0-17 who receive health care that meets the American Academy of Pediatrics (AAP) definition of medical home, defined as primary care that is accessible, continuous, comprehensive, family- centered, coordinated, compassionate, and culturally effective	<b>FL: 43%</b> <b>N=1,659,575</b> <b>US: 46.1%</b>
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### Children without health insurance

Children under age 18 who were not covered by health insurance at any point during the year	<b>FL: 19%</b> <b>N = 822,000</b> <b>US: 12%</b>
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### Children receiving preventive health care

% children ages 0-17 who had at least one preventive medical care visit in the past year (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 78.2%</b> <b>N=3,020,590</b> <b>US: 77.8%</b>
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### Children receiving preventive dental care

% children ages 0-17 who had at least one preventive dental care visit in the past year (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 65.1%</b> <b>N=2,383,392</b> <b>US: 72.1%</b>
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Data sources for these indicators are on pages 55-56

## SCREENING, IDENTIFICATION AND TREATMENT OF SPECIAL NEEDS

### Children with special health care needs

Children with special health care needs (CSHCN) 0-17 years of age	<b>FL: 13.4%</b> <b>N=551,263</b> <b>US: 13.9%</b>
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### Children with special health care needs who have a medical home

Children 0-17 with special health care needs (CSHCN) who receive coordinated, ongoing, comprehensive care within a medical home (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 41.9%</b> <b>N=215,426</b> <b>US: 47.1%</b>
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### Parents concerned about children's learning, development or behavior

% children ages 0-5 whose parents have one or more concerns about child's learning, development or behavior indicating moderate or high risk for developmental delay (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 37.7%</b> <b>N=478,565</b> <b>US: 36.6%</b>
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### Children not receiving specific health care services necessary for identified developmental delays and special needs

Children with special health care needs (CSHCN) <sup>13</sup> ages 0-17 with any unmet need for specific health care services (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 17.6%</b> <b>N=73,922</b> <b>US: 12.2%</b>
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<sup>13</sup> Children with special health care needs are defined as "those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (Maternal and Child Health Bureau, as cited by the Data Resource Center for Child and Adolescent Health, Child and Adolescent Health Measurement Initiative, November 2007)

Data sources for these indicators are on page 56-57

### Children receiving some mental health care in the past year

Percentage of children 1-17 with emotional, behavioral, or developmental problems receiving some mental health care in the past year	<b>FL: 54.7%</b> <b>N=157,883</b> <b>US: 61.9%</b>
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### Children with socio-emotional difficulties

% children ages 3-17 with moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 9.3%</b> <b>N=304,223</b> <b>US: 9.2%</b>
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## CHILD MORBIDITY/MORTALITY

### Children with moderate or severe health problems

% of children 0-17 with health problems rated as moderate or severe by parents (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 8.3%</b> <b>N=324,419</b> <b>US: 7.9%</b>
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### Children affected by asthma

% children ages 0-17 affected by asthma during past year (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 8.4%</b> <b>N=324,215</b> <b>US: 8%</b>
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### Child deaths

Deaths to children between ages 1 and 14, from all causes, per 100,000 children in this age range	<b>FL: 22</b> <b>US: 20</b>
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Data sources for these indicators are on pages 58-59

### Infant deaths that occur before age 1

Deaths occurring to infants under 1 year of age per 1,000 live births	<b>FL rate: 7.2</b>
	<b>US rate: 6.9</b>
	Child deaths occurring to infants under 1 by race, rate per 1,000 in Florida:
	Non-Hispanic white FL: 5.9 <b>N=582</b> US: 5.7
	Black or African American FL: 12 <b>N=531</b> US: 13.7
	American Indian FL: Suppressed <sup>14</sup> US: 8
	Asian and Pacific Islander FL: 4.4 <b>N=23</b> US: 3.8
Hispanic or Latino FL: 4.6 <b>N=451</b> US: 5.8	

<sup>14</sup> Estimates from the American Community Survey (ACS) are suppressed when the total confidence interval (upper bound minus lower bound) of the percent estimate, is 10 percentage points or greater. Rates from Vital Statistics data are suppressed when based on fewer than 20 births or death.

Data sources for these indicators are on page 59

## RISK INDICATORS

### Household smoking

<p>% children ages 0-17 who live in households where someone smokes</p> <p>(Weighted estimate of the number of children based on number of valid responses to survey questions)</p>	<p><b>FL: 30%</b></p> <p><b>N=1,017,720</b></p> <p><b>US: 29.5%</b></p>
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### Overweight adolescents

<p>Weight status of children 10-17 based on Body Mass Index (BMI) for age</p> <p>(Weighted estimate of the number of children based on number of valid responses to survey questions)</p>	<p><b>FL: 14.4%</b></p> <p><b>N=245,653</b></p> <p><b>US: 14.8%</b></p>
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### Binge alcohol drinking among youths

<p>Binge alcohol drinking within the prior 30 days among 12- to 17-year-olds</p>	<p><b>FL: 9%</b></p> <p><b>N=132</b></p> <p><b>US: 10%</b></p>
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### Illicit drug use other than marijuana

<p>Illicit drug use other than marijuana use in the past month among 12- to 17-year-olds</p> <p>Illicit drugs other than marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.</p>	<p><b>FL: 5%</b></p> <p><b>N=143</b></p> <p><b>US: 5%</b></p>
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### Marijuana use

<p>Marijuana use in the past month among 12- to 17-year-olds</p>	<p><b>FL: 7%</b></p> <p><b>N=97</b></p> <p><b>US: 7%</b></p>
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*Data sources for this indicator are on page 59*

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### Middle and high school students using tobacco

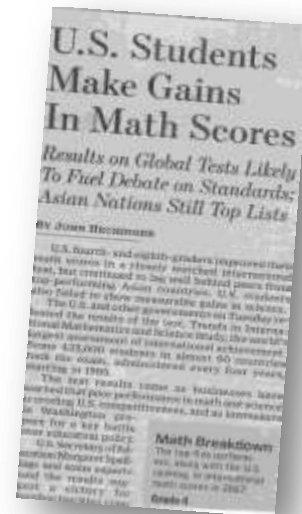
Tobacco product use in the past month among 12- to 17-year-olds	<b>FL: 7%</b> <b>N=162</b> <b>US: 11%</b>
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## Every Florida Child Deserves Quality Early Learning Experiences

High-quality comprehensive early childhood services for at-risk families with young children can improve children's life outcomes.<sup>15</sup> Features of effective early childhood programs include well-trained caregivers, smaller child-to-staff ratios, and more intensive and comprehensive programs.<sup>16</sup> Striking disparities in what children know and are able to do are evident well before they enter kindergarten. Brain research underscores the importance of early experience and environmental inputs in helping create and strengthen important neural pathways that impact hearing, vision, motor skills, and cognitive and emotional development.

High-quality early childhood settings offer economic benefits, as well. The economic development impacts of quality early childhood settings include effects on regional economies (in terms of jobs, income and purchase of commodities in other economic sectors), effects on parents (supporting workers and their employers), and effects on children (building human capital)<sup>17</sup>.

Early childhood education costs in Florida amount to \$5,720 to \$7,280 or more a year for one child.<sup>18</sup> For low-income families, assistance is essential in order for them to be able to work and remain self-sufficient. Mothers who receive child care assistance are 40% more likely to remain employed after two years than those who do not receive assistance.<sup>19</sup> Former welfare recipients with young children are 82% more likely to be employed after two years if they receive child care assistance.<sup>20</sup> Unfortunately, assistance often is not available and not provided in quality programs.<sup>21</sup> On average during FY 2007/2008, there were 48,857 children on the waiting list for subsidized child care each month in Florida. As of Dec. 31, 2008, that number had risen to an average of 57,225!<sup>22</sup> In addition, both the Child Care Development Block Grant (CCDBG) and Targeted Assistance to Needy Families (TANF) funds have been declining. Without new state or federal funds, the number of children in low-income families who receive assistance will continue to decline and the quality of the services they receive will fall farther behind. Studies show that families who lose child care assistance are often forced to quit their jobs, change work hours, spend their savings, go into debt, turn to welfare, or choose lower quality, less stable child care.<sup>23</sup>



<sup>15</sup> National Governors' Association, 2005

<sup>16</sup> Karoly et al, 2005

<sup>17</sup> Grunewald & Rolnick, 2006

<sup>18</sup> National Association of Child Care Resource and Referral Agencies, 2007

<sup>19</sup> Schulman & Blank, 2008

<sup>20</sup> Schulman & Blank, 2008

<sup>21</sup> Schulman & Blank, 2008

<sup>22</sup> AWI Office of Early Learning, 2009

<sup>23</sup> Matthews, 2006

Research demonstrates that children clearly benefit from:

- **Early learning environments, including the home, with positive social interaction.** Children in quality early learning environments have less anxiety, develop more secure relationships with caregivers, and have more positive interactions with peers compared to less competent play, more behavior problems, and more negative interactions with peers among children in low-quality settings.
- **Quality early learning settings and qualified early learning staff.** Higher scores on readiness assessments and standardized cognitive and language competence tests are found among children in quality early childhood environments.
- **Accessible and affordable early learning opportunities.** Children in quality early childhood settings are more likely to graduate, be gainfully employed, own a home, and avoid criminal activity. Employed parents/caregivers are more productive when they can depend upon and afford outside care for their children.
- **Appropriate early intervention for identified developmental issues.** There are key transition points in the development and adaptation of children and their parents. Early identification of a missed or delayed developmental stage can be a strong indicator of the need for treatment of, or intervention for, a disability or delay. Early intervention can lessen the impact of the delay or disability on the child and the family. Early identification of and intervention for behavioral issues may allow a child to remain comfortably in his or her early care and education setting instead of being expelled. In Florida, children are expelled from prekindergarten programs at a rate of 6.64 per 1,000 prekindergarten children,<sup>24</sup> which is about 880 prekindergarten students.<sup>25</sup>

Meaningful early learning experiences are not entirely relegated to early education and care settings. A family environment that values learning and creates opportunities for rich interactions and relationships helps encourage early learning and later educational success. For all children, not just those in early care and education programs, parents are the most influential adults in their lives.<sup>26</sup>

The goal statement in this section has been developed in tandem with the early childhood framework partners to align with the Cabinet's goals. The indicators and baselines in this section show Florida's status on accessible and affordable early care and education programs, quality early care and education settings, children ready to succeed, early intervention for children with special needs, and a qualified early care and education workforce. This section also contains several risk indicators that can be ameliorated by meaningful early learning experiences. Data sources for this section begin **on page 60**.

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<sup>24</sup> Gilliam & Shabar, 2006

<sup>25</sup> Agency for Workforce Innovation Office of Early Learning enrolled 132,718 prekindergarten students in 2007-2008. Retrieved online 2/18/09 at [http://www.floridajobs.org/earlylearning/factbook/vpk\\_1\\_c.aspx](http://www.floridajobs.org/earlylearning/factbook/vpk_1_c.aspx)

<sup>26</sup> Shonkoff & Phillips, 2000

**GOAL: All infants and young children will experience nurturing, developmentally appropriate early learning opportunities**

TABLE 2 - READY TO LEARN AND SUCCEED INDICATORS

Data sources for these indicators are on page 60

**ACCESSIBLE AND AFFORDABLE EARLY LEARNING OPPORTUNITIES**

**Affordability of child care**

<p>Percentage of median income expended on the annual average price of child care</p> <p>FL annual average price of preschool care: \$5,720-\$5,980 US: \$3,536 to \$10,920</p> <p>FL annual average price of infant care: \$6,760-\$7,280 US: \$4,160 to \$14,627</p> <p>FL annual average price for two children in care: \$13,000 US: \$7,072 to \$25,480</p>	<p><b>FL:</b></p> <p><u>Single parent:</u></p> <p>Preschool care: 24.3%</p> <p>Infant care: 31%</p> <p><u>Two parents:</u></p> <p>Preschool care: 8.6%</p> <p>Infant care: 11%</p> <p><b>US:</b></p> <p><u>Single parent:</u></p> <p>Preschool care: 27.4%</p> <p>Infant care: 38%</p> <p><u>Two parents:</u></p> <p>Preschool care: 9.3%</p> <p>Infant care: 11.8%</p>
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Data sources for these indicators are on page 60

### Child care issues affecting parents

% children ages 0-5 whose parents had to make different child care arrangements in the past month or a job change for child care reasons in the past year, or both  (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 38.1%</b>
	<b>N=483,154</b>
	<b>US: 33.2%</b>

### Eligible children under 6 receiving child care subsidies

Child Care and Development Fund (subsidized child care) estimates of eligible population served monthly by age cohort (FY 2006 – Final Data July 2008)  FL average adjusted number of children served monthly: 108,600  US average adjusted number of children served monthly: 1,770,100	<b>FL</b>	<b>US</b>
	0-1: 5%	0-1: 6%
	1-2: 11%	1-2: 10%
	2-3: 14%	2-3: 12%
	3-4: 14%	3-4: 13%
	4-5: 14%	4-5: 13%
	5-6: 11%	5-6: 10%

## QUALITY EARLY CARE AND EDUCATION SETTINGS

### Centers with Gold Seal accreditation

Percent of all child care programs in Florida designated Gold Seal in Florida	<b>FL: 22%</b>
	<b>N=2,994</b>
	<b>US: NA</b>

### Centers with NAEYC accreditation

Percent of licensed facilities with accreditation by the National Association for the Education of Young Children <sup>27</sup>	<b>FL: 8%</b>
	<b>N=519</b>
	<b>US: 7%</b>

<sup>27</sup> Florida Statute 402.281(1) regarding the Gold Seal quality care program acknowledges accreditation by the National Early Childhood Program Accreditation Commission (NECPA) as well as NAEYC accreditation. Currently there are 21 NECPA accredited programs in Florida (0.34% of licensed facilities) and 300 in the United States. Retrieved 2/25/09 from [www.necpa.net](http://www.necpa.net)

Data sources for these indicators are on pages 60-61

### Family child care homes accredited by the National Association for Family and Child Care (NAFCC)

Percent of family child care programs accredited by the National Association for Family and Child Care (NAFCC)	<b>FL: 7%</b> <b>N=295</b> <b>US: 0.9%</b>
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### Children who are read to by their parents and relative caregivers

% of children 0-5 read aloud to by family members every day during the past week	<b>FL: 42.9%</b> <b>N=537,625</b> <b>US: 47.8%</b>
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### Mothers who have not graduated from high school

Births to women who had completed fewer than 12 years of education at the time of the birth (2003 revised birth certificate for FL; 1989 birth standard birth certificate for US) Total FL births in 2003: 212,250	<b>FL: 21.2%</b> <b>N=44,997</b> <b>US: 20.9%</b>
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### State investments in early education and care commensurate with K-college educational investments

Per-capita annual investment of state funds invested in provision of ECE programs for 3- and 4- year-olds The amount spent for each K-12 Unweighted Full-Time Equivalent (UFTE) Student. A full-time equivalent (FTE) student for Florida Education Finance Program (FEFP) funding purposes is one student in membership in one or more FEFP programs for a school year or its equivalent. Data on university expenditures is from the Florida Expenditure Analysis Report. (See data sources for more information on this report.)	<b>ECE programs for 3- and 4-year-olds: \$1,000</b> <b>Pre-K per child per year (average): \$2,560</b> <b>K-12 annual per student: \$7,128</b> <b>State university annual per full-time student: \$8,343</b>
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## CHILDREN READY TO SUCCEED

Children who reach their developmental potential in physical well-being and motor development, social and emotional development, problem solving, language development and in cognition and general knowledge based on a valid and appropriate school readiness screening tool

<p>The Florida Kindergarten Readiness Screener (FLKRS) is administered to assess the readiness of each child for kindergarten. The FLKRS includes a subset of the Early Childhood Observation System™ (ECHOS™), which consists of 19 items from 7 domains: language and literacy, mathematics, social and personal skills, science, social studies, physical health and fitness, creative arts. And the FLKRS includes the first two measures of the Dynamic Indicators of Basic Early Literacy Skills™ (DIBELS™) for kindergarten (Letter Naming Fluency and Initial Sound Fluency) to gather information on a child's development in emergent literacy.</p>	<p><b>FL:</b></p> <p><b>DIBELS results 2006:</b></p> <p>Letter naming fluency status: 69.6% were above average/low risk</p> <p>Initial sound fluency status: 63.44% were above average/low risk</p> <p><b>ECHOS results:</b></p> <p>44% were consistently demonstrating what children should know and be able to do at the start of kindergarten</p> <p><b>US: NA</b></p>
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### Children reading on or above fourth grade level

<p>Percentage of fourth-grade public school students at or above grade level</p> <p>Total enrollment 2007: 195,857</p>	<p><b>FL: 34%</b></p> <p><b>N=66,591</b></p> <p><b>US: 32%</b></p>
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Data sources for these indicators are on pages 62-63

### Children with math proficiency on or above fourth grade level

Percentage of fourth-grade public school students on or above grade level Total enrollment 2007: 195,857	<b>FL: 40%</b> <b>N=78,342</b> <b>US: 39%</b>
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## WELL QUALIFIED EARLY CARE AND EDUCATION WORKFORCE

### Early childhood staff with a Child Development Associate credential or equivalent

Percentage of early childhood staff with a Child Development Associate credential or equivalent (See Data Sources for more detailed information about Florida's data and comparability of national data)	<b>FL: 31%</b> <b>N=7,901</b> <b>US: NA</b>
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### Early childhood staff with an associate's degree

Percentage of early childhood staff with an associate's degree (See Data Sources for more detailed information about Florida's data and comparability of national data)	<b>FL: 7%</b> <b>N=1,783</b> <b>US: NA</b>
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### Early childhood staff with a bachelor's degree

Percentage of early childhood staff with a bachelor's degree (See Data Sources for more detailed information about Florida's data)	<b>FL: 11%</b> <b>N=2,643</b> <b>US: 33%</b>
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### Salaries of child care workers

Average salary of a child care worker	<b>FL: \$16,440</b> <b>US: \$18,060</b>
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Data sources for these indicators are on pages 63-64

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### Salaries of preschool teachers

Average salary of a preschool teacher	FL: \$23,520 US: \$24,560
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### Turnover rate for early education and care workforce

Annual average turnover rates of all early care and education teaching staff	FL: 30%+ estimated <sup>28</sup> US: 30%
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## RISK INDICATORS

### Youth in juvenile detention centers

Rate per 100,000 persons under 21 detained, incarcerated or placed in residential facilities. To preserve the privacy of the juvenile residents, cell counts have been rounded to the nearest multiple of three	FL: 397 N=7,302 US: 295
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### Teens not attending school and not working

Teenagers between age 16 and 19 who are not enrolled in school (full- or part-time) and not employed (full- or part-time)	FL: 10% N=87,071 US: 8%
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### Teens who are high school dropouts

Teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates	FL: 9% N=74,719 US: 7%
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<sup>28</sup> Florida has not conducted a comprehensive statewide study of this indicator; however, some counties have commissioned studies which have confirmed national statistics. For example, Duval County found that teachers experienced a 28% turnover rate but teacher aides experienced a 41% rate of turnover. In Seminole County, teachers experienced a 35% turnover rate and teacher aides 39%. It is safe to say that teacher turnover in Florida is at least as poor as national statistics report and likely worse since national data sources generally combine teachers and teacher aides when determining a turnover rate.

## Every Florida Child Deserves a Stable and Nurturing Family

As the primary providers of love, nurturing, security and stability for their children, the adults in families need to have opportunities to gain adequate income, support and housing. Too often, a full-time job at low wages is not enough to support a family, and families require work support benefits that ensure that earning more improves family financial security.

Research suggests that, on average, families need an income equal to about two times the federal poverty level to meet their most basic needs.<sup>29</sup> Forty-one percent of Florida's children live in families with incomes below 200% of poverty, with 29% living in families at 150% of poverty and 7% living in extreme poverty.<sup>30</sup> Most of Florida's jobs are in the retail and service sectors where wages are generally lower paying than other sectors such as manufacturing, transportation and communication.<sup>31</sup> Most of these jobs are located away from low-income housing areas and families often lack reliable, affordable transportation.

In Florida, some funding and eligibility rules for family support programs are lower and more restrictive than the national average, including those related to child care subsidies and income support programs. Even working full-time, many parents cannot get ahead simply by earning more. Work support benefits (e.g., earned income tax credit, child care subsidies, health care coverage, food stamps) are means-tested so that as earnings increase, families begin to lose eligibility before they are self-sufficient. The result is that parents can work and earn more without moving closer to financial security. With fewer resources, these families face tough choices – go hungry; go without health insurance or needed medical care; select cheaper, less stable child care; or live in an unsafe neighborhood or over-crowded housing. Since eligibility and phase-out rules for different programs are typically developed independently, they can have a cumulative effect that is far more severe than policymakers intended.<sup>32</sup>

Families with good formal and informal support systems, economic security, good health and education are better able to respond to stress and threats in appropriate and healthy ways that keep children safe from harm. Socially isolated families lack important informal and formal supports. Such supports also protect families in times of crisis and reduce the risk of child abuse and neglect and of domestic violence.

Although Florida is slowly improving child and family well-being, there remain far too many children and families at risk of and suffering from child abuse, neglect and abandonment. Child



<sup>29</sup> National Center for Children in Poverty, 2006

<sup>30</sup> Annie E. Casey Foundation, 2007

<sup>31</sup> Colburn & deHaven-Smith, 2002

<sup>32</sup> Caughen, 2006

maltreatment and re-abuse rates exceed national averages and the standard set by the federal government.

Research demonstrates that families benefit from:

- **Wages that meet the cost of living.** Working full-time should ensure that families have adequate resources to meet basic needs.
- **Job training and education supports.** In an economy that values education, only about a quarter of the working poor have any education beyond a high school education.<sup>33</sup>
- **Coordination of support program eligibility rules.** Coordination of service eligibility rules and requirements across programs with gradual phase-out of benefits can ensure that family financial security is not threatened even as earnings increase.
- **Higher eligibility limits.** Providing additional supports can help low-wage workers achieve resource adequacy.
- **Educational and parent skill building supports.** Improved educational levels as well as home visiting and parent skill building programs are associated with better parenting skills.
- **Family formation supports.** Resources and services are needed that support healthy marriages and pregnancy planning, including family planning programs to reduce teen pregnancies, lengthen inter-pregnancy intervals and reduce unplanned pregnancies.
- **Domestic violence services and mental health and substance abuse prevention and treatment programs.** Ample and effective services and programs are essential to keeping children safe, including investment in strategies that remove the causes of child maltreatment, sexual violence and domestic violence.
- **Economic and social policies that encourage both parents to be engaged in the care and nurturing of their children.** Children benefit from both parents' involvement in their care and nurturing.
- **Integrated and comprehensive family support services.** Access to needed resources and services and thorough family assessment help to ensure that families have adequate supports in times of crisis and stress.

The goal statement in this section has been developed in tandem with the early childhood framework partners to align with the Cabinet's goals. The indicators and baselines in this section show Florida's status on family employment and income, foster care, child abuse and neglect, family stability and family functioning. Data sources for this section begin **on page 65**.

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<sup>33</sup> Shore, 2000

**GOAL: Parents and caregivers have the resources, knowledge and skills to foster safe, stable and nurturing home environments**

TABLE 3 - STABLE AND NURTURING FAMILIES INDICATORS

*Data sources for these indicators are on page 65*

**FAMILY EMPLOYMENT AND INCOME**

**Children with female householder in the labor force**

Percentage of female households (no husband present) with children under 18 where the mother is in the labor force	<p><b>FL: 64%</b></p> <p><b>N=322,543</b></p> <p><b>US:</b></p>
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**Children with male householder in the labor force**

Percentage of male households (no wife present) with children under 18 where the father is in the labor force	<p><b>FL: 20.6%</b></p> <p><b>N=30,661</b></p>
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**Children with all parents in the labor force**

Percentage of families with own children under 18 where all parents are in the labor force	<p><b>FL: 63.5%</b></p> <p><b>N= 806,818</b></p> <p><b>US: 62-64%</b></p>
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**Median annual income of employed parents with children**

Median annual income for families with own children under age 18 living in the household	<p><b>FL: \$55,534</b></p> <p><b>US: \$60,374</b></p>
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Data sources for these indicators are on pages 66-67

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### Children living in extreme poverty

Percentage of children under age 18 who live in families with incomes less than 50% of the federal poverty level, as defined by the U.S. Office of Management and Budget

**FL: 7%**  
**N=273,534**  
**US: 8%**

### Children living in families with income below the poverty threshold

Percentage of children under age 18 who live in families with incomes below the federal poverty level (100%), as defined by the U.S. Office of Management and Budget

**FL: 18.4%**  
**N=730,048**  
**US: 17.8%**

### Children with a household head who has a bachelor's degree

The share of all children under age 18 living in households where the household head has a bachelor's degree or higher

**FL: 25%**  
**N=976,905**  
**US: 27%**

## CHILD ABUSE AND NEGLECT

### Children who have "some indication" or "verified" evidence of being abused or neglected

Child abuse rate per 1,000 children  
Florida number from FY 2005-2006

**FL: 29.6**  
**N=121,197**  
**US: 12.1**

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Data sources for these indicators are on page 67

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Children who have "some indication" or "verified" evidence of being re-abused or neglected within 6 months of the first report

Percent of children re-abused within 6 months of initial report	FL: 10.8% N=13,089 US: 6.1 %
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Child deaths from abuse or neglect

Child deaths from verified abuse or neglect	FL: 166 US: 2,000
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**FOSTER CARE**

Children in foster care who are placed in a permanent home within 12 months

Percent of all children exiting state supervised foster care who were discharged to a permanent home (does not include private adoptions)	FL: approx. 85% N-3,674 US: 86.3%
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Children awaiting adoptions

Number of children in public foster care waiting to be adopted	FL: 7,478 US: 126,967
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Data sources for these indicators are on page 68

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## STABLE FAMILIES

### Single women giving birth

Percentage of births occurring to women who were unmarried at the time of the birth	<b>FL: 42.8%</b> <b>N=102,408</b> <b>US: 36.9%</b>
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### Children whose mothers are emotionally healthy

% children 0-17 whose mothers' emotional health is excellent or very good (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 74.6%</b> <b>N=2,672,850</b> <b>US: 71.4%</b>
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### Children without family supports necessary for identified developmental delays and special needs

Children with special health care needs (CSHCN) <sup>34</sup> ages 0-17 with one or more unmet needs for family support services	<b>FL: 6%</b> <b>N=33,246</b> <b>US: 4.9%</b>
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### Children living in single parent households

Children under age 18 who live with their own single parent either in a family or subfamily	<b>FL: 36%</b> <b>N=1,406,746</b> <b>US: 32%</b>
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<sup>34</sup> Children with special health care needs are defined as "those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (Maternal and Child Health Bureau, as cited by the Data Resource Center for Child and Adolescent Health, Child and Adolescent Health Measurement Initiative, November 2007)

Data sources for these indicators are on pages 68-69

### Teen mothers with two or more children

Births that were second or higher order births to mothers who were under the age of 20 at the time of the birth	<b>FL: 19.4%</b> <b>N=16,101</b> <b>US: 19.8%</b>
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### Divorce rate

Divorce rate per 1,000 total population	<b>FL: 4.8</b> <b>N=86,367</b> <b>US: 3.6</b>
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## FAMILY FUNCTIONING

### Religious participation

% children ages 0-17 who attend religious services at least once a week (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 55%</b> <b>N=2,142,232</b> <b>US: 55.7%</b>
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### Young children who frequently go on family outings with family members

% children ages birth to 5 who went on family outings with family members 7 or more times during the past week (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 24.6%</b> <b>N=311,161</b> <b>US: 23.8%</b>
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### Children who share meals with their families

% children 0-17 who ate a meal together with their family every day during the past week (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 47.3%</b> <b>N=1,848,030</b> <b>US: 47.2%</b>
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## Every Florida Child Deserves to Live in a Safe and Supportive Community

Safe and stable neighborhoods and communities engender better social interactions among residents and are healthier places for children to grow and develop. Family-friendly neighborhoods provide opportunities for children to play outside and interact with other children and adults in a clean and healthy environment. Neighborhoods associated with poverty, residential turnover, violence, significant unemployment, lack of accessibility and lack of social relationships and trust between neighbors are high-risk environments for families.<sup>35</sup>

Community well-being provides numerous protections for families. Access to social support is a strong mediating factor to crisis and risk for individuals and families. Social support, both informal family and friend networks and formal supports, offers families the resources that often prevent difficult financial, personal or relationship situations from resulting in bankruptcy, homelessness, mental health relapses, child neglect or abuse and other forms of crisis.<sup>36</sup> In socially rich environments, needs and resources tend to balance as individuals can afford to give and share with neighbors. In socially impoverished environments, however, individuals tend to operate in a “scarcity” mode. Interactions among children are more likely to be developmentally destructive with negative effects on cognitive function, physical health and/or emotional well-being. Strong connections with others are more likely to exist in family-friendly neighborhoods.

The availability and accessibility of community services also softens risks for families. Family-friendly neighborhoods have a network of formal supports, including services to assist with education and training, good health, employment and economic security, recreation and housing. When neighborhood services are difficult to find or are uncoordinated, families suffer.

Research demonstrates that families benefit from:

- **Neighborhood planning and code enforcement policies.** Communities can ensure that new home developments incorporate elements that promote neighborhood interactions and pride, a healthy environment, and access to schools, health care and other family supports.



<sup>35</sup> Prevent Child Abuse North Carolina

<sup>36</sup> Atlantic Health Promotion Research Centre, 1999

- **Integrated comprehensive community services.** Coordination and integration of service agencies ensures families have access to the supports they need for family well-being.
- **Neighborhood safety provisions.** Families need to live in homes and neighborhoods that are free of violence.
- **Identification of and intervention for high- risk neighborhoods.** Studies suggest that neighborhoods should be screened to identify high- and low-risk areas. Parents in high-risk areas are less self-sufficient, participate in less reciprocal exchange and do not view their neighborhoods as good places to raise their children. Strong support systems are most needed but are less available in high-risk areas.<sup>37</sup>
- **Community meeting spaces.** Families need opportunities for their children to play and for adults to meet and develop social relationships with their neighbors.

The goal statement in this section has been developed in tandem with the early childhood framework partners to align with the Cabinet’s goals. The indicators and baselines in this section show Florida’s status on safety, housing and homelessness, community support and civic engagement. Data sources for this section begin **on page 70**.

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<sup>37</sup> Garbarino et al, 1992

**GOAL: Citizens are engaged in communities that are safe and promote positive child and family development**

TABLE 4 - SAFE AND SUPPORTIVE COMMUNITIES INDICATORS

Data sources for these indicators are on page 70

**SAFETY**

**Young children with injuries requiring medical attention**

<p>% of children birth to 5 who have had injuries requiring medical attention in the past month  (Weighted estimate of the number of children based on number of valid responses to survey questions)</p>	<p><b>FL: 9.9%</b>  <b>N=125,349</b>  <b>US: 9.4%</b></p>
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**Children dying from injuries**

<p>Deaths to children between ages 1 and 14, from all causes, per 100,000 children in this age range</p>	<p><b>FL: 22</b>  <b>US: 20</b></p>
<p>Deaths to children 15-19, all causes, per 100,000 children in this age range</p>	<p><b>FL: 75</b>  <b>US: 65</b></p>

**Number of days when air quality is good**

<p>Average number of days in Florida metropolitan statistical areas when the air quality was good according to the Air Quality Index (AQI) of the Environmental Protection Agency.</p>	<p><b>FL: 245</b>  <b>US: NA</b></p>
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## HOUSING AND HOMELESSNESS

### Homeless children

Children under 18 who lack a fixed, regular and adequate nighttime residence, or one whose primary nighttime residence is one of the

following places:

A public or private shelter or transitional housing;

A place not meant for human habitation, including parks, the street, or

automobiles;

A temporary residence for persons intended to be in an institution.

**FL: 8,667**

**US: 800,000**

### Children in low-income households where housing costs exceeding 30% of income

The share of children living in low-income households where more than 30% of the monthly income is spent on rent, mortgage payments, taxes, insurance, and/or related expenses. Low-income households are households with incomes less than 200% of the federal poverty level, as defined by the U.S. Office of Management and Budget. The 30% threshold for housing costs is based on research on affordable housing by the U.S. Department of Housing and Urban development (HUD).

**FL: 72%**

**US: 66%**

**Condition of housing**

<p>Percentage of occupied housing units lacking complete plumbing facilities, complete kitchen facilities, or where no telephone service is available</p>	<p><b>FL:</b></p> <p>Lacking complete plumbing, 0.3%</p> <p><b>N=22,061</b></p> <p>Lacking complete kitchen facilities, 0.4%</p> <p><b>N=30,524</b></p> <p>No telephone service available, 6.7%</p> <p><b>N=474,581</b></p> <p><b>US:</b></p> <p>Lacking complete plumbing, 0.4%</p> <p>Lacking complete kitchen facilities, 0.5%</p> <p>No telephone service available, 5%</p>
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**COMMUNITY RESOURCES AND SUPPORTS**

**Children participating in after-school programs**

<p>% of school-age children 6-17 participating in one or more organized activities outside of school</p> <p>(Weighted estimate of the number of children based on number of valid responses to survey questions)</p>	<p><b>FL: 75.8%</b></p> <p><b>N=1,999,279</b></p> <p><b>US: 81%</b></p>
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Data sources for these indicators are on pages 71-72

### Children in supportive neighborhoods

% children ages 0-17 living in neighborhoods parents describe as supportive (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 77.2%</b> <b>N=2,902,418</b> <b>US: 81.4%</b>
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### Children in safe neighborhoods

% children ages 0-17 living in neighborhoods or communities parents feel are usually or always safe (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 83.6%</b> <b>N=3,212,292</b> <b>US: 83.8%</b>
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## CIVIC ENGAGEMENT

### Children who volunteer or do community service

% children ages 12-17 who participate in volunteer work or community service at school, church or in the community during the past 12 months (Weighted estimate of the number of children based on number of valid responses to survey questions)	<b>FL: 58%</b> <b>N=786,957</b> <b>US: 60.2%</b>
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### Voter participation rate

Voting age population turnout rate 2008 general election	<b>FL: 58.4%</b> <b>US: 56.8%</b>
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## Moving from Indicators to Outcomes

The indicator information presented to this point is just one of seven steps that are key to meeting the goals of the Cabinet for Children and Youth. The steps comprise a model for outcomes-based accountability<sup>38</sup> (Figure 4), which starts with a definition of the goal population and ends with action plans that specify performance measures and link to budgets.

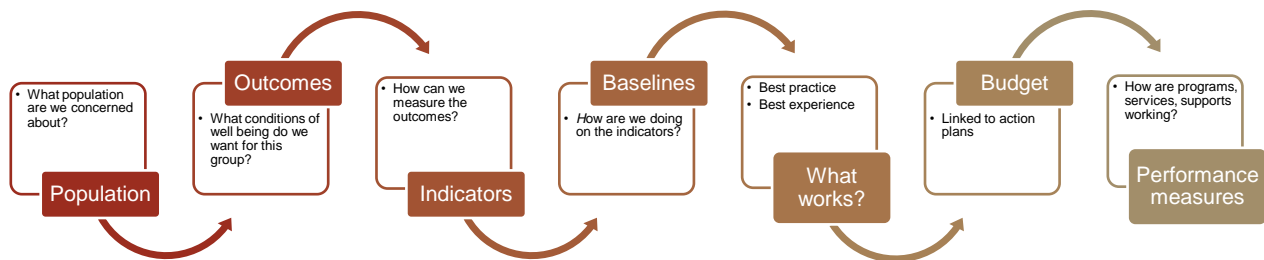


FIGURE 4 - OUTCOMES-BASED ACCOUNTABILITY MODEL

### Establishing the Population

Legislation establishing the Florida Cabinet for Children and Youth directs focus on the population of all of Florida’s children and youth birth to 18 years of age. This report provided several demographic features of Florida’s youth population, **beginning on page 4**.

### Articulating Outcomes

The Cabinet’s strategic plan states a goal of meeting the “health, safety, educational and support needs of children and their families.” The outcomes information in this report answers the question, “What conditions of well-being do we want for this group?” related to each of the goal’s objectives. The outcomes information helps finish the statement, **“Every Florida child deserves ...”**

**... to be healthy (beginning on page 6)**

**... to have quality early learning experiences (beginning on page 15)**

**... to have a stable and nurturing family (beginning on page 23)**

**... to live in a safe and supportive community (beginning on page 30).**

### Selecting Indicators

The research on child well-being outcomes is clear and compelling. Agreement on the outcomes we want for all children provides the foundation for choosing and agreeing on indicators that measure progress. “Indicators can measure risk, process or outcomes. The most important

<sup>38</sup> Friedman, 2005

indicators measure the outcomes of a population as a means of tracking progress toward desired results ... Typically (and ideally), no single program 'owns' these indicators. Indicators reflect a broad responsibility of efforts, yet should have sufficient specificity as measurement tools."<sup>39</sup>

The indicator tables presented in each outcome section provide a baseline of where Florida's children are now, allowing the Cabinet to use the indicators to meet its goal of identifying gaps and allocating resources once the Cabinet establishes priority indicators. Many of the indicators also will be used by the early childhood frameworks partners and others working to align their efforts to improve child well-being.

Using indicators correctly requires making sure that the indicators:

- Measure the appropriate population
- Measure the appropriate geographic level
- Are well conceptualized.<sup>40</sup>

Indicators should not be used:

- To claim credit or blame someone for societal trends
- To claim credit for program success
- To evaluate programs or individuals without considering the larger context.<sup>41</sup>

Many states and communities use a "results-based accountability" approach with indicators of child and family well-being. Results-based accountability starts with the end in mind. Indicators, then, are measures, supported by reliable and routinely available data, which help quantify achievement of results or outcomes.<sup>42</sup>

There are several criteria for choosing indicators:

- **Communicability** – Is the indicator easily explained to policy makers and the public?
- **Relevance** – Does the indicator reflect something of key importance about the desired result?
- **Measurability** – Are data accessible, timely and reliable?

<sup>39</sup> Hogan & Murphey, 2002

<sup>40</sup> Friedman, 2005

<sup>41</sup> Moore et al, 2003

<sup>42</sup> Friedman, 2005

*Tracking important and useful trends and data over time, requires prudent choice and use of indicators. We want to trust that the information we are collecting will tell us what we need and want to know. Many fields successfully develop and use indicators to track all sorts of valuable information. Yet in the broad social policy arena, indicators are underutilized, perhaps because they differ from other types of research, and because policymakers may not know the best way or best time to use them.*

*Measuring and monitoring child well-being and using indicators to report progress has been done since 1940s. Child Trends and The Annie E. Casey Foundation's Kids Count are examples of current practice in social indicator reporting, in that they respond to the demand for accurate measures of the conditions children face and the outcomes of programs and services that address those conditions. (For a more detailed review of the child indicators movement, see The Child Indicators Movement: Past, Present, and Future [Ben-Arieh, 2008]).*

- **Program Neutrality** – Does the indicator keep accountability for populations separate from accountability for programs and agencies?<sup>43</sup>

Finally, a consideration for choosing indicators must be that they are inclusive of child well-being. Indicators increasingly include positive outcomes (as opposed to being primarily focused on negative outcomes), and they place an emphasis on “well becoming,” which means they are predictive of subsequent well-being as well as current well-being.<sup>44</sup>

Indicators that meet these criteria are intended to be used by policymakers and the public to understand trends and patterns and identify areas that need attention. They also may be used for tracking outcomes that may require action other than policy; setting goals; increasing accountability; and informing practice.<sup>45</sup>

*“It is widely recognized that the path to our nation’s future prosperity and security begins with the well-being of all our children. To this end, one of the most important tasks facing policymakers is to choose wisely among strategies that address the needs of our youngest children and their families. Until now, confusing messages about which strategies actually can improve children’s life chances have presented enormous challenges to this decision-making process.” – Center on the Developing Child, Harvard University, 2007*

Because of its importance to decision-making and accountability, an indicator system should not be quickly developed or judged. It takes several years to learn its effectiveness and value, or where there are defects in the system.<sup>46</sup>

### Determining Baselines

The indicators provided in this report utilized a variety of data. The baseline for this report was set to coincide with the inception of the Florida Cabinet for Children and Youth. From this point forward, the Cabinet may continue to track results over time as its strategic plan is implemented and policy and practice are aligned with the strategic plan.

### Knowing What Works

An important component of an outcomes framework is “what works” to achieve the outcomes. 47 “What works” is increasingly not defined on a programmatic level, but instead conceptualized as a collection of strategies or actions – informed policies, best practices, accumulated wisdom and evaluated programs - that have a reasoned chance of producing results. “Strategies are made up of our best thinking about what works, and include the contributions of many partners. No single action by any one agency can create the improved results we want and need.”<sup>48</sup> Knowing what works provides focus on what it will take to improve. The Strategies for Achieving Outcomes” section, **beginning on page40**, provides an overview of strategies that have been proven to be or to have a strong potential to be effective based on research and evaluation of results over time.

<sup>43</sup> Friedman, 2005

<sup>44</sup> Ben-Arieh, 2008

<sup>45</sup> Moore et al, 2003

<sup>46</sup> Hogan and Murphey, 2002

<sup>47</sup> Hogan & Murphey, 2002

<sup>48</sup> Friedman, 2005

## Aligning the Budget

Having baseline data, common goals, and knowing “what works” provides guidance on how to develop budgets for well-being results that span departments and go beyond the formal boundaries of the agencies governed by the budget process itself.”<sup>49</sup>

## Setting Performance Measures

Performance measures are measures of how well public and private programs and agencies are working. They should align to one or more of the outcome indicators and be specified in action plans. “Performance accountability is accountability *by managers to stakeholders for the performance of a program, agency or service system.* It involves identifying the most important performance measures for programs and agencies and holding managers accountable for doing a good job on those measures.”<sup>50</sup>

Indicators measure the ends we want for children and families. Performance measures tell how well we achieve the outcomes. “The focus is on results and performance, not just on the number of clients served or encounters. The question asked of agencies and service providers shifts from ‘Did you do what they told you to do?’ to ‘Did it work? What difference did it make in outcomes for children?’”<sup>51</sup>

*No one agency or program “owns” a common goal; we all do. But a single agency or program can and should own the performance measures or outcomes for which it is accountable and over which it has control.*

TABLE 5 – INDICATORS VS. PERFORMANCE MEASURES

Indicators are about <u>whole</u> populations.	Performance measures are about <u>client</u> populations.
Indicators are usually about peoples’ lives, whether or not they receive any service.	Performance measures are usually about people who receive service.
Indicators are proxies for the well-being of whole populations	Performance measures are about a known group of people who get service and conditions for this group can be precisely measured.

SOURCE: FRIEDMAN, 2005

<sup>49</sup> Friedman, 2005

<sup>50</sup> Friedman, 2005

<sup>51</sup> Schorr, 1994

## Strategies for Achieving Outcomes

The vision of the Florida Cabinet for Children and Youth is that “all children in Florida grow up safe, healthy, educated and prepared to meet their full potential.”<sup>52</sup> There are numerous factors, many of which have been identified in this report, that affect whether family and child development proceeds with ease or with a struggle. Researchers interested in the course of development have identified protective and risk factors associated with the well-being of families and children as a means of assessing, designing and projecting support and service needs. Protective factors have been associated with positive life outcomes, and causal links between risk factors and poor outcomes have been established.

Some studies suggest that risk is cumulative, that is, the higher the number of risk factors over time, the greater the likelihood of subsequent emotional and behavioral problems. Others suggest that risk is additive, not cumulative. That is, children with a whole set of risks at one time are at a greater disadvantage than children that accumulate a few risk factors over a period of time. Findings do substantiate that children can move in and out of various levels of risk at different points in their life.<sup>53</sup>

The importance of protective factors cannot be overestimated. Ample evidence documents that strong parent/caregiver and child relationships are foundational to later success. Children who begin kindergarten socially and emotionally ready – able to make friends, get along with others, and communicate well with teachers – are much more likely to be successful. Their success extends beyond good academic performance, decreased likelihood of grade retention, and lower rates of adolescent pregnancy and delinquency to better odds for obtaining higher education and vocational, relationship and financial success.

In general, risk factors do not operate in isolation. Mothers who use drugs are also likely to smoke, drink alcohol, neglect their health and have poor nutrition. For families and children with numerous risk factors, productivity and success often is elusive. Early labeling can result in lower academic track placements, lower expectations from teachers and parents, and decreased likelihood of positive social interactions.<sup>54</sup> Protective factors in the community are essential for these families but are too often unavailable or difficult to access. For example, access to prekindergarten and early intervention programs that might ameliorate these challenges is highly uneven.<sup>55</sup>

Research has proven the effectiveness of several strategies that foster protective factors and mitigate risk factors. Within each of the broad categories that follow, there is ample room for specific programs and services to be fostered or developed as the Cabinet moves forward from this baseline report.

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<sup>52</sup> [http://www.flgov.com/youth\\_cabinet](http://www.flgov.com/youth_cabinet)

<sup>53</sup> Peth-Pierce, 2000

<sup>54</sup> Peth-Pierce, 2000

<sup>55</sup> National Research Council & Institute of Medicine, 2000

(Note: Some of this section is excerpted directly from *The Florida Vision: A State that Promotes the Well-Being of All of its Children*.<sup>56</sup>)

### Prevention Orientation

Maximizing prevention opportunities may mean making difficult decisions about how organizations and agencies utilize their funding. Prevention is the best investment Florida can make. Helping out communities and families create healthy, nurturing environments for children will reduce costs in the long-run. Primary prevention services such as public awareness and education, home visiting, developmental and behavioral assessments and services, parent skill-building, parent support groups, telephone warm lines offering support to parents and latch-key children, before- and after-school programs, family resource centers, early needs assessment and intervention, high-quality early care and education, primary health care for pregnant moms, infants and young children, and nutrition education are prevention services that are crucial to helping families succeed, preventing children from entering out-of-home care, and ensuring that children can reach their maximum developmental potential.<sup>57,58</sup> In addition to these types of services, prevention includes safe streets, drug free neighborhoods, safe parks and recreational



areas, neighborhood enrichment activities, volunteer transportation assistance, food banks, zoning laws that facilitate integration of affordable housing into safe neighborhoods and employment policies and practices that support families who are raising children.

Integration of the full range of family supports requires a re-conceptualization of community services. Primary prevention services

are rarely connected to each other and are infrequently viewed as having an instrumental role in child and family development and functioning. They are even less often connected to specialized services. Specialized services address the physical, cognitive, emotional, or behavioral difficulties of children and/or parents. Interventions of mental health, speech, occupational, or physical therapy are examples. Some services are directed at limitations within a child's or parent's own functioning, such as developmental disabilities or substance abuse. Services are also designed to address problems that are the result of interactions within the family, such as parent-child conflict or abuse.<sup>59</sup> Reform efforts in the delivery of specialized services have acknowledged the importance of addressing the entirety of child and family needs and functioning and building on individual and family strengths.<sup>60,61,62</sup> Many specialized services have a narrowly defined focus.

<sup>56</sup> Ghazvini & Foster, 2003

<sup>57</sup> Ahearn, Nalley, & Cabson, 2000

<sup>58</sup> Wynn et al., 1994

<sup>59</sup> Wynn et al., 1994

<sup>60</sup> Karr-Morse & Wiley, 1997

Connections with primary prevention services can increase the effectiveness of specialized services. By providing support, “normalized” social interactions, and settings to practice new skills, primary prevention services can maximize positive outcomes of a child’s or parent’s use of specialized services.

### **Holistic Approach**

Holistic service delivery is based on a strength-based philosophy of service provision. It views the family rather than the child or individual as the client and considers the broader ecological contexts in which families grow and develop (i.e., schools, neighborhoods, work, churches, etc.).<sup>63</sup> It requires flexibility in service provision that enables professionals to go beyond rigid eligibility criteria and prescription of services in order to meet the unique and diverse needs of families.

The outcomes from addressing concerns identified in childhood without involving family members are weak at best and likely to be ineffective. Researchers have repeatedly found that the effects of the home environment outweigh those of out-of-home childhood settings such as early care and education settings. Positive outcomes are increased when parents are involved.<sup>64,65</sup> Both primary and specialized services should strive to develop strong family-centered components.

In addition, efforts to create holistic service integration need the input of parents in order to develop a system that can be responsive to families. Evaluations of reform efforts have repeatedly emphasized the importance of including parents in planning, governing and evaluating service delivery innovations.<sup>66,67,68,69</sup> Parents are in the best position to identify the best ways for them to access services, service management issues and the value of services.

Holistic service delivery requires that helping professions are able to access a wide array of services for families and share and integrate data and information. Flexibility in creating cooperation, coordination, and collaboration strategies is particularly important to services that are typically disconnected from other family and child services. For example, even though dental disease is the most common childhood disease and untreated oral disease can exacerbate already fragile conditions in many children, oral health services usually are isolated from other child services. Parent skill-building and mental health services are also infrequently linked to other services.

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<sup>61</sup> Walsh, 2000

<sup>62</sup> Wynn et al., 1994

<sup>63</sup> Friedman, 2002

<sup>64</sup> National Research Council, 2001

<sup>65</sup> Vandell & Wolfe, 2000

<sup>66</sup> Miller, Melaville, & Blank, 2002

<sup>67</sup> Hayes, 2002

<sup>68</sup> Walsh, 2000

<sup>69</sup> Wynn et al., 1994

## Data-Driven and Evidence-Based Practices and Programs

System planners, policy-makers, administrators, front-line staff and evaluators have access to an ever-growing body of evidence-based practices and programs and data that supports best practices. The expansion of the child and family study research field, federal and state investments in research and evaluation, and accountability requirements have produced important information on the development, implementation, and dissemination of best practices and programs and spurred the focus on effective service delivery systems.<sup>70</sup> Efforts that explicitly develop logic models and theories of change that are research-supported and evidenced-based stand a much better chance of garnering widespread support and identifying successful mechanisms for implementation and accountability.

The identification of evidence-based practices is but an initial step. The research on the program or practice may not address implementation in the real world with diverse families and children or may describe results in a particular system or setting.<sup>71</sup> There are unique challenges relative to bringing a model program or practice to scale. Without ample time, funding, expertise and commitment, these challenges can undermine attempts to replicate successful models.<sup>72</sup> In the end, providing ineffective, inappropriate or poor practices and programs does not improve results.<sup>73</sup> Thus, it is imperative that the best information and data inform practice and policy.

## Integrated Service Approach

An integrated service approach involves collaboration and interdisciplinary and interagency involvement. Integrated services (i.e., an entity offers a variety of service options for families) are different from integrated systems of service delivery (i.e., different service systems, such as child welfare and health care), are working in concert to offer services to families through a single access point or other mechanism that ensures that both needs are met in a complementary fashion.

This report has focused on promoting integrated service delivery by clustering indicators in the areas of child health, school readiness, stable families and supportive communities. This focus recognizes that many different state agencies may impact outcomes, and no single agency is responsible for a specific outcome. The report's focus also recognizes the diversity of families in Florida in terms of their economic status, ethnicity, health status, (i.e., physical, mental, and dental), education, political affiliation, religious beliefs and personal priorities. It also acknowledges the preference by many families to utilize natural supports – family, friends and neighbors – for assistance. The availability of natural supports differs across families. Whether natural supports are extensive or tenuous, most families supplement natural supports with community services (i.e., primary and specialized services).

Integrated service delivery is a process that takes place as families interact with prevention opportunities and primary and specialized service providers. It recognizes the efficacy of

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<sup>70</sup> Friedman, 2002

<sup>71</sup> Friedman, 2002

<sup>72</sup> Bruner, 2000

<sup>73</sup> Bruner, 2000

prevention and early intervention in ensuring the well-being of Florida’s children and families, building on strengths and avoiding, or at least reducing, risks of negative health, education and parenting consequences. Integrated service delivery looks beyond narrow definitions of eligibility and service provision and seeks to eliminate fragmentation of services.

Initiatives that strive to integrate services and supports for children and families offer a promising approach to improving the quality and scope of service delivery. When well-planned, local efforts can meet the unique needs of diverse communities and build constituencies of support for child and family issues. Poorly planned efforts, however, can lower expectations and support and hurt families. Fortunately, there are elements of successful initiatives to guide future initiative development.<sup>74</sup>

### Family Supportive Policies

Family supportive policies enable families to shape and choose appropriate activities and services for their children and themselves over time and stages of development. They provide a basis for facilitating ways home, school and community partnerships can balance the needs for stability amidst change. Family supportive policies recognize the importance of natural supports (i.e., extended family, friends, neighbors, faith communities and co-workers) and facilitate the availability of primary (e.g., early care and education, flexible workplace policies, neighborhood recreational activities, health care providers, parent skill-building opportunities), secondary (e.g., economic assistance, parenting supports, early intervention, home visiting, housing assistance), and tertiary (e.g., shelters, foster care and adoption, substance abuse treatment, domestic violence services) supports on an “as needed” basis.



Although service providers frequently concentrate on the provision of one type of service, any agency or organization can embrace family supportive policies. Integrated service delivery enables service providers to share information and resources in ways that can meet multiple family needs. A strong screening and assessment system that begins at birth and continues throughout the life of the child, and that recognizes family strengths and natural supports and can identify multiple stressors is essential to family support in an integrated network.

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<sup>74</sup> Miller et al., 2002

## Flexible Fiscal Policies that Promote Integration of Quality Services

Adequate and stable funding streams are essential to service integration. Although policymakers may be able to create service networks with limited budgets, strict eligibility requirements and inadequate quality standards, families will not experience the result as service integration. Instead, families will continue to have difficulties accessing services, and intended outcomes will not be realized. Stable and adequate funding ensures that service providers will continue to have flexibility in service provision, can meet quality standards, and are able to share and integrate data and information.

Creating more flexibility within existing funding categories is an important component of service integration. One way to create flexibility is through pooling, a strategy that combines funds from several agencies and programs into a single, unified funding stream. States frequently use this strategy to combine a portion of funds from federal block grants and other state programs into block grants for local entities. Pooling enables more local discretion on spending priorities and can be used for activities such as collaboration and planning that are typically restricted in other funding streams.<sup>75,76</sup>

Aligning categorical funding from a number of agencies to support integrated service delivery is another strategy. Too often senior staff members spend great amounts of time and effort working to find ongoing funding in order to sustain critical services for young children.<sup>77</sup> While offering many community agencies the opportunity to expand services to the families they serve, funding coordination requires good management information, data integration mechanisms and accounting systems. Flexibility also can be increased when funding is not tied to categories and when services and funding are decentralized. With the removal of strict eligibility requirements and rules, communities gain more flexibility over funds.<sup>78,79</sup>



## Investing Early for a High Rate of Return

A significant body of research (e.g., on family formation, child development and economic well-being) has shown that early investments – in prenatal and health care, in high quality affordable early learning programs, in family support and education programs, in helping communities support families in their role as children’s first and most important teachers – yield tremendous financial and social benefits. Research shows that early experiences determine whether a child’s brain architecture will provide a strong or weak foundation for all future learning, behavior and

<sup>75</sup> Hayes, 2002

<sup>76</sup> Thompson et al., 2001

<sup>77</sup> Duerr-Berrick & Edelstein, 2001

<sup>78</sup> Flynn, Hayes, Uyeda, & Halfon, 2002

<sup>79</sup> Orland, Danegger, & Foley, 1995

health – our human capital.<sup>80,81,82</sup> Many notable researchers from heretofore incompatible disciplines have analyzed and are sharing widely how our long-term U.S. economic strength depends on our future work force. Investing in children is a vital economic growth strategy and a priority of business, government and philanthropy, particularly in an environment of limited resources.

In Florida, business leaders represented by the Florida Chamber Foundation have identified prosperity, vibrant communities and global competitiveness as critical to Florida's future. They believe reaching these goals requires six key drivers, one of which is talent and includes early life experiences from a healthy birth to early learning. Identifying and rallying behind long-term economic solutions is part of that focus, and early investments are a critical part of long-term solutions.<sup>83</sup>

### **Accountability for Results**

A growing national orientation on results reflects the need of policymakers, program developers and community leaders to demonstrate that initiatives offered to families and children have their intended impact. Politicians need compelling evidence that initiatives work in order to provide initial and continued support.<sup>84</sup> A clear theory of change with indicators and performance measures to track progress enables communities to monitor whether programs are effective in terms of costs.

Simply selecting outcomes and indicators or generating a list of performance measures fails to anchor the selected measures in a context that can facilitate interpretation and use of the resulting information. An approach that incorporates the development of logic models and program theory development establishes mechanisms to inform service delivery through evaluation.<sup>85</sup> Evaluating efforts is more than simply collecting and analyzing data; it also includes using findings to continuously improve program activities.<sup>86,87</sup>

It is also important to consider the amount of time initiatives take to produce results. Evaluation should be an ongoing process and use a variety of approaches to collect and analyze data from many sources.<sup>88</sup> It is important to acknowledge that different efforts work in tandem and that no one service is solely responsible for global results. Building relationships between community stakeholders and researchers increases opportunities for learning and improvement of services and service delivery.

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<sup>80</sup> Shonkoff & Phillips, 2002

<sup>81</sup> Grunewald & Rolnick, 2006

<sup>82</sup> Heckman, 2007

<sup>83</sup> <http://www.flchamber.com/mx/hm.asp?id=chamberfoundation>

<sup>84</sup> Mintrom, 2001

<sup>85</sup> Hernandez, 2000

<sup>86</sup> Bryant & Hayes, 2002

<sup>87</sup> Annie E. Casey Foundation, 1997

<sup>88</sup> Annie E. Casey Foundation, 1997

## Next Steps

This report has presented information aligned with the Cabinet’s goals and that accomplishes Steps 1 to 5 involved in outcomes accountability (Figure 5.) While this report has presented a broad overview of research and information about “what works,” next steps include determining what specific strategies and programs should be fostered and/or developed moving forward.

The State Agency Budget Committee chaired by Gay Lancaster is ready to move forward on Step 6, while state agencies can take a leadership role in linking performance measures to desired outcomes.

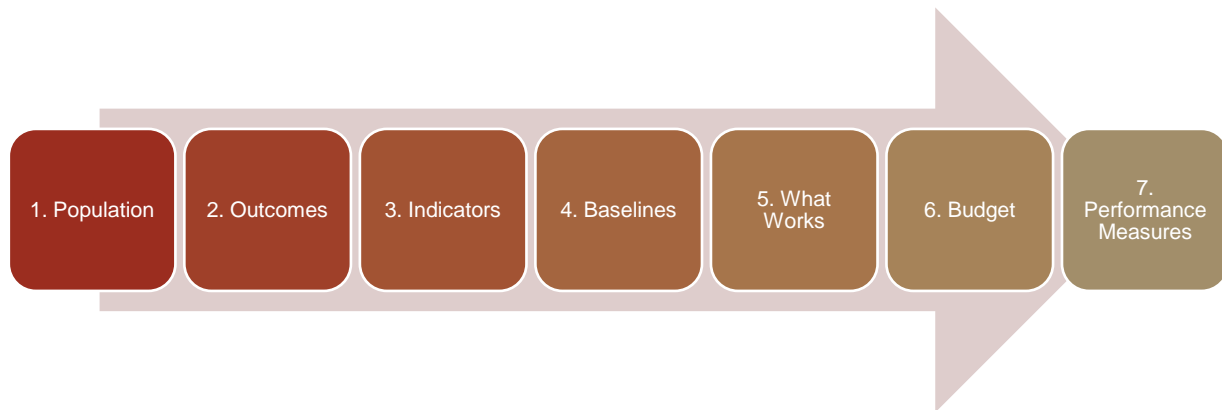


FIGURE 5 - OUTCOMES ACCOUNTABILITY PROCESS

### Recommendations for moving forward are that the Cabinet:

1. Adopt the outcomes accountability process described in this report.
2. Identify and adopt a prioritized set of indicators that it will use as a roadmap for improving the lives of Florida’s children by linking them to outcomes, budget and strategies to achieve the goals set forth in its strategic plan. The Cabinet may wish to shorten the list of indicators in each outcome area for priority focus moving forward.
3. Discuss and adopt strategies for financing an agenda to improve outcomes for children and families<sup>89</sup> as the Cabinet State Agency Budget Committee continues work on aligning state expenditures for children to *outcomes adopted by the Cabinet*. Specifically, the Cabinet examine and determine ways to redeploy resources already in the system, find new resources and restructure funding in a way that creates incentives to invest in prevention, use some funds flexibly and change the way programs and services work together for children and families.

<sup>89</sup> [http://www.raguide.org/RA/financing\\_self\\_assessment.htm](http://www.raguide.org/RA/financing_self_assessment.htm)

4. Study, discuss and determine performance measures that allow state agencies to articulate and monitor their participation *programmatically* in reaching the goals discussed in this report and in improving results on the prioritized indicators.
5. Develop and implement *cross-agency* action plans focused on improving prioritized indicators. The Cabinet may wish to assign a state agency lead in convening partners and developing plans, but is encouraged to maintain a focus on integration of effort toward changing outcomes.
6. Determine where gaps and inconsistencies occur and develops ways to address them.
7. Establish a process for ongoing monitoring and updating of progress, including continued collaboration with the early childhood partners developing a framework, the Governor's Office on Child Adoption and Protection, the Child Abuse Child Abuse Prevention and Permanency Advisory Council and others interested in ensuring continuity and consistency across disciplines.

## Collaborations

As this report was developed, there were many opportunities for collaboration. Input provided through these collaborations was welcome and helpful. Hopefully, this work has informed the work of others, as well. Many thanks are extended to the following:

### **Children's Summit Workgroup**

The Children's Summit Workgroup was instrumental in originating the discussion and recommendation that led to this report. They also provided input into the content and structure of the report. Summit Workgroup members are:

Vivian Alarcon - Florida Children's Service Council  
 Mike Cusick - Florida Coalition for Children  
 Ann Davis - Florida Association of Healthy Start Coalitions  
 Debra Dowds - Florida Developmental Disabilities Council  
 Chris Duggan - Early Learning Association of Florida  
 Ed Feaver - Whole Child Project Leon  
 Christie Ferris - Ounce of Prevention, Prevent Child Abuse Florida  
 Mark Fontaine - Florida Alcohol and Drug Abuse Association  
 Joy Frank - Florida Association of District School Superintendents  
 Alisa Ghazvini - Early Childhood Consultant  
 Ted Granger - United Way of Florida  
 Phyllis Kalifeh - The Children's Forum  
 Karen Koch - Florida Council for Community Mental Health  
 Susan Main - Early Learning Association of Florida  
 Carol McNally - Ounce of Prevention, Healthy Families Florida  
 Linda Merrell - Florida Child Health Coalition  
 Luanne Panacek - Hillsborough Children's Board

Larry Pintacuda - Florida Afterschool Network  
Diana Ragbeer - The Children's Trust  
Alisa Snow - Consultant Advocate, Children's Health  
Kate Stowell - The Policy Group for Florida's Families and Children  
Karen Woodall - Florida Center for Fiscal and Economic Policy  
Jason Zaborske - Children's Week, Capital Events Inc.

### ***AWI Office of Early Learning, DOE Office of Early Learning and DCF Child Care Licensing***

Three state agencies – the Agency for Workforce Innovation (AWI) Office of Early Learning, the Department of Education (DOE) Office of Early Learning and the Department of Children and Families (DCF) Child Care Licensing - are spearheading the development of an early childhood framework for Florida. Facilitated by Abby Thorman, Ph.D., of Thorman Strategy Group, Miami, the early childhood framework is designed to provide an infrastructure for planning and accountability, support the diverse work done throughout the state on behalf of young children and present a unified political voice.

Stakeholders began meeting in September of 2008, and plan an 18-month process for developing and finalizing the framework. Initial work on defining and selecting outcomes and indicators has been done in tandem with development of this report. Well-being areas described in this report are also those being used in the early childhood framework. Most of the indicators in this report, particularly those related to preconception and ages 0 through 5, are the same as those in the framework. Certain data indicators may be selected for use in the early childhood framework that only provide state level data. These are presented in this report and noted as to their use in the early childhood framework.

### ***State Agency Budget Committee***

The Cabinet's State Agency Budget Committee, chaired by Gay Lancaster of the Juvenile Welfare Board of Pinellas County, has focused its work on linking state children's expenditures to outcomes. The committee has examined funding sources (e.g., state general revenue, federal funding sources, match requirements and sources, private sources) and identified benchmarks/child outcomes currently used by state agencies. Information derived from research during The State of Florida's Child Report development has been shared with Ms. Lancaster. The State Agency Budget Committee is poised to assist the Cabinet in "next steps" of aligning outcomes with funding, as shown in Figure 4, **page 36**.

### ***Governor's Office of Child Adoption and Protection***

The Governor's Office of Adoption and Child Protection provides staff support to the 20-member Children and Youth Cabinet and the 32-member Child Abuse Prevention and Permanency (CAPP) Advisory Council. In this capacity, staff members provided support and information to assist in the development of this report. Over 2007 and 2008, the CAPP reviewed child well-being, maltreatment and adoption indicators as well as information provided by 75 state and national experts. Additionally, the CAPP prepared instructions for local prevention and permanency

planning efforts by 20 circuit-level teams comprising approximately 600 members. Based on these efforts, the Governor's Office presented to the Governor and the legislature a plan for the prevention of child maltreatment, the promotion of adoption and the support of adoptive families. This plan aligns closely with the strategic goals of the Children and Youth Cabinet. Accomplishment of the plan goals would directly and/or indirectly assist Florida with positively impacting the indicators articulated in this report.

***And ...***

Special thanks to Joe Baldwin, senior planner with the Health and Human Services Coordinating Council of Pinellas County. Mr. Baldwin has been working on community-level indicators and serves on the board of the national Community Indicators Consortium. He was instrumental in suggesting indicator sources, commenting on content, and serving as a dependable sounding board for the use of child and family well-being indicators. Also thanks to the Center for the Study of Social Policy and PolicytoResults.org for asking for Florida input on indicators for their developing web site. The Web site will showcase how state and local governments track and produce results using indicators.

## Data Sources

There are many respected sources of data that were used for this report. They include:

**The Annie E. Casey Foundation Kids Count Data Center**, [www.kidscount.org](http://www.kidscount.org). The Kids Count Data Center is a national and state-by-state effort to track the status of children in the United States. The data system contains national, state and city data for more than 100 measures of child well-being.

**The U.S. Census Bureau**, [www.census.gov](http://www.census.gov), especially the *American Community Survey (ACS)*, available online at [www.census.gov/acs/www](http://www.census.gov/acs/www). The Census Bureau's American Community Survey is an ongoing survey that produces statistics about the country's people and housing. It covers the same type of information that had been collected every 10 years from the decennial census long form questionnaire. The American Community Survey eliminates the need for a separate long form in the 2010 Census. American Community Survey data are collected continuously throughout the year and throughout the decade. This allows the Census Bureau to produce new data every year about how communities are changing.

The **Centers for Disease Control**, National Center for Health Statistics, [www.cdc.gov/nchs](http://www.cdc.gov/nchs). Some NCHS data systems and surveys are ongoing annual systems while others are conducted periodically. NCHS has two major types of data systems: systems based on populations, containing data collected through personal interviews or examinations; and systems based on records, containing data collected from vital and medical records.

The **Child Trends Data Bank**, [www.childtrends.databank.org](http://www.childtrends.databank.org), which uses federal reports and web sites to produce original analyses of national data by Child Trends, a non-partisan, non-profit research firm.

The **Substance Abuse and Mental Health Services Administration** of the U.S. Department of Health and Human Services. The Office of Applied Studies provides current national data on alcohol, tobacco, marijuana and other drug abuse; drug-related emergency department episodes and medical examiner cases; and the nation's substance abuse treatment system. Data are available online at [www.samsha.gov](http://www.samsha.gov).

The **Maternal and Child Health Bureau**, Health Resources and Services Administration, U.S. Department of Health and Human Services. The Bureau produces a series of chartbooks and reports that document women's and children's health in annual snapshots based on the most current available data. Data is available online at [www.hrsa.mchb.gov/data/](http://www.hrsa.mchb.gov/data/).

The **Data Resource Center for the Child and Adolescent Health Measurement Initiative (CAHMI)**. Available online at [www.childhealthdata.org](http://www.childhealthdata.org), the Data Resource Center on Child and Adolescent Health Web site makes national, state and regional survey findings readily available. Users can search the National Survey of Children's Health or the National Survey of Children with Special Health Care Needs to query over 60 child health indicators, obtain state profiles, or view survey questions.

The **Forum on Child and Family Statistics**, [www.childstats.gov](http://www.childstats.gov). This Web site offers federal and state statistics and reports on children and their families, including population and family characteristics, economic security, health, behavior and the social environment and education.

Specific data sources for individual indicators begin **on page 53**.

## Data Sources – Healthy Children

Arrows designate desired direction of indicators

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### Maternal and Newborn Health

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#### *Infants born to mothers receiving late or no prenatal care*



**Source:** **Annie E. Casey Foundation** – [www.kidscount.org](http://www.kidscount.org)

Updated July 2008. According to NCHS beginning in 2003, the adoption of the revised birth certificate in several states produced substantive changes in both question wording and the sources for prenatal care information that have resulted in data that are not comparable with data for previous years. The data from which this information was taken is for states that have adopted the revised birth certificate. For more detail on all reporting issues refer to Definitions, Data Sources, and Reporting Issues for States at: [http://www.kidscount.org/sld/rs\\_state\\_def.jsp](http://www.kidscount.org/sld/rs_state_def.jsp).

Child Trends analysis of 1990-2005 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics.

Birth Data for the city of Miami and Jacksonville is not available for 2004 and 2005. The National Center for Health Statistics is investigating a possible data error that might have occurred. The District of Columbia, Puerto Rico and the U.S. Virgin Islands are not included.

Also: **U.S. Department of Health and Human Services**, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 56, No. 6, "Births: Final Data for 2005" (December 5, 2007), Tables 26a and 26b. Retrieved 1/20/09 from <http://www.childrensdefense.org/site/DocServer/state-of-americas-children-2008-report-child-health-and-.pdf?docID=9087>

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#### *Subsequent pregnancies that occur within two years of the birth of the last baby*



**FL Source:** **Medicaid Maternal Child Health Status Indicators (2002-2006)**, Prepared by the Maternal Child Health and Education Research and Data Center, University of Florida College of Medicine

A branch of The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida, 2008

**US Source:** **Centers for Disease Control (2007)**. Summary of health indicators. Retrieved 2/24/09 from [http://www.cdc.gov/pednss/pnss\\_tables/pdf/national\\_table2.pdf](http://www.cdc.gov/pednss/pnss_tables/pdf/national_table2.pdf)

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#### *Children whose mothers are healthy*



**Source:** **Child and Adolescent Health Measurement Initiative**. 2003 National Survey of Children's Health, *Data Resource Center for Child and Adolescent Health website*. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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#### *Low birth weights (under 2,500 grams or 5.5 pounds)*



**Source:** **National Vital Statistics System**, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. [Online]. Retrieved 2/15/09 from <http://205.207.175.93/VitalStats/TableViewer/tableView.aspx>

Also: **Annie E. Casey Foundation** – [www.kidscount.org](http://www.kidscount.org) and **Children's Defense Fund**, State of America's Children [Online]. Retrieved 2/15/09 from <http://www.childrensdefense.org/child-research-data-publications/data/state-of-americas-children-2008-report.pdf>

Also: **Medicaid Maternal Child Health Status Indicators (2002-2006)**, Prepared by the Maternal Child Health and Education Research and Data Center, University of Florida College of Medicine

A branch of The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida, 2008

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## Health Care

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### *Young children who complete the basic series of immunizations*



**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

4:3:1 Series Coverage is four or more doses of diphtheria and tetanus toxoids and pertussis (DTP) vaccine, diphtheria and tetanus toxoids (DT) vaccine, and diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; three or more doses of poliovirus vaccine; and one or more doses of measles-containing vaccine. Centers for Disease Control and Prevention, National, State, and Urban Area Vaccination Levels Among Children Aged 19-35 Months - United States reports from 1998-2006, <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis>.

Updated: December 2008

Calculation of number of immunizations based on number of births January 2004 to July 2007.

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### *Children with medical home or primary health care provider*



**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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### *Children under age 18 without health insurance*



**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

Health insurance includes private sector insurance generally provided through work, as well as insurance provided through the public sector, such as Medicare and Medicaid. Children receiving health insurance through a variety of State Health Insurance Programs (CHIP) are counted as having health insurance. The figures used here are 3-year averages of data.

In March of 2007, the U.S. Census Bureau discovered that in a small percentage of cases, some residents of a household were erroneously considered to have no health insurance. Revised public-use data were released by the Census Bureau for the 1997 through 2006 CPS files. Health insurance coverage estimates posted on the Kids Count data website reflect those revisions. The Census Bureau has not released revised CPS data files for 1996 and prior. Therefore health insurance coverage estimates on the Kids Count website for years labeled 1996 and prior have not been updated. Because 1996 and prior are likely to have some degree of under-reporting of health insurance coverage it is not advisable to compare estimates labeled 1996 and prior to estimates labeled 1997 or beyond. You can read a more in-depth description of the data revisions by the Census Bureau at the following site: (<http://www.census.gov/hhes/www/hlthins/usernote/schedule.html>).

**Also:** The Urban Studies Institute at the University of Louisville, analysis of data from the U.S. Census Bureau, Current Population Survey (March supplement), 1990 through 2007 (including March 2001 bridge file). Population Reference Bureau, analysis of data from the U.S. Census Bureau, Current Population Survey (March supplement), 2006 through 2008.

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### *Children receiving preventive health care*



**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://fchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Children receiving preventive dental care**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Screening, Identification and treatment of special needs**

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**Children with special health care needs**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Raw Data Source: National Health Interview Survey - <http://www.cdc.gov/nchs/nhis.htm>

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Children with special health care needs who have a medical home**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Raw Data Source: National Health Interview Survey - <http://www.cdc.gov/nchs/nhis.htm>

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Parents concerned about learning, development or behavior**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Raw Data Source: National Health Interview Survey - <http://www.cdc.gov/nchs/nhis.htm>

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Children not receiving specific health care services necessary for identified developmental delays and special needs** 

**Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2005-2006*. [Online] Rockville, Maryland: U.S. Department of Health and Human Services, 2008. Available: [www.nschdata.org](http://www.nschdata.org)

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Children receiving some mental health care in the past year** 

**Source:** Shea, K.K., Davis, K. & Schor, E.L. (May 2008) U.S. variations in child health system performance: A state scorecard. New York: The Commonwealth Fund

Also: **Child and Adolescent Health Measurement Initiative**. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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**Children with socio-emotional difficulties** 

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

Also: **The Florida Initiative for Children's Healthcare** - Quality Child Health Care and Health Care Quality in Florida: A Chartbook. April 2008. Retrieved 1/6/09 from <http://flchartbook.childhealthdata.org/ViewDocument.aspx?DocumentID=25>

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**Child Morbidity/Mortality**

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**Children with moderate or severe health problems** 

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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**Children affected by asthma** 

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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**Child deaths**



**Source:** Annie Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

**Updated May 2008**

**Data Source:** Death Statistics: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).  
Special tabulations provided by CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State.  
2004 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2004 CD-Rom;  
2003 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2003 CD-Rom.  
2001 and 2002 data: Special tabulations provided by CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State, for the years 2001 and 2002.  
2000 data: CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State, 2000, accessed online at [www.cdc.gov/nchs/data/dvs/VS00100.TABLE23B\\_2000.pdf](http://www.cdc.gov/nchs/data/dvs/VS00100.TABLE23B_2000.pdf) (January 10, 2003).  
1999 data: Deaths From 358 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1999.  
1998 data: Deaths From 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1998.  
1997 data: Deaths From 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1997.  
1996 data: Special tabulations accessed online through CDC WONDER at <http://wonder.cdc.gov> (January 5, 1999).  
1990 through 1995 data: Special tabulations by CDC, NCHS, Division of Vital Statistics, Deaths from 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, for each year from 1990 through 1995.  
Population Statistics: U.S. Census Bureau.  
2003 data: State Characteristics Population Estimates File, accessed online at [www.census.gov/popest/states/asrh/files/SC-EST2003-race6.csv](http://www.census.gov/popest/states/asrh/files/SC-EST2003-race6.csv) (May 13, 2005).  
2001 and 2002 data: State Characteristics Population Estimates File, accessed online at [eire.census.gov/popest/data/states/files/STCH-6R.txt](http://eire.census.gov/popest/data/states/files/STCH-6R.txt) (November 21, 2003).  
2000 data: Census 2000 Summary File 1 (SF 1) 100-Percent Data, Table P14.  
1999 data: 1999 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://ire.census.gov/popest/data/states/files/STCH-icen1999.txt> (November 21, 2003).  
1998 data: 1998 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://eire.census.gov/popest/data/states/files/STCH-icen1998.txt> (November 21, 2003).  
1997 data: 1997 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://eire.census.gov/popest/data/states/files/STCH-icen1997.txt> (November 21, 2003).  
1996 data: 1996 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://eire.census.gov/popest/data/states/files/STCH-icen1996.txt> (November 21, 2003).  
1990 through 1995 data: Data from Population Division.

**Infant deaths that occur before age 1**



**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

Updated July 2008.

On death certificates, as on most federal data collection forms, the question regarding whether a person is Hispanic is separate from the question asking whether a person is white, black, Asian or Pacific Islander, or American Indian. Thus, people are asked to select a racial group and to indicate whether the deceased was of Hispanic origin. Race/ethnic groups represented in this table are not mutually exclusive. The category of white includes only non-Hispanic white. The categories Black or African American, American Indian, and Asian and Pacific Islander include both Hispanic and non-Hispanic. Those in the Hispanic or Latino category include those identified as being in one of the non-White race groups. Starting in 2003, multiple race reporting was allowed by several states.

**Data Source:** Centers for Disease Control and Prevention, National Center for Health Statistics: 2005 data: Population reference Bureau analysis of Multiple Causes of Death Public Use Files for 2005 accessed from National Bureau of Economic Research website <http://www.nber.org/data/vital-statistics-mortality-data-multiple-cause-of-death.html> and Births: Final Data for 2005, National Vital Statistics Reports, Vol. 56, No. 6 (December 5, 2007), Tables 2 and 5.

2004 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2004 CD-Rom and 2004 Natality Data Set CD Series 21, number 17Ha (ASCII version), National Center for Health Statistics.

2003 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2003 CD-Rom and 2003 Natality Data Set CD Series 21, number 16H (ASCII version), National Center for Health Statistics.

2002 data: Infant Mortality Statistics from the 2002 Period Linked Birth/Infant Death Data Set, National Vital Statistics Report, Vol. 53, No. 10 (November 24, 2004), Tables A, B.

2001 data: Infant Mortality Statistics from the 2001 Period Linked Birth/Infant Death Data Set, National Vital Statistics Report, Vol. 52, No. 2 (September 15, 2003), Tables A, B.

2000 data: Infant Mortality Statistics from the 2000 Period Linked Birth/Infant Death Data Set, National Vital Statistics Report, Vol. 50, No. 12 (August 28, 2002), Tables A, B.

1999 data: Infant Mortality Statistics from the 1999 Period Linked Birth/Infant Death Data Set, National Vital Statistics Report, Vol. 50, No. 4 (January 30, 2002), Tables A, B.

**Note:** Birth Data for the city of Miami and Jacksonville is not available for 2004 and 2005. The National Center for Health Statistics is investigating a possible data error that might have occurred. More information will be available soon.

Estimates from the American Community Survey (ACS) are suppressed when the total confidence intervals (upper bound minus lower bound) of the percent estimate, is 10 percentage points or greater. Rates from Vital Statistics data are suppressed when based on fewer than 20 births or death.

**Note:** The District of Columbia, Puerto Rico and the U.S. Virgin Islands are not included in maps and rankings because they are not states and therefore comparisons on many indicators of child well-being are not meaningful.

**Also:** **Medical Maternal Child Health Status Indicators (2002-2006)**, Prepared by the Maternal Child Health and Education Research and Data Center, University of Florida College of Medicine

A branch of The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, University of South Florida, 2008



## Risk Indicators

### Household smoking

**Source:** **Child and Adolescent Health Measurement Initiative**. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

### Overweight adolescents

**Source:** **Childhood Obesity Action Network**. State Obesity Profiles, 2008. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative. Retrieved 7/7/08 from <http://nschdata.org/Viewdocument.aspx?item=208>

Data also available from the **Annie E. Casey Foundation**, [www.kidscount.org](http://www.kidscount.org)

### Binge alcohol drinking among youths

**Source:** **Annie E. Casey Foundation** - [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the prior 30 days.

**Also:** Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. State Estimates of Substance Use from the National Survey on Drug Use and Health accessed online at <http://www.oas.samhsa.gov/>

### Illicit drug use of other than marijuana

**Source:** **Annie E. Casey Foundation** - [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

Any illicit drug other than marijuana includes cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically.

**Also:** Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. State Estimates of Substance Use from the National Survey on Drug Use and Health accessed online at <http://www.oas.samhsa.gov/>.

### Marijuana use

**Source:** **Annie E. Casey Foundation** - [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. State Estimates of Substance Use from the National Survey on Drug Use and Health accessed online at <http://www.oas.samhsa.gov/>.

### Middle and high school students using tobacco

**Source:** **Annie E. Casey Foundation** - [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. State Estimates of Substance Use from the National Survey on Drug Use and Health accessed online at <http://www.oas.samhsa.gov/>.

## Data Sources – Quality Early Learning Experiences

Arrows designate desired direction of indicators

### Accessible and affordable early care and education

#### Affordability of child care

Source: **National Association of Child Care Resource and Referral Agencies** – Parents and the High Price of Child Care, 2007 Update. Retrieved 2/10/09 from [www.naccrra.org](http://www.naccrra.org)

#### Child care issues affecting parents

Source: **Child and Adolescent Health Measurement Initiative**. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

#### Eligible children under 6 receiving child care subsidies

Source: **U.S. Department of Health and Human Services**, Administration for Children and Families, FFY 2006 CCDF Data Tables. Retrieved 1/20/09 from [http://www.acf.hhs.gov/programs/ccb/data/ccdf\\_data/06acf800/table9.htm](http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/06acf800/table9.htm)

### Quality early care and education settings

#### Centers with Gold Seal accreditation

Source: **Florida Children's Forum** (Christian Winterbottom, M.S., Director of Child Care Training and Accreditation Provider Evaluation Services, email communication 1/20/09)

Note: There are 13,691 programs in Florida, including school sites

#### Centers with NAEYC accreditation

Source: **Florida Children's Forum** (Christian Winterbottom, M.S., Director of Child Care Training and Accreditation Provider Evaluation Services, email communication 1/20/09). Also, [http://www.naeyc.org/academy/summary/center\\_summary.asp](http://www.naeyc.org/academy/summary/center_summary.asp)

Note: There are 6,517 licensed facilities

#### Family child care homes accredited by the National Association for Family and Child Care (NAFCC)

Source: **Florida Children's Forum** (Christian Winterbottom, M.S., Director of Child Care Training and Accreditation Provider Evaluation Services, email communication 1/20/09). Also, <http://nafcc.org/accreditation/acclist5db.asp> Note: There are 4,277 family child care homes in Florida

Arrows designate desired direction of indicators

#### Children who are read to by their parents and relative caregivers

Source: **Federal Interagency Forum on Child and Family Statistics**. America's Children: Key National Indicators of Well-Being, 2006. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office. Table ED1. Based on National Household Education Survey analysis.

Also, National Survey of Children's Health: [www.nschdata.org](http://www.nschdata.org)

Note: 2008 data show 60% of children 3-5 nationally were read to daily by a family member.

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### **Mothers who have not graduated from high school**



**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

Updated July 2008.

According to NCHS beginning in 2003, the adoption of the revised birth certificate in several states produced substantive changes in both question wording and the sources for prenatal care information that have resulted in data that are not comparable with data for previous years. The existing data is from states that continued to use the 1989 standard birth certificate. Data for New York is excluded because non-comparable questions on maternal education have been used in two different parts of the state, and data for Florida and New Hampshire were excluded from some data compilations because non-comparable questions on maternal education have been used in two different parts of the year. For more detail on all reporting issues refer to Definitions, Data Sources, and Reporting Issues for States at: [http://www.kidscount.org/sld/rs\\_state\\_def.jsp](http://www.kidscount.org/sld/rs_state_def.jsp).

**Also:** Child Trends analysis of 1990-2005 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics.

Note: Birth Data for the city of Miami and Jacksonville is not available for 2004 and 2005. The National Center for Health Statistics is investigating a possible data error that might have occurred.

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### **State investments in early education and care commensurate with K-college educational investments**



**Sources:** Florida Policy Matters Domain Framework, The Policy Group for Florida's Families and Children (per capita investment in ECE)

**Update 2006 - Financing a Quality Voluntary Prekindergarten Program: The Florida Cost Model**, The Policy Group for Florida's Families and Children (2006), available online at <http://www.policygroup.org/downloads/upk%20series/2006-K001.pdf> (Pre-K expenditures)

**www.floridaperforms.org** – Link Jarrett, [asfoffr@fldoe.org](mailto:asfoffr@fldoe.org), Nate Johnson, 850-245-9719 (K-12 and state university expenditures). The Florida Expenditures Analysis Report is compiled using the history year of the Operating Budget and the Instruction and Research (I&R) Data File. Student credit hour information was derived from the Student Data Course File for the Summer, Fall, and Spring terms during the 2006-2007 fiscal year and reported as part of the I&R Data File. Direct expenditures include instruction, research public service, institutes and centers, museums and galleries, radio/TV, agricultural extension, teaching hospitals and clinics. Indirect expenditures include academic administration, academic advising, libraries/audio/visual, student services university support, and plant operation and maintenance. Contract and grant expenditures and auxiliary expenditures are not included. The full-time-equivalent undergraduate definition is total undergraduate student credit hours divided by 30. Thirty is used assuming a full-time student takes 15 hours in fall and spring. The full-time-equivalent graduate definition is total graduate student credit hours divided by 24. Twenty-four is used assuming a full-time student takes 12 hours in fall and spring.

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### **Children Ready to Succeed**

*Children who reach their developmental potential in physical well-being and motor development, social and emotional development, problem solving, language development and in cognition and general knowledge based on a valid and appropriate school readiness screening tool*



**Source:** [http://www.fldoe.org/news/2006/2006\\_12\\_08-4.asp](http://www.fldoe.org/news/2006/2006_12_08-4.asp)

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### Children reading at or above fourth grade level

**Source:** U.S. Department of Education, National Assessment of Education Progress, The Nation's Report Card: Reading 2007 (2007), Tables A-8 and A-9; and U.S. Department of Education, National Assessment of Education Progress, The Nation's Report Card: Mathematics 2007 (2007), Tables A-8 and A-9. Calculations by Children's Defense Fund, retrieved 2/10/09 from <http://www.childrensdefense.org/child-research-data-publications/data/state-of-americas-children-2008-report-education.pdf>

Enrollment numbers from the Florida Department of Education, <http://www.fldoe.org/eias/eiaspubs/pdf/pk-12mbrship.pdf>

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### Children with math proficiency at or above fourth grade level

**Source:** U.S. Department of Education, National Assessment of Education Progress, The Nation's Report Card: Reading 2007 (2007), Tables A-8 and A-9; and U.S. Department of Education, National Assessment of Education Progress, The Nation's Report Card: Mathematics 2007 (2007), Tables A-8 and A-9. Calculations by Children's Defense Fund, retrieved 2/10/09 from <http://www.childrensdefense.org/child-research-data-publications/data/state-of-americas-children-2008-report-education.pdf>

Enrollment numbers from the Florida Department of Education, <http://www.fldoe.org/eias/eiaspubs/pdf/pk-12mbrship.pdf>

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### Well qualified early care and education workforce

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#### Early childhood staff with a Child Development Associate or equivalent

**Source:** Center for Family Policy and Research, The State of Early Childhood Programs 2008. Retrieved 1/14/09 from <http://mucenter.missouri.edu/stateprograms08.pdf>

**State Data Source:** Staff Credential and Enrollment Data Summary – Statewide, Florida Department of Children and Families (DCF). Contact Mike Boland, 850-921-8228. The percentage calculation is based on data collected by the 65% of facilities that report this data to DCF. This does not include staff credentials from counties who conduct their own child care licensing independent of the state. As well, the calculation does not include those staff who work with mixed age groupings, or staff who work with children 5+ years of age.

Note on comparability with national data: Because the state data was extrapolated for those working with children 5 and under, and because it only represents 65% of facilities, a national comparison is not reasonable to make.

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#### Early childhood staff with an associate's degree

**Source:** Center for Family Policy and Research, The State of Early Childhood Programs 2008. Retrieved 1/14/09 from <http://mucenter.missouri.edu/stateprograms08.pdf>

**State Data Source:** Staff Credential and Enrollment Data Summary – Statewide, Florida Department of Children and Families (DCF). Contact Mike Boland, 850-921-8228. The percentage calculation is based on data collected by the 65% of facilities that report this data to DCF. This does not include staff credentials from counties who conduct their own child care licensing independent of the state. As well, the calculation does not include those staff who work with mixed age groupings, or staff who work with children 5+ years of age.

Note on comparability with national data: Because the state data was extrapolated for those working with children 5 and under, and because it only represents 65% of facilities, a national comparison is not reasonable to make. However, the national Center for the Child Care Workforce estimates that of center-based child care workers, 47% of center teachers, 45% of center assistants and 27% of center directors have "some college, including associate degree." Retrieved 2/23/09 from <http://www.ccw.org/pubs/workforceestimatereport.pdf>.

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**Early childhood staff with a bachelor's degree**



**Source:** Center for Family Policy and Research, The State of Early Childhood Programs 2008. Retrieved 1/14/09 from <http://mucenter.missouri.edu/stateprograms08.pdf>

**State Data Source:** Staff Credential and Enrollment Data Summary – Statewide, Florida Department of Children and Families (DCF). Contact Mike Boland, 850-921-8228. The percentage calculation is based on data collected by the 65% of facilities that report this data to DCF. This does not include staff credentials from counties who conduct their own child care licensing independent of the state. As well, the calculation does not include those staff who work with mixed age groupings, or staff who work with children 5+ years of age. However, the national Center for the Child Care Workforce estimates that of center-based child care workers, 33% of center teachers, 12% of center assistants and 69% of center directors have “a bachelor degree or more.” Retrieved 2/23/09 from <http://www.ccw.org/pubs/workforceestimatereport.pdf>.

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**Salaries of child care workers**



**Source:** AFT Center for the Child Care Workforce, Salaries for Staff Costs to Children. Retrieved 1/14/09 from <http://www.ccw.org/pubs/2005Compendium.pdf>

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**Salaries of preschool teachers**



**Source:** AFT Center for the Child Care Workforce, Salaries for Staff Costs to Children. Retrieved 1/14/09 from <http://www.ccw.org/pubs/2005Compendium.pdf>

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**Turnover rate for early education and care workforce**



**Source:** AFT Center for the Child Care Workforce, Then and Now: Changes in Child Care Staffing, 1994-2000, Technical Report. Retrieved 1/14/09 from <http://www.ccw.org/pubs/Then&Nowfull.pdf>

**Source:** Barrlos, N. (2006). Stabilization of the early learning workforce in Duval County. A report for the Early Learning Coalition of Duval County. Retrieved on 1/19/09 from: [http://74.125.47.132/search?q=cache:KqH0x17Xo1UJ:www.elcofduval.org/Uploads/VPK\\_Other/RICE\\_Report\\_121306.pdf+child+care+teacher+turnover+rate+in+Florida&hl=en&ct=clnk&cd=25&gl=us&client=firefox-a](http://74.125.47.132/search?q=cache:KqH0x17Xo1UJ:www.elcofduval.org/Uploads/VPK_Other/RICE_Report_121306.pdf+child+care+teacher+turnover+rate+in+Florida&hl=en&ct=clnk&cd=25&gl=us&client=firefox-a)

**Source:** Esposito, B. & Kallfeh, P. (2006). Seminole child care workforce study: A research study commissioned by the Early Learning Coalition of Seminole County, The Children's Forum, Tallahassee, FL. Available from: <http://www.flchild.com/downloads/publications/Seminole%20WorkforceStudy%202006.pdf>

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## Risk Indicators

### Youth in juvenile detention centers

**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

To preserve the privacy of the juvenile residents, state level cell counts have been rounded to the nearest multiple of three. "State of Offense" refers to where the juvenile committed the offense for which s/he was being held. Figures include persons under age 21 who had been (1) charged with or adjudicated for an offense; (2) assigned a bed in a facility that can hold accused or convicted juvenile offenders; and (3) placed in the facility because of the offense. The Census of Juveniles in Residential Placement (CJRP) does not capture data on juveniles held in adult prisons or jails. Figures include both pre-adjudicated and post-adjudicated individuals. CJRP does not include facilities exclusively intended for drug or mental health treatment even though such facilities may house some offenders. There may, however, be numerous juveniles in residential placement captured by CJRP that were receiving such treatment.

Also: **Census of Juveniles in Residential Placement Databook.** Sickmund, Melissa, Sladky, T.J., and Kang, Wei. (2005) Online. Available: <http://www.ojjdp.ncjrs.org/ojstatbb/cjrp/>

### Teens not attending school and not working

**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Because of the addition of group quarters in 2006, estimates between 2005 and later years are not fully comparable for this item.

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey.

Updated September 2008

### Teens who are high school dropouts

**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

This measure focuses on teens ages 16 to 19 rather than young adults 16 to 24 because a large share of 18- to 24-year-olds migrate across state lines each year. The high interstate migration rates confound the connection between state policies and programs and state dropout rates. Raw numbers are rounded to the nearest thousand.

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey

Updated September 2008

## Data Sources – Stable and Nurturing Families

Arrows designate desired direction of indicators

### Family employment and income

#### Children with female householder in labor force

**Source:** U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2007, Tables B23003 and B23008, at [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-context=st&-qr\\_name=ACS\\_2007\\_3YR\\_G00\\_S2302&-ds\\_name=ACS\\_2007\\_3YR\\_G00\\_-CONTEXT=st&-tree\\_id=3307&-redoLog=false&-geo\\_id=04000US12&-format=&-lang=en](http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S2302&-ds_name=ACS_2007_3YR_G00_-CONTEXT=st&-tree_id=3307&-redoLog=false&-geo_id=04000US12&-format=&-lang=en) Accessed 2/15/09

#### Children with male householder in labor force

**Source:** U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2007, Tables B23003 and B23008, at [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-context=st&-qr\\_name=ACS\\_2007\\_3YR\\_G00\\_S2302&-ds\\_name=ACS\\_2007\\_3YR\\_G00\\_-CONTEXT=st&-tree\\_id=3307&-redoLog=false&-geo\\_id=04000US12&-format=&-lang=en](http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S2302&-ds_name=ACS_2007_3YR_G00_-CONTEXT=st&-tree_id=3307&-redoLog=false&-geo_id=04000US12&-format=&-lang=en) Accessed 2/15/09

#### Children with all parents in the labor force

**Source:** U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2007, Tables B23003 and B23008, at [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-context=st&-qr\\_name=ACS\\_2007\\_3YR\\_G00\\_S2302&-ds\\_name=ACS\\_2007\\_3YR\\_G00\\_-CONTEXT=st&-tree\\_id=3307&-redoLog=false&-geo\\_id=04000US12&-format=&-lang=en](http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2007_3YR_G00_S2302&-ds_name=ACS_2007_3YR_G00_-CONTEXT=st&-tree_id=3307&-redoLog=false&-geo_id=04000US12&-format=&-lang=en) Accessed 2/15/09

Calculations by **Children's Defense Fund**. Retrieved 1/20/09 from <http://www.childrensdefense.org/site/DocServer/state-of-americas-children-2008-report-early-childhood-c.pdf?docID=9092>

Ranking information extrapolated from [www.kidscount.org](http://www.kidscount.org)

#### Median annual income of employed parents with children

**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Updated January 2008. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, caution is advised when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Income data are collected for the 12 months prior to the survey and are adjusted to reflect income in December of the survey year. For example, respondents who received the survey in January 2000 reported income for January through December 1999. Respondents who received the survey in December 2000 reported income for December 1999 through November 2000. All of that income data was weighted to reflect December 2000 dollars.

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2006 American Community Survey.

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### Children living in extreme poverty



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Updated September 2008.

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, caution is advised when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, a 50% poverty threshold for a family of two adults and two children was \$8,731. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 18 (such as foster children).

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey.

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### Children living in families with income below the poverty threshold



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Updated September 2008. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, caution is advised when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, the poverty threshold for a family of two adults and two children was \$17,463. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 18 (such as foster children).

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey

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### Children with a household head who has a bachelor's degree



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2006 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, caution is advised when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2006 American Community Survey.

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## Child abuse and neglect

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*Children who have "some indication" or "verified" evidence of being abused or neglected* 

**Source:** Department of Children and Families, Child Abuse Annual Statistical Tables 2004-2005

As reported in Florida State's Plan for the Prevention of Child Abuse, Abandonment and Neglect: July 2005-June 2010 - Progress Report developed by The Florida Interprogram Task Force, June 2006

**National Source:** U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment 2006, retrieved online at <http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf>

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*Children who have "some indication" or "verified" evidence of being re-abused or neglected within 6 months of the first report* 

**Source:** Department of Children and Families, Child Abuse Annual Statistical Tables 2004-2005

As reported in Florida State's Plan for the Prevention of Child Abuse, Abandonment and Neglect: July 2005-June 2010 - Progress Report developed by The Florida Interprogram Task Force, June 2006

**National Source:** The **Child Welfare Outcomes 2003: Annual Report** is the sixth annual report in the series, which is published by the Children's Bureau. The report contains information by State on key child maltreatment indicators. As cited in U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment 2006, retrieved online at <http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf>

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*Child deaths from abuse or neglect* 

**Sources:** Florida Child Abuse Death Review Annual Report December 2008, available online at [http://www.childdeathreview.org/reports/FL\\_2008CADRrpt.pdf](http://www.childdeathreview.org/reports/FL_2008CADRrpt.pdf)

And National MCH Center for Child Death Review, available online at <http://www.childdeathreview.org/causesCAN.htm>

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## Foster care

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*Children in foster care who are placed in a permanent home within 12 months* 

**Source:** U.S. Department of Health and Human Services, Administration for Children and Families, Child Welfare Outcomes 2003: Achieving Permanency-Related Outcomes for Children in Foster Care. Available online at: <http://www.acf.hhs.gov/programs/cb/pubs/cwo03/chapters/chapterthree2003.htm>

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*Children awaiting adoptions* 

**Source:** U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Children's Bureau, Adoption and Foster Care Analysis and Reporting Systems (AFCARS). Available online at [http://www.acf.hhs.gov/programs/cb/stats\\_research/afcars/waiting2006.htm](http://www.acf.hhs.gov/programs/cb/stats_research/afcars/waiting2006.htm). Data represents FY 2006. There is no federal definition for a child waiting to be adopted. For analytical purposes, the definition used includes children who have a goal of adoption and/or whose parental rights have been terminated. It excludes children 16 years old and older, whose parental rights have been terminated and who have a goal of emancipation. The number of children waiting to be adopted reported by individual states will likely differ somewhat from the data presented here because state definitions vary according to state policies and practices.

**Note:** Florida's Department of Children and Families also post this data on the Florida Performs website ([www.floridaperforms.org](http://www.floridaperforms.org)). However, data there will differ from that on the AFCARS because the AFCARS data include children with a goal of adoption and/or termination of parental rights (TPR). These include children with a goal of adoption but both parents have not been TPR'd, with a goal of adoption and both parents are TPR'd, that are TPR'd but do not have an adoption goal yet, or in adoptive placements that have not been finalized. The DCF data represents children where both parents were TPR'd and have a goal of adoption and excludes children in adoptive placements since these children have been placed with an adoptive family.

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## Stable families

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### Single women giving birth



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Child Trends analysis of 1990-2004 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics. Data for Nevada for 1995 and 1996 only are from the Technical Notes in Ventura, S.J., Martin, J.A., Curtin S.C., Mathews T.J. (1998), Births: Final data for 1997,? National Vital Statistics Reports; Vol 47 no 18. Hyattsville, Maryland: National Center for Health Statistics.

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### Children whose mothers are emotionally healthy



**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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### Children without family supports necessary for identified developmental delays and special needs



**Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2005–2006. [Online] Rockville, Maryland: U.S. Department of Health and Human Services, 2008. Available: [www.nschdata.org](http://www.nschdata.org)

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### Children living in single parent households



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Updated September 2008

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, caution is advised when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation.

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey.

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### Teen mothers who have two or more children



**Source:** Annie E. Casey Foundation – [www.kidscount.org](http://www.kidscount.org)

Birth certificates that did not contain information on birth order were not included in this calculation. For more detail on all reporting issues refer to Definitions, Data Sources, and Reporting Issues for States at:

[http://www.kidscount.org/sld/rs\\_state\\_def.jsp](http://www.kidscount.org/sld/rs_state_def.jsp).

Child Trends analysis of 1990-2004 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics.

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### Divorce rate



**Source:** Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control [http://www.cdc.gov/nchs/data/nvss/divorce90\\_04.pdf](http://www.cdc.gov/nchs/data/nvss/divorce90_04.pdf)

Arrows designate desired direction of indicators

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**Religious participation**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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**Young children who frequently go on outings with family members**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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**Children who share meals with their families**



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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## Data Sources – Safe and Supportive Communities

Arrows designate desired direction of indicators

### Safety

#### Young children with injuries requiring medical attention

**Source:** **Child and Adolescent Health Measurement Initiative**. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

#### Children dying from injuries

**Source:** **Annie E. Casey Foundation** – [www.kidscount.org](http://www.kidscount.org)

Death Statistics: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Special tabulations provided by CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State.

2004 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2004 CD-Rom;

2003 data: Population Reference Bureau, analysis of data from the Multiple Causes of Death Public Use Files for 2003 CD-Rom.

2001 and 2002 data: Special tabulations provided by CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State, for the years 2001 and 2002.

2000 data: CDC, NCHS, Division of Vital Statistics, Deaths by 10-Year Age Groups: United States and Each State, 2000, accessed online at [www.cdc.gov/nchs/data/dvs/VS00100.TABLE23B\\_2000.pdf](http://www.cdc.gov/nchs/data/dvs/VS00100.TABLE23B_2000.pdf) (January 10, 2003).

1999 data: Deaths From 358 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1999.

1998 data: Deaths From 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1998.

1997 data: Deaths From 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, 1997.

1996 data: Special tabulations accessed online through CDC WONDER at <http://wonder.cdc.gov> (January 5, 1999).

1990 through 1995 data: Special tabulations by CDC, NCHS, Division of Vital Statistics, Deaths from 282 Selected Causes, by 5-Year Age Groups, Race and Sex: U.S. and Each State, for each year from 1990 through 1995.

Population Statistics: U.S. Census Bureau.

2003 data: State Characteristics Population Estimates File, accessed online at

[www.census.gov/popest/states/asrh/files/SC-EST2003-race6.csv](http://www.census.gov/popest/states/asrh/files/SC-EST2003-race6.csv) (May 13, 2005).

2001 and 2002 data: State Characteristics Population Estimates File, accessed online at [eire.census.gov/popest/data/states/files/STCH-6R.txt](http://eire.census.gov/popest/data/states/files/STCH-6R.txt) (November 21, 2003).

2000 data: Census 2000 Summary File 1 (SF 1) 100-Percent Data, Table P14.

1999 data: 1999 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://ire.census.gov/popest/data/states/files/STCH-icen1999.txt> (November 21, 2003).

1998 data: 1998 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://eire.census.gov/popest/data/states/files/STCH-icen1998.txt> (November 21, 2003).

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1996 data: 1996 Intercensal State and County Characteristics Population Estimates File, accessed online at <http://eire.census.gov/popest/data/states/files/STCH-icen1996.txt> (November 21, 2003).

1990 through 1995 data: Data from Population Division.

#### Number of days when air quality is good

**Source:** **Environmental Protection Agency** – [www.iaspub.epa.gov](http://www.iaspub.epa.gov)

EPA calculates the AQI for five major air pollutants regulated by the Clean Air Act: ground-level ozone, particle pollution (also known as particulate matter), carbon monoxide, sulfur dioxide, and nitrogen dioxide. For each of these pollutants, EPA has established national air quality standards to protect public health. Retrieved 2/14/09 from <http://www.epa.gov/air/data/monaqi.html?st~FL~Florida>

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## Housing and homelessness

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### Homeless children

**Source:** Department of Children and Families, Office on Homelessness, *Homeless conditions in Florida Annual Report FY 2007-2008*

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### Children in low-income households where housing costs exceeding 30% of income

**Source:** Annie E. Casey Foundation - [www.kidscount.org](http://www.kidscount.org)

Updated January 2008.

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2006 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2006 American Community Survey.

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### Condition of housing

**Source:** U.S. Census Bureau. [http://factfinder.census.gov/servlet/ADPTable?\\_bm=y&-geo\\_id=04000US12&-qr\\_name=ACS\\_2007\\_3YR\\_G00\\_DP3YR4&-context=adp&-ds\\_name=&-tree\\_id=3307&-\\_lang=en&-redoLog=false&-format=](http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US12&-qr_name=ACS_2007_3YR_G00_DP3YR4&-context=adp&-ds_name=&-tree_id=3307&-_lang=en&-redoLog=false&-format=)

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## Community resources and supports

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### Children participating in after-school programs

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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### Children in supportive neighborhoods

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 7/7/08 from [www.nschdata.org](http://www.nschdata.org)

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### Children in safe neighborhoods

**Source:** Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 1/5/09 from [www.nschdata.org](http://www.nschdata.org)

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## Civic engagement

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*Children who volunteer or do community service*



**Source:** **Child and Adolescent Health Measurement Initiative.** 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved 2/19/09 from [www.nschdata.org](http://www.nschdata.org)

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*Voter participation rate*



**Source:** **U.S. Census Bureau November 2006 -** <http://www.census.gov/population/www/socdemo/voting/cps2006.html>

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